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CALAOMS - Sponsored Senate Bill 501 Signed Into Law by Governor Jerry Brown

CALAOMS - Sponsored Senate Bill 501, which establish new provisions governing the use of deep sedation and general anesthesia for dental patients, was approved and signed into law by Governor Jerry Brown on September 29th, 2018

After nearly three years of intense stakeholder negotiations, legislative procedural drama, and national media coverage, the CALAOMS board of directors are pleased to announce that SB 501 (Glazer), the comprehensive piece of dental anesthesia legislation sponsored by CALAOMS, has passed both houses of the California state legislature and was signed into law by Governor Jerry Brown on September 29, 2018.

In 2016, Assembly Bill 2235 called for the Dental Board of California (DBC) to appoint a special committee to study the safety and effectiveness of office-based anesthesia on pediatric dental patients, to compare these to other states, and to offer recommendations based on their findings.

In January 2017, the special committee completed their comprehensive study and concluded that the anesthesia delivery

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in this issue:

CALAOMS also does business as:
* Oral & Facial Surgeons of California
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EDITORIAL

The Best Is Yet To Come

by Jeffrey A. Elo, DDS, MS, FACS

It's funny how we look at age as we get older. When you go up to a little child and ask, "How old are you?" they'll say, "I'm 3…*and a half*." I like how they put "*and a half*" in there; that's very important to them. Then they enter into their older years – their pre-teen years – maybe they're twelve or thirteen and you ask, "How old are you?" and they might say, "I'm *gonna be* sixteen…" You suspiciously follow-up, "Yeah, but how old are you *now*, though?" "Thirteen…but I'm *gonna be sixteen*." That's the 'big' age in their minds – sixteen. And then when you finally reach sixteen, adulthood arrives and it's very official. Then you *become* 21. "They *became* 21," we say; sort of like an official ceremony took place. Then things start going downhill. Have you ever noticed that? You *become* 21, but then you *turn* 30. And then you're *pushing* 40. "How old are they?" we ask. "They're *pushing* 40." Then you *reach* 50. And then you *make it* to 60. And then you build up so much speed, and BOOM, you *hit* 70. Well, then you hit your 80s and it becomes a *day-by-day* thing. You hit *Wednesday*. And as you advance in age from there, so do your goals. Then when you're in your 90s you hit *lunch*. And then maybe if you make it past 90 and you make it to 100 someone might ask you, "How old are you?" You say, "I'm 100…*and a half*" so you start over again. And so it goes.

2018 marks the 100th year celebration of AAOMS, and CALAOMS' roots (Southern California Society) date back 97 years. I believe it's safe to say that in California CALAOMS has *become* the go-to expert for anesthesia- and surgery-related issues in dentistry; we've *turned* into an active legislative association – sponsoring and helping craft language for bills that we firmly believe will enhance the delivery of safer dental-surgical-anesthetic care, and we continue to strive to *hit* our goal of *reaching* as many pre-teens, teens, and young people as possible with the important message to avoid misusing and abusing opioids.

It can be overwhelming and quite humbling to think about the many surgeons who have gone before us as pioneers into the great unknown over just these last 100 years. It can be just as overwhelming to think about where the next 100 years might lead us. CALAOMS needs each and every one of our members to stay motivated to positively lead in your communities. We all must remain engaged in each of the many issues affecting oral and maxillofacial surgery, such as specialty recognition (yes, the American Dental Association has done away with the word *specialist* and wants everyone to simply say that you all have just completed *advanced education* in oral surgery), opioid prescription drug misuse/abuse, and anesthesia in dentistry. Each of us must continue to promote and demonstrate our strong specialty status and leadership within our daily circles of influence. Our lawmakers have come to expect it, and our patients desperately need it.

The past 100 years have tested our mettle. The next 100 years promise to be no different. But I feel the best of CALAOMS is yet to come.

SB 501 CONTINUED FROM PAGE 1

system is safe, consistent with, and compares favorably with accepted practices across the country. The special committee made various recommendations that it felt could further improve anesthesia safety in the dental office setting. Most of these recommendations are already required for CALAOMS members in our standards of care.

CALAOMS was supportive of most of the DBC's recommendations regarding pediatric dental anesthesia, which prompted our sponsorship of SB 501 in 2017. CALAOMS supports making the use of any level of dental-related anesthesia as safe as possible without negatively impacting access to dental care.

Sponsored by California State Senator Steve Glazer, SB 501 revamps the current system of providing dental anesthesia to pediatric patients by mandating competent, well-trained personnel and updated safety technology. The bill also addresses the question of whether or not a mandated second licensed anesthesia provider would impede access to care by requiring a study to determine the appropriateness and the efficacy of a second provider. Other bills – which were defeated through the legislative process – would have mandated that a separate anesthesia provider be utilized on pediatric patients under the age of 7.

CALAOMS' desire has been to implement in statute the items that are known to improve patient safety, such as the mandatory use of capnography for deep sedation and general anesthesia. We also believed that by updating the definitions of the levels of anesthesia to meet those as defined by the American Society of Anesthesiologists, all anesthesia providers would be speaking the same language by using the same terms.

As Oral and Maxillofacial Surgeons, our mission is to assure the public of safe, comfortable, and optimal care that is affordable and accessible. We have accomplished this with the development and implementation of mandatory standards of practice, which are more robust than what is currently required by law in California.

SB 501 mandates the use of capnography to monitor patients under deep sedation/general anesthesia. This requirement is a significant step toward enhancing safety for patients of all ages. By requiring consistent higher levels of advanced life support training and the use of technology, in-office personnel will be adequately prepared to deal with an emergency. CALAOMS is confident that SB 501 puts statutes in place that will enhance safety in the practice of dentistry and oral and maxillofacial surgery.

Endorsed by the Dental Board of California, the provisions of SB 501 do not take effect until 2022 but will serve as a starting point to make pediatric dental anesthesia safer in the state.

Congratulations to the CALAOMS Board of Directors and all of our members on this hard-fought victory.

CALAOMS members arrive at the Capitol to meet with over a dozen legislators to discuss patient safety and anesthesia. (From left to right): Dr. Jeff Elo (CALAOMS President), Dr. Milan Jugan (CALAOMS Legislative Committee), Dr. Ed Balasanian (CALAOMS Legislative Committee), Dr. Monty Wilson (CALAOMS Past President), Dr. Alan Kaye (CALAOMS Immediate Past President), Dr. Shama Currimbhoy (CALAOMS Director), Mrs. Pamela Congdon (CALAOMS Executive Director), Dr. Larry Moore (CALAOMS President-Elect), Mr. Gary Cooper (CALAOMS Legislative Advocate), Dr. James Jensvold (CALAOMSPAC Chair), and Dr. Abhishek Mogre (CALAOMSPAC Committee Member).

PRESIDENT'S MESSAGE

by Jeffrey A. Elo, DDS, MS, FACS
CALAOMS President

Perseverance and passion drives effort

If your intake is less than your output, then your upkeep will be your downfall. – Greg Laurie

Socrates has been credited to say that *when debate has been lost, slander becomes the tool of the losers*. Such is how the three-year process toward the passage of Senate Bill (SB) 501 (Glazer) came about.

On September 29, 2018, Governor Jerry Brown signed into law SB 501, the bill sponsored by CALAOMS and carried through to the end by one fearless state legislator, Senator Steven Glazer (D-Orinda) and his diligent staff, who deserve our immense thanks and gratitude. The passage of this bill was the culmination of a three-year collaborative effort by *dozens* of California oral and maxillofacial surgeons and our extremely gifted legislative advocate, Mr. Gary Cooper, to whom we also offer our immense thanks and gratitude. To best appreciate the significance of this accomplishment, a brief review of the pertinent history is important.

A tragic event in 2015 led to many in the media throughout the state and across the country questioning whether oral and maxillofacial surgeons (aka, "dentists") should be allowed to administer anesthesia to patients undergoing dental/surgical procedures. Much negativity was aimed in our direction, and emotions ran extremely high. OMSs were left to fend for ourselves while organized dentistry remained relatively silent. Several "professionals" in various medical and dental disciplines sought to undermine the training of OMSs and refused to acknowledge our proven safety record. Outright lies were told at public legislative hearings by our detractors in efforts to change the delivery model of anesthesia in dentistry. Prominent CALAOMS members Dr. Len Tyko, Dr. A. Tom Indresano, and Dr. Larry Moore, along with Mr. Gary Cooper, bore the brunt of the initial negative emotional onslaught – attending these early hearings before studies and data were gathered to support our narrative.

It's important for CALAOMS members to understand that this process brought out the very best of our great association. CALAOMS president (*at the time*) Dr. Len Tyko formed an anesthesia task force consisting of several California OMSs – each with unique individual skill sets, and quick action was taken. With facts and data now in hand, a reasoned, measured, and delicate approach was taken to educate lawmakers and the public about who OMSs are, what training we undertake, and what we do daily in our practices.

Dozens of surgeons, including the succeeding CALAOMS president Dr. Alan Kaye, along with Dr. George Maranon, Dr. Mary Delsol, Dr. Monty Wilson, and Executive Director Pamela Congdon – *among many others* – made countless trips to the Capitol to meet with lawmakers and/or give interviews to media outlets. Other OMSs, including Dr. Jim Jensvold, Dr. Bob Hale, Dr. Ayleen Peterson, and Dr. Ned Nix, hosted lawmakers in their private practices – giving them first-hand glimpses into what we actually do and what our treatment environment looks like.

Simultaneously, Mr. Gary Cooper drew upon his extensive experience at the Capitol and became the master educator of lawmakers and their staffs, while Dr. Larry Moore spent literally hundreds of hours crafting and polishing language that would eventually become SB 501.

Please believe me when I tell you that I've only skimmed over some of the many, many events (and names of active and involved OMSs) over the past three years. The teamwork and selfless collaborative effort demonstrated by dozens of California OMSs will no doubt go down in CALAOMS records as some of our finest work in the history of the association.

CALAOMS is very proud that our bill, SB 501, was the only significant piece of legislation dealing with dental anesthesia that has been enacted after the very lengthy and emotional debate that occurred during the last three years. With that being said, please understand that the provisions of SB 501 do not take effect until January 2022.

While this bill is a very strong foundation on which to build, there will continue to be debate as to whether or not this legislation goes far enough. Therefore, I strongly recommend that all CALAOMS members stay involved – at all levels – to participate in the debate.

On behalf of a grateful CALAOMS Board of Directors, *thank you* to all of you for your support of our specialty and association in 2018.

AAOMS DISTRICT VI TRUSTEE REPORT

Mark Egbert, DDS, FACS
AAOMS District VI Trustee

Greetings from the District VI Trustee

Now well into my second year as your District VI Trustee, I am looking forward to continued service to our profession, the Western District OMSs, and the AAOMS. I was honored to have received a second nomination and election as your Trustee in Chicago this October at our 100th year Annual Meeting. This meeting turned out to be a landmark event with many special activities planned by our President, Dr. Brett Ferguson, and his wife, Dr. Rita Burnett, that OMSs were able to partake in and enjoy. It was a momentous occasion that deserved a grand celebration! I enjoyed seeing many of you there! There are two things to stay abreast of… The opioid issue continues to boil and roil. At the beginning of 2018, the AAOMS carried out its second annual membership survey on opioid prescribing practices. The survey showed that OMSs are taking the lead in being part of the solution to this problem. The survey results indicated 79 percent of respondents reported they reduced their opioid prescribing for third molar cases over the last two years, and 85 percent reported prescribing less than a three-day supply of opioids following third molar surgery. Clearly, the AAOMS membership has responded to the updated information about the addictive potential of well-known (or commonly prescribed) opioids. The AAOMS continues to advocate for our membership's attention to this very important, albeit occasionally political, public health issue. Additionally, the AAOMS continues to monitor legislative and rulemaking activities in states across the country. The AAOMS provides resources and background materials to support state OMS societies and advocacy groups in their efforts to fend off or modify actions that are overly restrictive and that will significantly affect our ability to provide excellent care for our patients. We are part of the solution, and we should not suffer undue, labor intensive, and overly intrusive regulatory requirements in the care of our patients.

The OMS anesthesia team model continues to be a focus of the AAOMS advocacy efforts as well. This is highly evident in the state of California and important because "as California goes, so does the rest of the nation." The legislative effort of CALAOMS in Sacramento has been effective and it stands out as a model for others to emulate when challenges arise in their own locales. CALAOMS succeeds due to its leadership, funding, and unification. Congratulations to Dr. Elo, Dr. Moore, Dr. Kaye, Dr. Maranon, Mr. Cooper, Mrs. Congdon, and to the whole of your leadership team! And thank you, Governor Brown, for signing SB 501 into law! I will continue to press the importance of support to the CALAOMS in this effort at the AAOMS BOT conference table.

Finally, on a personal note, I am extremely proud of the CALAOMS. You are a model organization that the entire organized OMS community should endeavor to emulate. I am equally proud to say that many of your Western Society colleague organizations are also robust; and together, the Western Society and our Sixth District are very strong.

Please read my Trustee Newsletter for more details about topical issues with your AAOMS. But for now, good fortune to you all.

Best Regards,

Mark A. Egbert, DDS, FACS
AAOMS District VI Trustee

TECHNICAL ARTICLES

Pharmacological Therapeutic Failures - Welcome to our Emerging Reality

by Peter Krakowiak, DMD, FRCD(C)

The Dental Board of California receives and investigates numerous complaint cases annually that frequently include therapeutic and pharmacological failures in the dental management of odontogenic infections. Patients often place the blame on the providers, albeit often there is significant negligence on the patient's part to get timely care, and the treatment course is often compounded by their lack of proper administration of the prescribed antibiotics. With that said, we are increasingly seeing our arsenal of pharmacological agents being decimated by a growing epidemic of resistant microorganisms, and the growing trend is now approaching truly alarming proportions. The WHO and CDC have identified antibiotic resistance as one of the greatest threats to our continued ability to provide definitive infectious disease (ID) care to the world's population in the coming two decades.

Each year over 2 million Americans are infected with antibiotic resistant bacteria. Close to 25,000 of these patients die from their infection. Our collective ability to deliver surgical care and support advanced medical care, including bioimplants, organ transplantation, cancer care, and any surgical management of immunocompromised patients hinges on the availability of effective antimicrobial agents. Pivotal changes in our management of infections, prophylactic medication applications, development of new agents, and fast species-specific point of care diagnostic capabilities and standardized use of adjunctive therapies must occur in the coming years or we will have a real progressive health care crisis globally.

Being at the bottom of the food chain or the top of the food pyramid, depending on what your personal view of our specialty is, we tend to be the ones who are referred most of the non-responding cases of odontogenic and head and neck infections. Most of these cases are patients who initially have been seen by a general dental provider and/or, to a lesser extent, family medicine/urgent care practices. That is not surprising based on the very limited education in micropathology, pharmacology, and management of infections that contemporary dental schools offer. Treating odontogenic infections is not covered by dental insurances. It's time-consuming and certainly not as smashingly captivating as gimmicky dental lasers, teeth-in-a-day courses, sleep appliances, Botox injections, or whatever new gizmo or pinhole procedure-of-the week is becoming in vogue. Hence, very few dentists have shown active and ongoing interest in continuing education in these areas. Just look at the scope of courses presented at large dental meetings. We also are faced with old dogma. Many providers, and even other dental-surgical specialists, still believe that you treat infections with a beta lactam antibiotic and let them get better before attempting any dental or surgical care. This is, of course, a very flawed paradigm in the face of our new era of antibiotic resistance and pharmacological therapy failures.

The contemporary training at a busy community or county facility, such as at all of our current California-based OMS residency programs, allows OMS residents ample opportunity to get involved in the management of some dramatic and severe life-threatening infections. In most of the private suburban practice settings, however, we rarely see the magnitude and complexity of infections that we see at community hospital facilities. This may change, as even in private outpatient-based OMS practices we will, in the near future, be facing an increasing number of cases of localized hard and soft tissue infections that are challenging. These patients will present with infections that are resistant to the most conservative surgical care and first-line empiric antibiotic therapy. The basic therapeutic approaches that were once quite predictable and definitive merely two decades ago will be such no more. Most serious infections in the past would routinely respond to short-term penicillin GK and/or clindamycin infusions especially if they were of the acute-onset variant. Similarly, early post-surgical infections that occurred within 4-6 weeks following surgical care would also improve with just an empiric single first-line oral antibiotic regimen. Well, it's amazing what 10-20 years can do to the microflora's virulence as demonstrated by alarming rates of therapeutic failures and resistant strains isolated in the head and neck region (Figure 1).

The rate of therapeutic failure with single empiric oral antibiotics is now passing the 50% benchmark in severe infections when considering single agent therapy using beta lactams, fluoroquinolones, and even macrolides. Penicillin and amoxicillin are no longer considered effective in the treatment of space-occupying odontogenic infections. Staph aureus is now virtually always resistant to most beta lactam antimicrobials. Even carbapenems, which just two decades ago were considered the "big guns" or "wonder drugs," are now becoming frequently ineffective with Enterobacteriaceae isolates, including Klebsiella. Recent published studies of isolates are truly alarming as our tried, tested, and true oral surgery empirical coverage choices are becoming dangerously inept and grossly ineffective. The classic penicillin regimen has been highly questionable for a while in the management of severe infections, especially in patients with immune dysfunction. Recent studies have shown that isolates from severe infections have species possessing resistance mechanisms to beta lactam antibiotics that top 60%. Even clavulanic acid formulations have repeatedly demonstrated therapeutic failures, and pathogens show significant degrees of resistance in culture and sensitivity testing.

Alpha- and beta-hemolytic Streptococci, Porphyromonas, and Prevotella – all common pathogens in mixed oral infections – have likely developed resistance from genetic transfer of resistance gene sequence from Strep pneumoniae species. This is likely sequela of over-prescribing for common cold symptoms and viral flu infections. Of course, the liability-driven risk management "knee-jerk" prophylaxis for dental procedures further compounds the problem and has effectively made these agents useless in the treatment of significant bacterial infections in the head and neck sites. Interestingly,

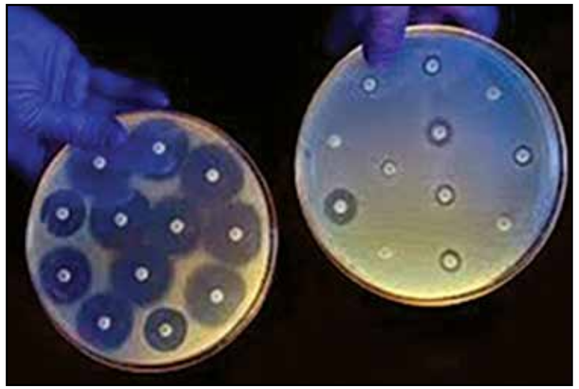


Figure 1. Antibiotic resistance

our recent southern California OMS provider study showed penicillin accounting for over 80% of the empiric prophylactic antibiotic choice in oral surgical practice. Augmentin was reported as the number one agent in the management of severe infections. It may be time to rethink these paradigms.

As per the other major players, the anaerobes, a large portion of these species now produce beta lactamase, rendering penicillin agents very ineffective. The natural solution was to include clindamycin in the management of these cases, as it has been historically shown to have great success with killing these obligate pathogens especially in the maxillofacial region. That is changing rapidly. Bacteroides fragilis is now increasingly resistant to clindamycin and so are an increasing number of gram-negative rods such as Bacteroides and Prevotella species. Unfortunately, the most recent studies with aerobic gram-positive cocci, such as the very adaptive Staph aureus isolates, have noted alarming rates of therapeutic failures when clindamycin is used as a singular agent, with the incidence of resistance hovering around 40%. Erythromycins, also popular with the dental providers, were even more affected with 44% resistance rates in Staph aureus isolates. Clindamycin is also quite ineffective in the treatment of aerobic gram-negative bacteria, such as Pseudomonas and Haemophilus influenzae species, which are endemic to panfacial sinuses and frequently associated head and neck infections. Interestingly, older generation antimicrobials – such as tetracycline – have a resistant microbe prevalence of only 10%. Metronidazole is also another seasoned agent that may be of renewed interest due to lower drug resistance profile findings. It is, however, having reduced susceptibility findings in Bacteroides cultures and Helicobacter pylori species.

Broad-spectrum agents such as erythromycin, methicillin, gentamycin, ceftazidime, vancomycin, levofloxacin, imipenem, and linezolid, as well as ceftriaxone and ceftaroline have now been added to the list of compromised antimicrobials with multiple resistant strains present in our North American patient populations. The most promising cationic peptide class of antibiotics, including Colistin – once thought to be the absolute silver bullet of antimicrobials, capable of conquering even the multi-drug resistant gram-negative bacteria – now has strains of these bacteria that are resistant to it. This medicine line is thought to be our last line of defense. No new agents are being currently developed or going through final trials to keep up with the resistance progression. Unfathomably, no new classes of antibiotics have been developed in almost 40 years. We are really in trouble if these conditions and trends continue. We will have almost no antimicrobials at our disposal with adequate efficacy to control the new and existing superbugs, and we will be facing this widespread global situation within just a few years.

Epidemiological research suggested that the more antibiotics are in use, the greater will be the resistance to them. No surprise there. Food industry and agricultural uses are compounding the bacterial exposure to antimicrobials on huge scales, as well. There is very little control or planning in these industries globally. In most species of bacteria, the resistance traits are transferred from specie to specie via plasmids. The horizontal gene transfer process allows the resistance to be passed not just from one single population of bacteria to another, but to other unrelated species, as well. This is the main mechanism of developing resistance, but bacteria can and do also spontaneously mutate. The overuse of antibiotics has compounded the problem more by selecting against the bacteria that were sensitive to the agents in favor of the resistant strains. In the USA, antibiotics are prescribed to many patients who are simply in no need of their antimicrobial activity. We are treating patients daily with antimicrobials because we have a literature-unsupported community standard of care as we all practice litigation-averse risk-based preventative care. Decades of following the arbitrary fear-based antibiotic prophylaxis regimen are also a big contributing factor for antimicrobial overuse.

Another unique factor is the presence of biofilm in oral infections, which is also a complicating factor in our specialty's efforts to treat infections in the oral cavity. The oral plaque biofilms have been shown to serve as a community support network for bacteria, which affords them a "sanctuary" status from the immune cells and traditional antimicrobial agents. Strategies to disrupt this mechanism must also be quickly developed and utilized appropriately as standardized adjunctive therapy methods.

It is becoming more important than ever to apply these new and old adjunctive surgical therapies to aid the pharmacological agents in cases where the pathogen vs. host imbalances are too great. All non-healing oral infection sites (Figure 2) need timely surgical exploration, debridement, and re-debridement, and in severe space-occupying infections surgical drainage (Figure 3) with copious mechanical/chemotherapeutic irrigation. The old adage, "Do not let the sun set on pus" is more valid today than it has ever been before. It is often heard from patients that the referring provider placed them on antibiotics to get the soft tissue swelling down so they could be better treated. Both patients and providers, it seems, are led into the false sense of security that contemporary antibiotic therapy alone will manage odontogenic infections and get the patients out of danger until definitive surgical correction can be contemplated at a more convenient and comfortable time. We also have seen referred cases that did not respond to routine empiric first-line antibiotics and have been switched either too early or too late to a second-line agent without any consideration for additional work-up and without prudent evidence-based consideration for that second-line agent's selection based on the culture and sensitivity findings. This approach is a shot-in-the-dark luxury that we cannot afford to use anymore. Our "best guess" second-line agents may soon be of very little value with what is occurring in the genome of the evolving and resistant microorganisms. To make things more difficult, there is also no quick portable bacterial isolate testing that is available to allow for immediate targeted antibiotic selection at most outpatient points of care. Two- to

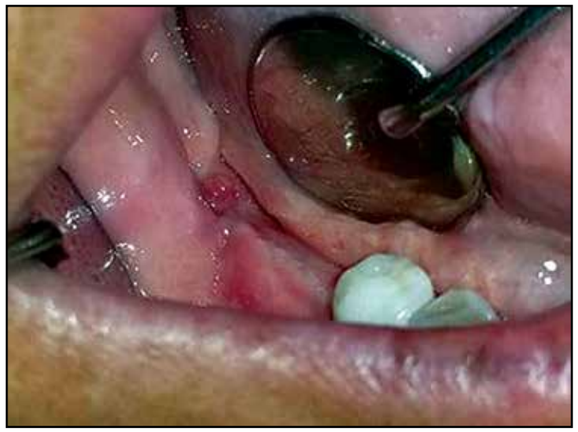


Figure 2. Sentinel fistulous tract from postextraction infection

Figure 3. Extraoral drainage of deep fascial space infection

three-day off-site microbiology lab delay is sometimes just too long. The more and more prevalent HMO- and network-based medical care model further compounds our ability to get proper and timely microbiology assays, as all things must be submitted through primary care and in-network providers with whom very few OMS specialists are in-network with.

Irrespective of the difficulties, however, it is now quite prudent to consider procuring cultures (Figure 4) of every space-occupying abscess or non-healing surgical site in the higher-risk patients especially if the response to first-line antibiotics is clinically not adequate at the 48-hour mark. Often, the difficulty in a typical OMS private practice setting lies in procuring quality aerobic and anaerobic diagnostic samples, and getting them timely and securely delivered to and processed at microbiological facilities where accurate testing and analysis can be quickly completed and rapidly communicated back to us. A recent SCOA member study of southern California surgeons found that only 36% of transoral incision and drainages were being sampled for microbiological analysis. Extraoral drainages were, however, followed by culture acquisition in over 90% of cases. This level of vigilance must continue despite our difficulties associated with out-of-hospital points-of-care settings. In addition, the wound culture is now more important not just to identify the species based on a gram stain, but also to actually get the sensitivity subset of culture and sensitivity data. In the past, our antibiotic choice was usually made based on the gram stain findings, but that is no longer adequate to select the appropriate agent. Susceptibility and sensitivity testing takes additional precious time. Modern bacterial DNA- and RNA-based testing is increasingly available and provides a more acute frame of analysis. Soon, it is hoped that existing diagnostic technologies such as PCR, fluorescence-in-situ, and mass spectrometry can be combined or enhanced with new ways to provide objective real-time diagnosis of bacteria in fluids that may include droplet microfluidic and biosensor platforms. These novel methods may have their application in our point-of-care setting.

In addition to culture and sensitivity testing, any infections that may involve the hard tissues should be evaluated for potential spread into marrow spaces and development of acute suppurative or non-suppurative osteomyelitis. This can often occur despite the removal of the infected teeth and initial debridement of the sites. The sites with subclinical infections of marrow spaces may initially show clinical improvement with extraction and first-line oral antibiotics, but can later develop into latent infections that rebound in 2-4 weeks following cessation of the oral antimicrobial therapy. Therefore, it is prudent to see most, if not all, exodontia patients for a clinical follow-up 1-3 weeks after extraction, especially if a medullary space infection was suspected or noted at the time of surgery. CBCT imaging can be very helpful to see almost "real-time" acute osteolytic changes in these rapidly progressing infections even on a weekly follow-up basis. Panoramic films do not possess the ability to enhance the visualization of acute bone breakdown (Figure 5) to the extent and sensitivity afforded by CBCT (Figure 6). Hyperbaric oxygen (HBO) therapy should also be considered in the most severe and resistant cases, but its potential side effects, cost, and accessibility can be taxing. In some complex ICU cases, immunoglobulins and corticosteroids may also be considered in critically ill patients based on ID and intensive care consultant's recommendations.

Figure 4. Culture and biopsy

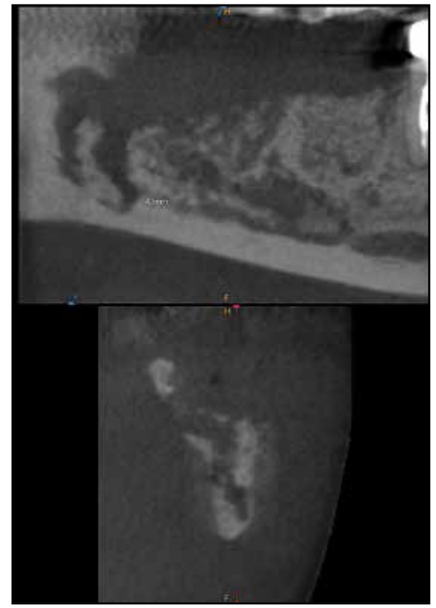


Figure 5. Dramatic infection-related osteolytic changes noted on CBCT

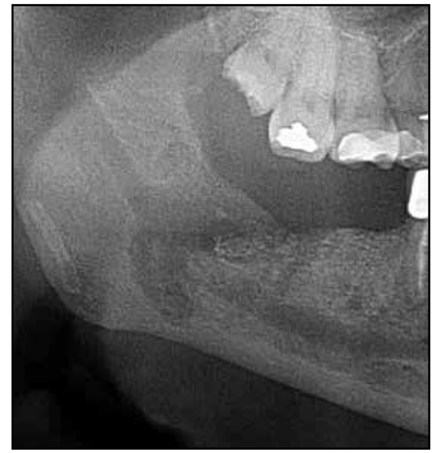


Figure 6. Panoramic radiograph of patient in Figure 5 demonstrating some osteolysis

The classic laboratory work-up for refractory and severe infections must include standard laboratory serum markers for immune function (including baseline CBC with differential) and comprehensive metabolite levels. Testing for C-reactive protein (CRP) and Procalcitonin (PCT) may function as adjuncts to evaluation of early host responses to antibiotic therapy, but they have limited value in determining long-term status and outcomes. More likely, careful and detailed serial clinical and radiographic examinations are paramount to accurately gauge the progress and resolution of the infection.

The other critical component of our collaborative care for infections includes the involvement of a local ID specialist early in the course of our treatment of patients who are deemed to be at higher risk of antimicrobial resistance and/or demonstrate evidence of initial therapy failure. The ID specialists are invaluable in getting the patients to receive prompt antimicrobial infusion therapy. Rapid-onset and duration-appropriate infusion schedules with either empirically chosen broad spectrum or culture- and sensitivity-based second-line agents, coupled with gram-negative and anaerobic-spectrum oral antibiotics are common recommendations of the contemporary ID experts. The two routes of systemic administration for medications that are delivered consequently and/or subsequently have much better success rates than the oral antibiotics alone. This is due to the obvious reasons of improved compliance and absorption with infusion over GI tract-based absorption. This method of delivery results in more consistent serum therapeutic levels and tissue penetration. This then means a much better chance of developing levels of antimicrobials above the minimum inhibitory concentration (MIC) needed to eradicate the targeted species. Peripherally inserted central catheters (PICC) lines (Figure 7) can be placed and maintained on an outpatient basis and are covered under most medical insurance plans. Most patients will receive 4-6 weeks of infusions and oral medications. In our experience, the local ID folks frequently will choose either Invanz or Rocephin coupled with oral metronidazole or tetracycline as empiric choices for second-line agents. However, vancomycin and Levaquin are also reasonable choices in the absence of systemic contraindications to those other more caustic agents. Of course, all these second-line empiric choices will need to be reviewed for appropriateness upon receiving the full culture and sensitivity findings and adjusted if needed. Good communication with the ID specialists with frequent exchange of diagnostic and clinical findings is very important in titrating the medications and their courses. Adjustments based on patient responses and tolerances are frequently made upon joint discussions and input from both specialists.

In conclusion, we are certainly entering a new era in medicine and surgery that will involve us facing a greater number of serious challenges in the treatment of bacterial infections. Oral and maxillofacial surgeons, like many other surgeons, will be increasingly treating complicated head and neck infections that may not respond to most empiric antimicrobial therapy as we have come to know it in the past 65 years. There is a looming crisis of massive poly-specie antibiotic resistance that will be compounded by the current lack of new or forthcoming antimicrobials, and the absence of cost effective, accurate, and rapid point-of-care testing of the causative infectious agents. Collaborative care with ID specialists, coupled with prompt and aggressive surgical treatments, as well as vigilant clinical monitoring, will be required for us to have any chance of arriving at optimal therapy outcomes. A massive rapid global change in policies on the multi-sector use of antimicrobials is critical, and without implementation of these global pharmaceutical initiatives most of our current antibiotic armamentarium will soon cease to be of any significant therapeutic value.

Figure 7. PICC line set-up

Steven B. Kupferman, DMD, MD, FACS

A Game Changer

Every ten years or so, something comes along and changes the way we practice – a game changer. I have thought about this ever since I was a resident. I can vividly recall the first time I understood this concept. I was an OMS intern in the old UCLA hospital. At the time, our program had us do our anesthesia rotation for 4 months of the intern year. That had its pluses and minuses, but that's for another article. I had just had my first two kids – twins. They are 16½ now. Time flies. But I was two days into my anesthesia rotation with two 2-month old babies at home. I knew just how important anesthesia was to my training, so I hired a nurse to help my wife with the kids.

I was getting ready to start my cases for the day and the anesthesia attending told me to get an LMA (laryngeal mask airway) from the stock room. Back then they used non-disposable LMAs. They were skin-colored and looked peculiar. I brought it back to the operating room and learned how to place it for the first time.

My anesthesia attending – a burly academician who looked as though he never changed out of his scrubs – sat me down and explained to me how lucky I was to be practicing in a time when the LMA was available. He told me how it was a game changer in the field of anesthesia. And indeed it was.

When the LMA was made available in the U.S. in the late 1980s after Dr. Brain had patented it in the U.K., its use soared to over 1 million (uses) within a short couple of years. Its life-saving use as an emergency airway earned its way next to my laryngoscope on my anesthesia table at all times, and its minimally-invasive comfort for difficult airways allows me to use it regularly during difficult-airway third molar cases. I tell the residents who rotate through my office, "There was once a time where we only had endotracheal tubes."

But I digress about the LMA. Today's game changer is liposomal bupivacaine. If you have not used it yet, you are missing out. It is truly the LMA of 2018. I don't think I need to get into much of the pharmacology of it, because we all know how bupivacaine works. Liposomal bupivacaine, sold as Exparel® by Pacira Pharmaceuticals, has been in use since 2012. I began to use it about 18 months ago. I no longer prescribe narcotics for my third molar patients. Not oxycodone, not hydrocodone, not codeine; no narcotics at all. All I use is ibuprofen and acetaminophen. It's been a true game changer.

Honestly, I was a doubter at first. When the drug rep came and gave me a few samples, my gut reaction was, "I've had no issues with post-op pain." But then when I tried it on a few patients who were in rehab who had difficult impactions and did not want narcotics, I was surprised when I saw them for their post-operative visits. None of them reported significant pain.

Then I began to use it on my routine cases and they all came back asking me why I was prescribing oxycodone. Some of them didn't even take their NSAIDS. Slowly, I began to realize that the Exparel® was indeed a game changer. I completely stopped prescribing narcotics before the summer and I have decided to give Exparel® to all of my third molar patients. It won't be long before I tell the residents, "There was once a time where we prescribed narcotics to third molar patients."

CALAOMS "2019 January Meeting"
Palace Hotel, San Francisco
January 19 & 20, 2019

Saturday Presenter:
Michael Block, DMD

Sunday Presenters:
Nor-Cal OMS Residents

CALAOMS "19th Annual Meeting & Anesthesia Update"
The Island Hotel, Newport Beach
May 4 & 5, 2019

Back by Popular Demand

Saturday Presenter:
Michael K. Rollert, DDS

Sunday Presenters:
So-Cal OMS Residents

OPIOID CRISIS

Solomon Poyourow, DDS, MD, MPH

Two Decades Into the Opioid Crisis in America

The opioid crisis in the United States began long before it was declared a public health emergency in 2017 by the Department of Health and Human Services. It can be traced back to the early 1990s. At that time, two key forces emerged that directly influenced opioid prescribing: one inadvertently, the other overtly. The first was the concept that pain was under-assessed and undertreated in medicine. In 1990, the president of the American Pain Society, Dr. Mitchell Max, wrote an article in the Annals of Internal Medicine criticizing deficiencies in pain management. Dr. Max referenced a methodologically limited New England Journal of Medicine article that stated, "Therapeutic use of opiate analgesics rarely results in addiction."[1] A year later, the American Pain Society published standards for pain relief, which recommended measuring, recording, and treating pain whenever vital signs were taken.

The Veterans Health Administration branded pain as the fifth vital sign in the mid 1990s. Assembly Bill 791 was passed by the California legislature in 1999, which mandated the inclusion of pain when assessing vital signs by all licensed health care facilities. The federal government followed suit in 2000 when Congress proclaimed 2001-11 the Decade of Pain Control and Research (H.R. 3244, title VI, Section 1603).

In 2001, the Joint Commission established standards for pain assessment and management, which stated a patient's self-reporting of pain was to be accepted and respected, and reinforced the idea of pain as the fifth vital sign.[2] Interestingly, the Joint Commission quickly recognized the problem with labeling pain as a vital sign and removed this verbiage from all of its literature by 2004, and the requirement of assessing pain in all patients was eliminated in 2009.[3]

The aforementioned regulatory changes demonstrated a strong push toward identifying and eradicating pain. The American Medical Association's Council on Scientific Affairs (CSA) urged caution, questioning whether pain relief was being treated as a patient's rights issue, and noted the potential for overreliance on opioids. In hindsight, these were serious concerns.

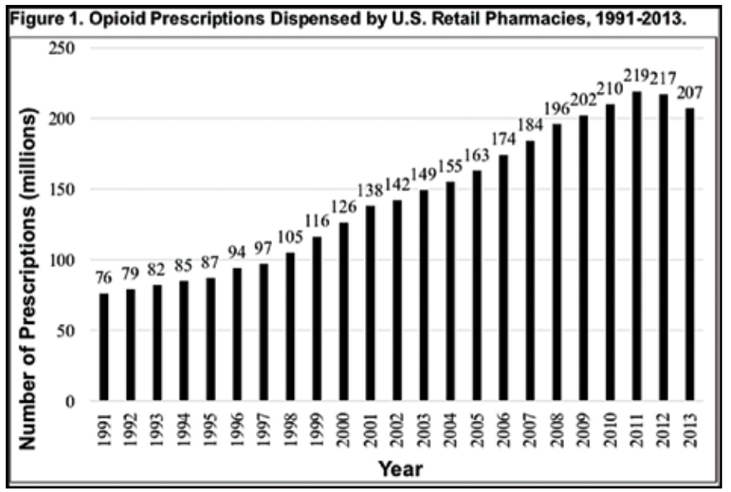
During this time, medicine was being squeezed for time and efficiency. Office appointments became shorter and doctors were required to see more patients in a day. Greater emphasis was placed on patient satisfaction, sometimes with insurance reimbursement hinging on it. Doctors experienced significant pressure to quickly and effectively manage their patients' pain.

Despite a paradigm shift in the approach to pain management, the risks of opioids were not similarly embraced. To this day there is a lack of education in medical and dental schools about pain management, let alone substance abuse.

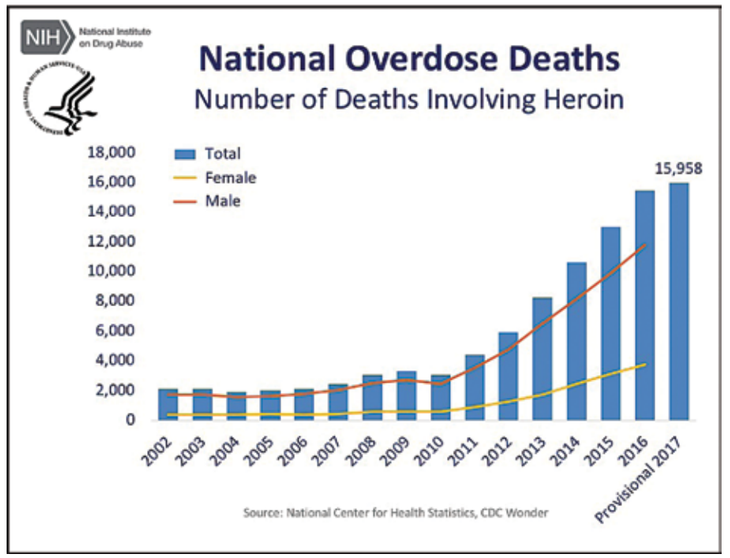
The second important variable in the increase of opioid prescriptions was the pharmaceutical industry. In 1995, the FDA approved OxyContin®, a sustained-release form of oxycodone. Manufactured by Purdue Pharma, OxyContin® was believed to have reduced abuse potential, and the FDA approved a product label stating that addiction was "very rare." Purdue Pharma aggressively marketed OxyContin® to doctors and falsely advised there was little concern for addiction.[4]

It quickly became clear that OxyContin® possessed extreme addictive potential and the FDA made a series of label changes and fined Purdue Pharma $634 million for false advertising.[5] Despite the label change on OxyContin®, the message had already been widely disseminated that long-acting opioids were less addictive.

From 1991 to 2011, opioid prescriptions nearly tripled. In the mid-2000s, alarms were beginning to sound about the risks of opioids. However, like a large ship, medical dogma does not change course rapidly. It was not until 2011 that opioid prescriptions leveled off and began declining in 2012.[6]



The downtrend in opioid prescriptions was accompanied by a rapid increase in heroin deaths. As doctors tightened prescribing practices, opiates were harder and more expensive to acquire. Heroin was cheaper, more easily purchased, and extremely potent.[7] Deaths from heroin increased nearly threefold from 2002 to 2013. 80% of heroin users stated they abused prescription opioids before using heroin.[6]



What is the oral and maxillofacial surgeon's role in prescription opioid abuse? 66% of opioid prescriptions in dentistry are given after dental surgery. The other 33% are given after restorative dentistry. Oral and maxillofacial surgeons perform thousands of surgeries per year and write a nearly equal number of prescriptions. Many of us prescribe opioids for a large number of our patients; especially following impacted third molar extractions.

Teenage third molar patients belong to a susceptible cohort. Brain development is ongoing. Drug use and high-risk behavior is not uncommon. It is worth considering whether or not to use opiates as well as the quantity of pills prescribed. Risk of dependence is known to increase with greater duration of treatment. It has also been shown that over 50% of opioids prescribed after dental surgeries go unused. A portion of patients can then use these pills recreationally or give them to other individuals for nonmedical use.[8]

Prescribing practices are frequently based on historical norms rather than available research. There is research to show good pain relief can be obtained with ibuprofen and acetaminophen compared to hydrocodone. The University of Michigan Department of General Surgery examined its own historical norms and found that doctors routinely prescribed 45 opioid pills for gallbladder patients. They implemented a new guideline where gallbladder patients would be given 15 opioid pills instead of 45. The patients increased their use of ibuprofen and acetaminophen and decreased their use of opioids. Patients reported no increase in pain.[9]

Every day we have the opportunity to refine and improve our surgical practices. Prescribing practices are an easy area to evaluate and try new methods. There are numerous guidelines available by the ADA, AMA, and every state medical board pertaining to regimens for pain management. As the practice of dentistry and medicine is personal to each of us, we will individually decide if, when, and how we wish to modify our opioid prescribing practices. It is naïve to think that individually each of us is immune from impacting the number of opioid abuse events.

Anecdotally, I began to pay attention to my own practice over the past several years, asking third molar patients if they used the Norco® I had prescribed. I noticed a trend towards minimal use. Frequently, patients used none or only one of the

pills, favoring ibuprofen 600mg four times daily. I began to reduce the number of opioids I prescribed and now encourage most of my third molar patients to use a non-opioid pain regimen. I recommend ibuprofen 600mg QID and acetaminophen 500-1000mg TID as needed for severe pain.

I look at patients in terms of risk assessment. Patients with concurrent depression, anxiety, alcohol abuse, or on psychotropic medications are at higher risk of opioid abuse. Surgical morbidity is also an important consideration. A bony impaction in a 40-year old patient may warrant adjunctive opioids compared to a routine set of wisdom teeth in a 15-year old.

I believe in the benefits of bupivacaine for long-lasting anesthesia on day 1, and the advantages of low-dose ketamine for decreasing the 'wind up' of pain receptors. I spend 30 seconds during the consultation discussing pain medication options and ask the patient and parent if he or she is comfortable trying a non-opiate approach.

It can be uncomfortable to change the way we practice and 'rock our boat,' so-to-speak. In the end, our practices are an evolution towards improved patient outcomes, greater surgeon satisfaction, and decreased risk. Changing the way we prescribe opioids is quite possibly the easiest and least risky aspect of practice to alter. I would encourage everyone to give it a try.

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Alan Kaye, DDS
CALAOMS Immediate Past President

CALAOMS Opioid Project Needs Member Participation for Success

AAOMS Immediate Past President Brett L. Ferguson, DDS, FACS (Kansas City, MO) recently announced that the United States government has determined that dentists, especially oral and maxillofacial surgeons, have been contributing to the opioid epidemic in America. Needless to say, Dr. Ferguson considered that an outrageous statement.

In an effort to stem the tide of opioid misuse and abuse, CALAOMS is combating the epidemic by educating high school students and first responders throughout the state. Prescription-drug misuse is one of the fastest growing drug problems in our nation with nearly 5,000 young adults aged 15 to 24 dying from drug-related overdose in 2015 alone – half of which were the result of opioids according to the U.S. Department of Health and Human Services.

In 2017, during my CALAOMS presidency, I brought a proposal to the board that we should take a proactive stance against the government's narrative and carry a message to all California high school students about who we – as oral and maxillofacial surgeons – are and how we are seriously responding to the opioid epidemic. As surgeons, and more to the point – as surgeons being accused of being part of the problem – we need to bring a positive and educational message to all high school-aged students that OMSs can and do offer very effective non-opioid pain medications for post-operative discomfort. That doesn't mean we won't prescribe an opioid when absolutely necessary, but we do not view them as first-line or solo medications for the treatment of post-operative discomfort.

Explaining to high school students who CALAOMS is and what OMSs are

Our current CALAOMS President, Dr. Jeff Elo, embraced the importance of this message, and together we composed a short and powerfully educational PowerPoint presentation for students that contains important statistical information, as well as the consequences of opioid misuse and abuse.

Over recent months, I have delivered this (roughly) 20-minute presentation to several groups and organizations, including the Beverly Hills Fire Department, high school students in Health class at Marina High School (Huntington Beach), the Beverly Hills Rotary Club, and high school students in Health class at Beverly Hills High School. I was elated at each audience's response, and am very pleased to tell you that the presentation and information was very well received.

This past July, CALAOMS issued a statewide press release announcing that we had already begun this education effort. The press release was then picked up nationally because of its timely importance and demonstration of leadership.

As members of our communities and as individual surgeons who are part of a bigger collective – CALAOMS – we now need to carry this message statewide and hopefully nationwide to let young people know that oral and maxillofacial surgeons care about them and their well-being.

This is where all of you, our members, come into play. What began as a pilot project to determine how this message would be received has blossomed into an explosion of excitement in my community, and I know it can in yours. But it will take all of us participating to get this message out. As busy as we all are with our practices and life events, this is a message that strongly demands our in-person face-time. Working together as one body, we can blanket the state's high schools with this life-saving information.

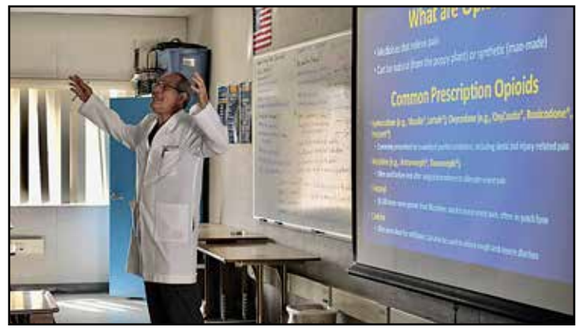
Reviewing facts about opioids with high school students

By delivering this presentation in person, you will be helping students on their journey to understand the dangers of opioid misuse and abuse, and at the same time will be teaching them about who we (OMSs) are, what we do, and why we care. Our state legislature is taking notice and will applaud both our association and each of you for the proactive nature of this program.

This is our moment to step up to the plate and really do something at the grassroots level that will deliver incalculable goodwill and benefits. As surgeons who can prescribe opioids for post-surgical care, we have an obligation to help people understand the potential for misuse and dependency so they are better prepared for pain management after a procedure. They need to be made aware of good alternative pain relief medications.

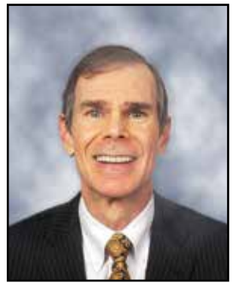
This PowerPoint presentation will soon be posted to the CALAOMS.org website for free download and use by our membership. We are also looking at the possibility of mailing out a thumb drive with the presentation on it to our members. So please, when you receive the presentation, review it and think about whom in your community would benefit from hearing its message; but most importantly, immediately get in contact with your local high school(s). We will provide you letters of introduction to facilitate the schools' acceptance of this project.

During the January 2019 CALAOMS meeting, those in attendance will have an opportunity to see and hear a fifteen-minute presentation about this ongoing effort. This is our moment; seize it!



Passionately describing the dangers of abusing opioids.

MEANING IN ETHICS



Retrieval of Meaning in Clinical Ethics

by Richard Boudreau, MA, MBA, DDS, MD, JD, PHD

In the literary sense, retrieving meaning can present a challenging endeavor. For example, French literary theoretician and avant-gardist Alain Robbe-Grillet's phenomenological Heideggerian style is showcased in his novels and films which are filled with figurative imagery composed of fractured labyrinthine plots, stylistic free associations, repetitive symbolic descriptions, and parallel narratives; ultimately, rather profound psychoanalytic meanings are retrieved from his *nouveau roman* approach. Retrieving meaning in the existentially charged realm of clinical ethics and psychological moral reflection does not begin with the application of normative principles, nor can it be sustained by an attitude of resignation toward the pursuit of the good; it begins, rather, with a free and open confrontation with the meaning of the experiences we face.

Experience is not merely an objectively described empirical entity, though empirical analysis might have an important part in it. Already at the level of its etymological meaning, experience entails a reference to subjective intermediation: experience speaks of the predicament of the passing or living through a situation of crisis, and of the personal growth effected by such existential challenge. We are summoned by *logos* 'meaning' a la Viktor Frankl (*Man's Search for Meaning)* in an integral fashion, and the radicalness of such call can only be answered by a synthetic act of reciprocity, a response to an intrinsic source of value to borrow from the phenomenological tradition, which we confront with that most intimate and all-encompassing *conscience-self* we identify with, i.e. the notion of thought, feeling, and volition.

Some clinicians posit that questions of meaning can only have a secondary importance when difficult decisions need to be made in the so-called 'here and now' of concrete clinical challenges. In this perspective, steadily intently 'gazing into the meaning of things' can be, at best, an interesting theoretical exercise, and, at worst, possibly nothing more than a useless distraction utterly failing to address the call of the moment. Indeed, it does make good sense to put meaning in a secondary position and give priority, instead, to one's reality of the moment, e.g. addressing the immediacy of patient survival, or unraveling a complex bioethical case involving a mentally incapacitated unbefriended patient.

At the same time, when the larger world of wellness, suffering, being struck with affliction, being sick, dying and so on, does not find its proper way into the meaning of the decision-making process in clinical ethics; when, instead, clinical ethics relies, in a rather mechanical fashion, on an algorithmic approach to problem-solving with its plethora of predefined categories, e.g. advance directives, consent forms, values inventory, etc., we end up creating obstacles to good habits of moral reasoning hindering the disclosure of moral meaning while, quite paradoxically, producing the "right" answer for the quandary at stake. Bioethical controversies, by their nature, can be emotionally heated issues frustrated by complexity not solvable by algorithmic metrics, e.g. physician assisted suicide, abortion, A.I., and capital punishment.

Attending to the moral meaning of concrete situations entails recognizing that formal modes of logical argumentation are only derivative functions of the moral language. Prudential or practical meaning unfold as dimensions of a more original form of mindfulness, a synthetic act of discernment, which includes elements of detecting, sensing, sifting, discriminating, comparing, connecting, and, ultimately, deciding. It is a necessary albeit complex layered and laborious process.

Philosopher Thomas V. Morris (*Marking Sense of It All: Pascal and the Meaning of Life*) bases extracting the meaning and purpose of life based on Pascal's philosophy. Blaise Pascal was a 17th century French physicist, mathematician, and philosopher who suggested distinguishing between the *esprit de finesse* and *esprit de geometric*. Hence, two kinds of probing minds are suggested by Pascal: a deeply and rapidly penetrating mind concerned with the consequences of principles is the so-called 'intuitive mind' (*esprit de finesse*), and a mind that is capable of grasping a great number of principles without confusing them is the 'geometric mind' (*esprit de geometrie*). The first model has strength and rightness of mind and the second considers breath of mind. They are not mutually exclusive and one can co-exist with the other; that is, the mind can be strong and narrow and also broad and weak.

Retrieval of meaning also requires shared experiences, thus, societal participation and communication are relevant to the process. I share and underscore a germane view adroitly stated by sociologist, journalist, and urbanist William Hollingsworth Whyte: "The great enemy of communication, we find, is the illusion of it. We have talked enough; but we have not listened. And by not listening we have failed to concede the immense complexity of our society, and thus the great gaps between ourselves and those with whom we seek understanding."

Ethicist and phenomenologist Richard M. Zaner ("*Experience and Moral life: A Phenomenological Approach to Bioethics*") perspicaciously expresses retrieval of meaning when analogizing such phenomenological probing with the work of a detective: "One must deliberately be alert to the multiple ways in which participants interrelate and variously experience and interpret one another, and with that relationship, the relationship itself. Even a brief moment reveals a number of interrelated voices, each with its own emotional, volitional, valuational, and cognitive tonality…The ethicist's involvement is thus a work of circumstantial understanding."

California CareForce Sacramento Clinic 2018

California CareForce is proud to announce another successful Sacramento Clinic! With the help of 1,116 volunteers over the course of three days, we served 1,168 patients, providing more than $700,000 worth of dental, vision and medical services!

In Dental alone, 933 patients were registered throughout the three-day clinic. Over half a million dollars worth of dental services were provided with the help of hygienists, assistants, dentists and 23 OMSs!

CALAOMS members from all over California took part in making this clinic a success by sponsoring dental chairs and volunteering at the clinic (*bonus points for those who did both!*).

Here's how one CALAOMS member described his experience volunteering at the 2018 Sacramento Clinic. *"Best philanthropic experience of my life. They kept me busy the whole time which is a win-win for us surgeons and patients. Our course, our time and skill is valuable, and this event utilized it to the max."*

Getting involved is easy and rewarding! Sponsor a dental chair or volunteer at the next CCF clinic in the Coachella Valley, March 22-24, 2019.

Your support – whether it be simply spreading the word, or donating your time or money – is what keeps our clinics running. Thank you for making California communities happier and healthier by sharing your talents with those less fortunate. Not only do patients walk away from the clinic with bigger smiles, but our participating senior dental students walk away with bigger dreams and better relationships with OMSs. Thank you for being a part of a Force that cares.

For more information on how to give back and get involved, please contact California CareForce Volunteer & Outreach Coordinator, Emerald Carroll at emerald@californiacareforce.org

Aerial view of the Dental Floor at the Sacramento 2018 California CareForce clinic held at Cal Expo, September 21-23, 2018.

A few CALAOMS members volunteering at the clinic (left to right: Dr. Roger Kingston, Dr. Greg Hailey, Dr. Kenneth Wong and Dr. Samer Albadawi)

LEGISLATIVE UPDATE

by Gary Cooper
Legislative Advocate, CALAOMS

Fall 2018 Update

The 2017-18 legislative session ended on a very positive note for CALAOMS on Saturday, September 29, with Governor Brown's approval of **Senate Bill 501** by Senator Steve Glazer. In February 2017, CALAOMS sponsored the introduction of SB 501 as a means to practically address the very emotional issue of the inherent risks of dental anesthesia, specifically as it relates to pediatric patients. With the tragic dental anesthesia-related death in 2015 of six-year old Caleb Sears, CALAOMS was thrust into the center of a debate about the efficacy and safety of the so-called operator/anesthetist model of dental anesthesia. While years of statistics corroborate the fact that oral and maxillofacial surgeons have an impeccable safety record providing in-office anesthesia, when a rare tragedy does occur, that safety record immediately becomes suspect and fodder for legislative reform. Whether that reform is really necessary is unfortunately not always considered.

The emotional legislative approach to reforming dental anesthesia was to require a second general anesthesia permit holder to participate in each procedure involving a child less than seven years of age, no matter the cost and no matter the negative impact on access to dental and oral surgical care. CALAOMS took a different approach. CALAOMS, with the unwavering support of Senator Steve Glazer, embarked on a two-year collaborative effort to rewrite the Dental Practice Act pertaining to dental anesthesia. The goal was to make dental anesthesia at all levels as safe as possible, without negatively impacting access to care due to cost or lack of providers. By mandating the personnel involved in the procedures be exceedingly and certifiably well-trained, prepared, and experienced, in-office dental anesthesia in California should be much safer. In addition, SB 501 mandates the use of capnography for patients undergoing deep sedation or general anesthesia. This requirement, in and of itself, is a major step to increasing anesthesia safety in California dental offices.

Finally, a study will be required to be completed to determine what effect on access to dental care would occur if a second general anesthesia permit holder were to be mandated. While the provisions of SB 501 do not take effect until January 2022, this legislation is an excellent beginning to achieving the ultimate goal – **PATIENT SAFETY**.

OPIOID LEGISLATION

The opioid crisis has been on the agendas of several legislators during the 2017-18 session:

SB 1109 (Bates) This bill allows the Dental Board of California to mandate a continuing education course on risks of addiction associated with Schedule II drugs as a condition of license renewal.

AB 2789 (Wood) This bill requires a health care practitioner authorized to issue prescriptions to be capable of electronically prescribing by January 2022. All prescriptions for controlled substances must be electronically transmitted by January 2022.

The new legislative session reconvenes on December 1, 2018. With the new session will arrive newly elected legislators, and in January 2019 a newly elected governor. As happens with every new session and every new administration, new faces have "new and improved solutions" to "old problems." I ask all CALAOMS members to stay vigilant and involved in the legislative process. Your participation truly does have an impact as we have already demonstrated.

CALIFORNIA ASSOCIATION OF ORAL & MAXILLOFACIAL SURGEONS UPCOMING CE EVENTS

2019 Meetings

- **2019 January Meeting** - Palace Hotel, San Francisco — January 19 – 20
- **Spring ACLS** - Southern California — TBD
- **Spring ACLS** - Solano Community College — TBD
- **OMSA Spring 2019** - Hilton Hotel, Sacramento — April 13 – 14
- **19th Annual Meeting** - Island Hotel, Newport Beach — May 4 – 5
- **OMSA Summer 2019** - Southern California — TBD
- **OMSA Fall 2019** - Northern California — TBD
- **Medical Emergencies** - Northern California — November 6

California CCF volunteers CareForce™

Attention CALAOMS Members. Save the Date for California CareForce's next free clinic in the Coachella Valley on March 22-24, 2019

Earlier this year in Coachella, our volunteers served 1,650 patients over the 3-day clinic – including 685 patients needing fillings, extractions, and cleanings alone. (That's $456,263 worth of dental services!) You'll enjoy being part of our community of caring, dedicated healthcare professionals. Don't hesitate to ask your referring dentist to join us too! By the end of the weekend, our volunteers are smiling even wider than our patients. Visit www.californiacareforce.org to sign up.

RISK MANAGEMENT

Cybersecurity Insurance for Medical Practices—the Basics

by David J. Eismont, ARM, senior director of business development, The Doctors Company

More medical practices are purchasing—or at least considering—an insurance policy to cover the substantial costs of a data breach. Medical malpractice policies often provide basic coverage for this threat, but many practices find their risks have grown to the point where they are looking to a stand-alone cybersecurity policy to better meet their needs.

The following provides an overview of what your practice can expect from a cybersecurity policy. Keep in mind that not all policies are the same and actual coverage will be determined by a policy's terms, conditions, and exclusions.

Coverages are typically split into two types— first-party and third-party:

First-Party Coverage

First-party coverage addresses the costs and expenses your practice incurs from a data security or privacy breach event, such as:

- *A physician comes to the office one morning and logs in to the computer, but the screen goes blank and a message pops up claiming to have hijacked the data and demands payment to get it back.*

The "extortion threat" section of a cybersecurity policy may assist with this type of breach. Professional experts hired by the carrier will contact the cyber criminals to attempt to get the data released, including potentially paying the ransom. You should also be concerned with not only the financial impact to your practice, but also the impact on the treatment of your patients if your systems are down for any length of time due to a breach. The business interruption section of a cyber policy may provide reimbursement of lost profits during your downtime. Many standard property policies do not cover this exposure, since there was no physical damage to the equipment.

- *A physician discovers her system has been hacked and worries her patients' personal health information may have been compromised.*

If you discover your system has been hacked, your carrier can provide data breach response services to work with your IT staff to ascertain what happened. These forensic experts assess the nature of the hack and evaluate how much data has been compromised. This section of your coverage can assist with the costs of required patient notification. If you have records of patients from outside your home state, your insurance company should know the notification requirements for those states. You may also be required to provide those patients with credit monitoring services. Your coverage should help set up these services and cover the costs. The costs to notify patients and set up credit monitoring is approximately $8-$10 per patient record. If patient records are compromised, the data recovery and restoration section of your coverage could reimburse you to unencrypt, recover, restore, recreate, or recollect data.

- *The CEO of a company sends an e-mail to the CFO instructing the movement of funds into an account. The CFO makes the transfer, only to discover that the CEO's e-mail was a spear phishing attack in which the email address was a clever fake, and those funds are long gone.*

Your coverage's cybercrime section may cover the cost of the funds that were transferred. Employees who click on such phishing links could compromise your system. This section of your policy may also assist in those situations.

Third-Party Coverage

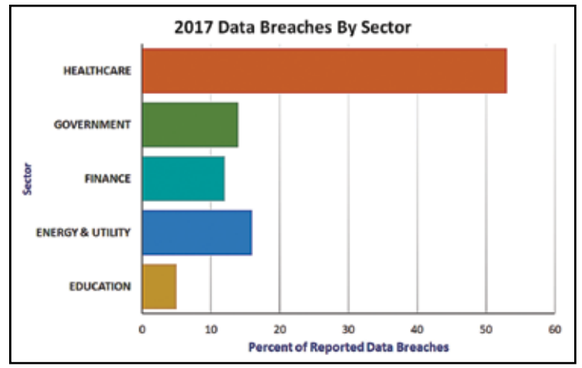
Third-party coverage provides protection from claims made against you by outside parties.

- It would not be unusual to have claims brought by regulatory agencies, such the U.S. Department of Health and Human services in the case of an alleged HIPAA violation involving a breach of patient records. Cybersecurity coverage for regulatory fines and penalties may allow for payment of fines on your behalf.

- If your practice accepts credit card payments and is not PCI-compliant (adhering to all the Payment Card Industry Data Security Standards), you could be subject to fines from the credit card companies. Policies with payment card industry coverage may provide payment for those fines.

- Some patients may bring claims against you for violating applicable privacy laws. The data security and privacy section of your cybersecurity policy may help in providing a defense and make payment to these claimants, if necessary. Employees of your practice could file such claims if their information was compromised.

- If you maintain a website or social media platforms, you might have a claim brought against you in the event someone believes your site or media content is defamatory or reveals private information about them. The cyber media section of a cybersecurity policy may also provide coverage in this case.



Healthcare accounted for 53 percent of reported data breaches in 2017, more than double the total of any other industry, according to Privacy Rights Clearinghouse. With healthcare data breaches on the rise, cyber liability insurance can help you recover faster in terms of financial coverage and remediation. In 2015, U.S. healthcare data breaches cost companies an average of $363 per record, the highest of any industry, according to the Ponemon Institute. Depending on the size and scope, fines and damages for a HIPAA violation related to a breach of unencrypted personal health data can run into the millions of dollars.

Ask your agent or underwriter for more details about what's included in your policy and whether it meets your needs. If you have cyber insurance, check your liability limits to determine if you need to increase your coverage.

To learn how to comply with HIPAA rules in the event of a breach, how to thwart ransomware attacks and prevent spear phishing, and more, download the free guide *Your Medical Practice Is at Risk of a Data Breach* from The Doctors Company.[1] More resources are available on the company's cybersecurity page.[2]

References

1. https://www.thedoctors.com/articles/cybersecurity-insurance-for-medical-practices-the-basics

2. https://www.thedoctors.com/articles/healthcare-cybersecurity-risks-and-solutions

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