BOARD MEETING
Friday, 30 November 2018

Terminal City Club
837 West Hastings St. Vancouver, BC
“Skidmore Room”

MINUTES

The meeting commenced at 8:30 a.m.

In Attendance
Dr. Peter Lobb, President
Dr. Patricia Hunter, Vice-President
Dr. Doug Conn, Treasurer
Mr. Gurdeep Bains
Dr. Deborah Battrum
Dr. Richard Busse
Dr. Ken Chow
Dr. Jeff Coil
Dr. Heather Davidson, PhD
Ms. Dianne Doyle
Ms. Sabine Feulgen
Ms. Barb Hambly
Dr. Dustin Holben
Mr. Oleh Ilnyckyj
Ms. Dorothy Jennings
Ms. Cathy Larson
Ms. Sabina Reitzik
Dr. Masoud Saidi
Dr. Mark Spitz
Mr. Neal Steinman
Dr. Lynn Stevenson, PhD

Regrets
Mr. Carl Roy

Staff in Attendance
Dr. Chris Hacker, Acting Registrar
Ms. Nancy Crosby, Manager of CEO’s Office
Ms. Joyce Johner, General Counsel
Dr. Meredith Moores, Acting Director of Professional Practice
Ms. Róisín O’Neill, Director of Registration and HR
Ms. Leslie Riva, Sr. Manager, CDA Certification and QA
Dr. Peter Stevenson-Moore, Dental Policy Advisor
Ms. Anita Wilks, Director of Communications
Mr. Dan Zeng, Director of Finance and Administration

Invited Guests
Dr. Ray Grewal, BCDA President
Ms. Jocelyn Johnston, BCDA Executive Director
Call Meeting to Order and Welcoming Remarks

The President called the meeting to order at 8:30 a.m. and acknowledged the territory on which the meeting was being held.

The President offered welcoming comments, led a round of self-introductions, and conveyed regrets on behalf of Mr. Carl Roy. He reviewed the agenda and acknowledged challenges over the past year, including the Registrar/CEO’s resignation and the Ministry review. The President referenced increased costs related to complaints and remediation programs, and the implications for the budget. Related to this, the President indicated that there would be a fee increase to registrants.

The President acknowledged the hard work of the staff and the Board and commented that the College remains committed to openness and transparency.

Declarations of Interest

It was declared that all dentists pay dues to the BC Dental Association of which they are a part. It was also noted that there are three past presidents of the BC Dental Association around the table.

Approve Agenda for 30 November 2018

The President noted two additional items to be added under New Business, which had been previously circulated.

CONSENSUS DECISION: The amended agenda for the 30 November 2018 Board meeting was accepted by consent.

Consent Agenda

a. Approval of Board Minutes of 15 September 2018 (attachment)
b. Reports from Committees – for information (attachment)
c. Executive Limitation Reports – for information
   • EL2: Treatment of Public (attachment)
   • EL3: Treatment of Registrants (attachment)
   • EL5: Financial Planning/Budgeting (attachment)
• EL6: Financial Condition and Activities *(attachment)*
• EL8: Asset Protection *(attachment)*
• EL9: Compensation and Benefits *(attachment)*
• Registration, Certification and Monitory, Quarterly Report *(attachment)*

d. Financial Statements to 30 September 2018 *(attachment)*
e. Report from the Acting Director of Professional Practice *(attachment)*
f. Management Report *(posted electronically to the online portal)*
g. Committee Membership – Dr. Rob Staschuk on Registration
h. Canadian Dental Regulatory Authorities Federation (CDRAF) – Update *(attachment)*
i. Deep & GA Standards and Guidelines – for information *(attachments)*

**MOTION:**
It was MOVED (Jennings) and SECONDED (Holben)
That the items on the Consent Agenda for the 30 November 2018 Board meeting be approved.

**CARRIED**

5. **Business Arising from the Consent Agenda**
There was no business arising from the consent agenda.

6. **BC Dental Association Presentation – Access to Care** *(attachment in Board portal)*

Dr. Ray Grewal, BC Dental Association (BCDA) President, and Ms. Jocelyn Johnston, BCDA Executive Director, reviewed a presentation titled "Meeting the Challenge of Access to Care".

Information was provided on the BCDA’s mandate, administration of $7.1 million in government funding, fundraising efforts, and Constitution. Various programs and services provided by the BCDA were referenced; a summary of BC’s oral health challenges, and access to care challenges was provided; and an overview of the Member of the Legislative Assembly (MLA) Network and the issues raised in Fall 2018, were offered.

Discussion ensued on:
• Need for a low-income seniors dental plan;
• Interest in the BCDA to focus more of its mandate on the public and patient side of care;
• BCDA not for profit courses for members to improve public and patient care;
• Focus of BCDA task forces and committees on public and patient care;
• Note that approximately 40% of the BCDA staff is resourced to public interest;
• Concern regarding increasing licensing fees;
• Clarification about standards set by the BCDA vs. the College;
• Acknowledgement that four Board members are past presidents of the BCDA.

7. BCDA Agreement for Ratification (attachment)

The President informed that the College approves the BCDA Agreement for Ratification each year to collect their membership fees. This year it is proposed that the College collect $1,600 from each registered practising dentist in all registration classes except for limited, temporary and non-practicing registration.

In response to a question, the President informed that the BCDA Board determines the fee, and that concerns about the fee should be brought to the BCDA Board.

**MOTION:**

It was MOVED (Coil) and SECONDED (Doyle)

That the Board ratify the agreement for the College of Dental Surgeons of British Columbia to collect fees for the British Columbia Dental Association pursuant to Bylaw 3.10, for the year 2019-20.

CARRIED

8. 2019-22 Strategic Plan – for final Board approval (attachment)

Dr. Chris Hacker, Acting Registrar, indicated that the Strategic Plan has not been revisited since 2012. In May 2018, the Board directed staff to draft a new Strategic Plan. The draft Strategic Plan was considered and approved by the Board in September 2018.

a. Stakeholder Consultation (attachment)

Dr. Hacker referenced the development of stakeholder questions at the Board’s September 2018 workshop, following which these questions had been sent to stakeholders for comment. Feedback was inserted at the end of the Strategic Plan that was approved at the September 2018 Board meeting and helped to inform the final Strategic Plan presented today for approval.

The following changes in the most recent draft were noted:

• Under Goal 1, the first initiative will include “patient-centred” and will now read: “Developing and maintaining patient-centred standards and guidance that are clear, consistent, enforceable and up to date”;
• Potential of removing Initiative 4 under Goal 4: “Developing and implementing an annual Board workplan”;

• The addition of Outcomes under each Goal.

Discussion ensued on:

• Suggestion to keep Initiative 4, and to clarify that the Board has a need for a strategic direction, with an understanding of roles related to determining policies and providing oversight;

• Interest to reference evidence informed practices and First Nations’ access to care;

• Support to keep development of the Board workplan under Goal 4, Initiative 4;

• Need for a stronger statement with regard to keeping the public informed.

Based on discussion, it was agreed to amend the Strategic Plan Values section as follows:

• Bullet 5, replace with “Inclusive and embracing the principles of diversity, cultural safety and humility”;

• Add bullet 7: “Committed to the highest level of public awareness”.

b. Insurance Company Information

Dr. Hacker informed that the College’s liability insurer had been asked to review the Strategic Plan and they responded that a review was not necessary.

MOTION:
It was MOVED (Coil) and SECONDED (Larson)
That the Board approve the Strategic Plan for 2019-22 as amended.

CARRIED

9. Operational Plan Progress Report

   (attachment)
Dr. Hacker advised that the Operational Plan Progress Report is presented for the Board members information. The timeline has been extended to February 2019 to allow for the initiation of the new Operational Plan for March 2019 – February 2022 and synchronize the Operational Plan with the Strategic Plan.

b. **2019-2022 Draft Strategic Plan, Including Success Measures and Draft Operational Plan** (attachment)

The Strategic Plan includes outcomes that are linked through success measures to help inform the Operational Plan. Quantitative Key Performance Indicators (KPI’s) will be developed and will be presented at the February 2019 Board meeting.

The New Registrant Course is a requirement for all new dentists within the first year of registration. It is an omnibus course on regulations and professional expectations intended to emphasize that the transition to become a professional is focused on licencing and accreditation with the College.

It was acknowledged that the go-forward plan is very ambitious, and questions were raised as to whether the College has the capacity to accomplish it. Dr. Hacker noted that staff feels it is attainable, but that the KPI’s could lead to a revisit of the Operational Plan at some point in future.

10. **Updated Safe and Respectful Workplace Policy** (attachments)

Vice-President Hunter acknowledged Ms. Róisín O’Neill for drafting the policy to address harassment and bullying in the workplace.

It was noted that once finalized, training would be provided on the application of the policy.

The Board was advised that the Governance Committee would like to make a few edits to the policy. As such, the Board could defer consideration to its February 2019 meeting, or approve the policy with the understanding that it could undergo some changes. A suggestion was made to revisit the wording under “Harassment”, to indicate that the intention is to prevent harassment entirely, not only in the form of discrimination on prohibited ground.

Clarification was provided that the procedures in support of the policy do not require Board approval. The policy was developed through a legal template and has been reviewed by Ms. Joyce Johner, General Counsel.
MOTION:
It was MOVED (Spitz) and SECONDED (Jennings)
That the Board adopt the interim Safe and Respectful Workplace Policy, and task the staff and Governance Committee to edit the policy with an expanded scope, to include all college relationships.

CARRIED

11. Bylaw Working Group – Update (attachments)

The President introduced the Bylaw Working Group’s recommendations and a process for considering two amendments to Bylaw 2. This was outlined in memos to the Board dated November 1, 2018, which included a request for feedback if there were concerns prior to the meeting. No concerns were received.

Point of Order – Mr. Neal Steinman raised a Point of Order that, in accordance with Sturgis Standard Code of Parliamentary Procedure that if the Chair wishes to limit debate for each motion to three minutes per Board member and one minute to speak a second time, that this must be a motion approved by a majority vote. The President in honouring Mr. Steinman’s request acknowledged that in fact a vote to limit debate would require a 2/3 majority vote.

MOTION:
It was MOVED (Saidi) and SECONDED (Holben)
With consideration to Bylaw 2 under Agenda Item 11, that the initial debate be limited to three minutes per member with one minute for rebuttal/comments for each motion.

CARRIED
(18 in favour; 2 opposed)

The recommendations of the Bylaw Working Group were then presented based on four motions passed at the 15 September 2018 meeting. The recommendations were framed in two separate motions.

The first motion, Board Composition, provided an example of a composition for a reduced Board of up to sixteen Board members. There was significant discussion about the option presented and concerns about who or who may not be part of a future Board under the proposed model presented. Some spoke in favour, while others shared their concerns and why they could not support the proposal. The President was asked the rationale for the proposal to have a ballot vote as opposed to a show of hands. The explanation was with this being a very emotional and contentious issue, it freed Board members to vote their conscience.
MOTIONS:

It was MOVED (Jennings) and SECONDED (Batrum)
1. That the proposed Board composition model of seven dentists, one CDA and up to eight public members be approved in principle for a 90-day consultation with registrants and stakeholders;
   DEFEATED
   (10 in favour; 11 opposed)

The second motion, Board Terms, Board Officers and Eligibility Requirements, was withdrawn from the agenda for discussion.

The Board suggested the Bylaw Working Group should continue to review Bylaw 2 and should also turn its attention to other Bylaws such as Bylaw 10.

NEW BUSINESS:

1. Motion to Extend Pediatric Sedation Moratorium

The President informed that the Sedation and General Anaesthetic Services Committee is seeking an extension on the Pediatric Sedation Moratorium.

MOTION:
It was MOVED (Holben) and SECONDED (Conn)
That the Moratorium on new applications to register credentials to provide moderate pediatric sedation (patients 12 years of age and under) for dentists who have learned the modality in a short-course format (i.e. less than one year), be extended until such time as the Committee determines new criteria for registration of qualifications and they have become a part of the standard.

CARRIED

The Board is directing the Committee to submit a report for the February 2019 Board meeting indicating the efforts being made and the direction the Committee is intending to go.

2. Educational Requirements and Professional Responsibilities for Implant Dentistry

The President read aloud a memorandum in response to the Board’s request for the Quality Assurance (QA) Committee to readdress the Royal College of Dental
The President presented a related proposed motion:

_That the Quality Assurance Committee and the College Communications Department draft a statement on the expectations of registrants to provide informed consent for all aspects of dentistry dental care and treatment._

Discussion ensued on:

- Concern that the proposed motion is not what QA was asked to do;
- Concern that a statement might not be adequate in that an increased number of complaints to the College are related to dental implants;
- Potential for the Board to direct the Quality Assurance Committee (QA) to create guidelines on implant dentistry;
- Clarification that guidelines are not qualifications or certifications, and are not required by the College;
- Concern that some dentists are taking on advanced surgery;
- Importance of continually reinforcing the need for informed consent, including treatment options;
- Lack of data about how many people are practising implant dentistry and for what reasons;
- Suggestion that the QA be asked to provide more succinct language around educational requirements for implant dentistry, and to identify criteria for creating the guidelines;
- Concern that this was not brought forward in a clear and timely manner.

The Board agreed that this is a bigger issue about when to implement guidelines, and that there is a need for a policy around this. Consideration of the motion was withdrawn, and concerns will be sent to the QA committee.

_This concludes the open portion of the meeting. The meeting ended at 12:25pm._

_The remainder of the meeting will be held in camera, per Section 2.15 (9) of the College Bylaws under the Health Professions Act._
BOARD MEETING
Friday, 30 November 2018
8:30 a.m. – 4:30 p.m.

The Terminal City Club
837 West Hastings Street, Vancouver, BC
“Skidmore/Wilson Beck”, Level 2

AGENDA

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<td>1.</td>
<td>Call Meeting to Order and Welcoming Remarks</td>
<td>Lobb</td>
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<td>2.</td>
<td>Declarations of Interest</td>
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<td>Approve Agenda for 30 November 2018 (attachment)</td>
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4. **CONSENT AGENDA (Continued)**

- Registration, Certification and Monitoring, Quarterly Report *(attachment)*
  
  d. Financial Statements to 30 September 2018 *(attachment)*
  
  e. Report from Acting Director of Professional Practice *(attachment)*
  
  f. Management Report *(posted electronically to the online portal)*
  
  g. Committee Membership – Dr. Rob Staschuk on Registration
  
  h. Canadian Dental Regulatory Authorities Federation (CDRAF) – Update *(attachment)*
  
  i. Deep & GA Standards and Guidelines - for Information *(attachments)*

**MOTION:**
That the items on the Consent Agenda for the 30 November 2018 Board meeting be approved.

5. **Business Arising from Consent Agenda**

   **Note:** Questions, if any, arising from Consent Agenda must be forwarded to the Chair at least 3 business days prior to Board meeting

   Lobb

6. **BC Dental Association Presentation – Access to Care** *(can be found on the board portal)*

   Dr. Ray Grewal, BCDA President
   Ms. Jocelyn Johnston, BCDA Executive Director

7. **BCDA Agreement for Ratification *(attachment)***

   **MOTION:**
   That the Board ratify the agreement for CDSBC to collect fees for the British Columbia Dental Association pursuant to Bylaw 3.10, for the year 2019-20

   Hacker

8. **2019-22 Strategic Plan – for final Board approval *(attachments)***
   
   a. Stakeholder Consultation *(attachment)*
   
   b. Insurance Company Information *(attachment)*

   **MOTION:**
   That the Board approve the Strategic Plan for 2019-22 as presented.

   Hacker
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<td>b. 2019-22 Draft Strategic Plan, including success measures and Draft Operational Plan (attachment)</td>
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<td>10.</td>
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<td>Hunter</td>
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<td>2. That the proposed terms of office, Board Officer positions and eligibility requirements be approved in principle for a 90-day consultation with registrants and stakeholders.</td>
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| New Business – Open Session |

This concludes the open portion of our meeting.

The remainder of the meeting will be held in camera, per Section 2.15 (9) of the College Bylaws under the *Health Professions Act*. 
The meeting commenced at 8:30 am.

**In Attendance**

Dr. Peter Lobb, President
Dr. Patricia Hunter, Vice-President
Dr. Doug Conn, Treasurer
Mr. Gurdeep Bains
Dr. Deborah Battrum
Dr. Richard Busse
Dr. Ken Chow
Dr. Jeff Coil
Dr. Heather Davidson, PhD
Ms. Dianne Doyle

Ms. Barb Hambly
Dr. Dustin Holben
Mr. Oleh Ilnyckyj
Ms. Dorothy Jennings
Ms. Cathy Larson
Ms. Sabina Reitzik
Mr. Carl Roy (by phone)
Dr. Masoud Saidi
Dr. Mark Spitz
Mr. Neal Steinman
Dr. Lynn Stevenson, PhD

**Regrets:**

Ms. Sabine Feulgen

**Staff in Attendance**

Dr. Chris Hacker, Acting Registrar
Ms. Nancy Crosby, Manager of CEO’s Office
Ms. Joyce Johner, General Counsel
Dr. Meredith Moores, Acting Director of Professional Practice
Ms. Róisín O’Neill, Director of Registration and HR
Ms. Leslie Riva, Sr. Manager, CDA Certification and QA
Ms. Marife Sonico, Administrative Assistant, Registrar’s Office
Dr. Peter Stevenson-Moore, Dental Policy Advisor
Ms. Anita Wilks, Director of Communications
Mr. Dan Zeng, Director of Finance and Administration

**Invited Guests**

Mr. Harry Cayton, Professional Standards Authority UK
1. Call Meeting to Order and Welcoming Remarks

The President, Dr. Peter Lobb, opened the meeting with the territorial acknowledgment.

Dr. Lobb welcomed everyone to the meeting and asked board members and staff to introduce themselves. He announced that Mr. Carl Roy is joining by phone while Ms. Sabine Feulgen is unable to attend.

Mr. Harry Cayton observed the meeting within his powers under the Public Inquiries Act.

2. Increasing Transparency at Board meetings

The President expressed excitement for the year ahead and announced that in the interest of openness and transparency, most of the meeting will be in the open portion.

3. Consent Agenda

a. Approve Agenda for 15 September 2018 (attachment)

b. Approval of Board Minutes of 16 June 2018 (attachment)

c. Reports from Committees (attachments)

Dr. Lobb outlined the following changes to the agenda:

• Between items 4 & 5, Mr. Harry Cayton will provide a brief summary on the progress of his review.
• Item 5 will be broken down as follows:
  a) Board Confidentiality Certification update
  b) Conflict of Interest discussion
• Item 20 (BC Health Regulators) and 23 (Electronic storage of motions and minutes from “board only” sessions) will be taken out of In Camera and moved to the open portion.

**MOTION:** Coil/Doyle

*That the board approve the amended agenda for the 15 September 2018 board meeting*

**Carried**
The other items in the consent agenda were approved by consent.

4. Business Arising from the Consent Agenda

There was no business arising from the consent agenda.

Review of the College

The President introduced Mr. Harry Cayton, who has been appointed by the government to conduct a review of the College early this year. Mr. Cayton was requested to provide a brief summary of the progress of his review.

Mr. Cayton thanked everyone for being very welcoming, open and helpful throughout his review. He explained that there are two parts in the process. One is to look into the performance of the College and make recommendations about potential reform of the framework of health regulation in BC. He noted that he is close to the end of the first part having completed the preparatory work of the governance piece. The other areas which will be included are the review on operations, external relationships and a fourth section about public protection and patient safety. The question to be asked and answered: Is the College fully committed to it’s mandate to protect the public?

The second part is about the HPA and looking at what the objectives of a modern regulatory framework should be and identifying what areas of regulation are or aren’t working. The final piece will be the transitional arrangements towards a changed system and updated legislation where it is deemed necessary to facilitate the regulators’ ability to protect the public.

He expects his report to be complete before the end of the year. In response to a question, Mr. Cayton added that he will share an interim report mainly for factchecking.

5. Board Confidentiality Certification – Update (attachment) and Conflict of Interest and Bias

A. Board Confidentiality Certification – Update

Dr. Chris Hacker provided a background on the discussion that happened at the June Board meeting regarding the unauthorized disclosure of confidential
information to The Globe & Mail. As part of the Board’s investigation into the unauthorized disclosure, a Confidentiality Certification was distributed to board members at the meeting on the recommendation of outside counsel, Mr. David Loukidelis, QC. By signing the certificate, the past or present Board member acknowledge that they, at no time, had given confidential information to an outside source. Dr. Hacker added that there is no greater responsibility that a board member has than to maintain confidentiality.

Ms. Joyce Johner informed the Board that all 2017/18 as well as incoming 2018/19 Board members were given a copy of the Confidentiality Certification to sign. A former public Board member and the former Registrar were likewise requested to sign the certification.

B. Conflict of Interest and Bias

The President spoke to this topic and reminded Board members of the expectation that if they are unable to make a completely free and honest assessment of a topic in the agenda, they should excuse themselves for that portion of the meeting. As best practice, he suggested that if, after receiving the board package, a Board member recognizes that there is something that they potentially have a conflict of interest, it will be disclosed immediately and that will be noted in the board minutes.

There was a suggestion to have a renewal of the declaration of interest at every board meeting. Dr. Hacker felt that this could be applied in 3 ways: a published declaration of interest, a renewal of that declaration of interest before a board meeting, and a declaration during discussion as soon as potential conflict is recognized.

Dr. Patricia Hunter reported that the Governance Committee is looking at these options and has tasked staff to develop a declaration of conflict of interest template. A board member suggested that the Governance Committee also consider having a template in the agenda as a constant reminder and affirmation.

**Action:** Staff to develop a Declaration of Conflict of Interest template to be included in the board package
6. **Public Participation at Annual General Meeting – for discussion** *(attachment)*

Ms. Joyce Johner presented her findings on how other health regulatory authorities in the province address public participation. Dr. Hacker noted that the policy of regulatory colleges regarding public participation at meetings vary. However, in the interest of increasing transparency, the Board can provide direction in terms of the extent the public can participate during College meetings.

While the Board is generally supportive of the move to engage with the public and hear their concerns, there were some questions and different suggestions on how to do it. Dr. Lobb suggested that this topic be added to the Governance Committee meeting agenda so they can provide suggestions.

**Action:** Governance Committee to present recommendations at November Board meeting

7. **Dental Therapist Update**

- Letter from Mr. John Mah, First Nations Health Authority *(attachment)*

At the June Board meeting, staff informed the Board about the request of FNHA to extend the tri-partite agreement between the Ministry of Health, FNHA and CDSBC that defines parameters by which dental therapists will be regulated by the CDSBC. The original agreement was intended to be time-limited with a sunset clause ending March 2019. The dental therapists had expressed concerns that the sunset clause threatens their job security. As such, the FNHA requested that the sunset clause be eliminated in the extended agreement.

Upon determining that the original tri-partite agreement could not be located, Dr. Hacker informed the board that based on conversations with Mr. Brian Westgate and Mr. Mark Mackinnon, since the regulation of the Dental Therapists is captured in amendments to the approved CDSBC Bylaws, the Ministry is comfortable that the College can continue to regulate Dental Therapists. Moreover, because there is no sunset clause in the regulations or bylaws, the only way this might change would be if either the Ministry or the CDSBC decided to seek an amendment.
Based on this, the FNHA was assured that the College nor the government has not indicated any desire to change the bylaws and that CDSBC will continue to regulate Dental Therapists without interruption.

Dr. Hacker then recommended that the motion approved at the June board meeting eliminating the sunset clause be kept as is, in the event that the original MOU is found.

As a follow-up item, Dr. Hacker informed the Board that their previous request for a presentation on what dental therapy is would require a minimum of 45 minutes. However, due to time constraints, he suggested for staff to send the Board a summary of the scope of dental therapy practice, which the Board agreed to.

8. Strategic Plan – Workshop Debrief and Next Steps

Dr. Lobb gave an update on the ongoing strategic planning process. He confirmed that Board and management staff completed a draft strategic plan at the workshop prior to the Board meeting.

Dr. Hacker expressed his appreciation to Board and staff on their commitment to this important activity and was proud to announce that the corrected version is already available and was distributed to everyone at the meeting.

After providing their questions and comments on the revised plan, the Board was asked to approve the Strategic Plan in principle.

**MOTION: Jennings/Busse**

*That the Board approve the Draft strategic plan in principle and allow the development of the Budget for 2019/20 based on the approved plan*

Carried

**Action:** Staff to develop 2019/20 budget

Stakeholder Engagement

Because of the timelines, Dr. Hacker reminded the Board of the consensus not to do a lengthy consultation. To ensure some form of stakeholder engagement, the Board
provided various suggestions including reaching out to specific health regulators, committee chairs, the Ministry of Health, FNHA, BCDA and CDABC and some non-usual respondents. A board member expressed desire to be informed of details such as questions asked, and list of groups/people consulted.

**MOTION: Doyle/Jennings**

*That the board direct staff to publish the draft strategic plan on the website and develop a consultation process with stakeholders asking them to provide feedback by October 19, 2018*

**Carried**

**Action:** Staff to determine details of consultation process and provide the board the list of stakeholders consulted, and the questions asked

**Legal Opinion**

Regarding a Board officer’s suggestion to seek legal opinion on the risks posed by the plan, a board member suggested that the College General Counsel be consulted initially. Staff can come to the Board Officers if external legal advice is necessary and only needs to come back to the Board if expense will exceed the allowable limit.

**MOTION: Steinman/Coil**

*That the board directs College General Counsel to consult with our liability insurer and address risk arising from the strategic plan*

**Carried**

**Action:** General Counsel to report back to the Board on findings

9. **Bylaw Working Group – Update**

- Bylaw 2 – College Board (*attachment*)

Staff distributed voting ballots to all board members present. Dr. Lobb explained that the voting ballots will be used for each of the four (4) motions to be voted on for this agenda item. Staff will collect the ballots and provide a tally of the votes.
The President emphasized that Bylaw 2 is a priority for the Bylaw rewrite and requires direction to enable the working group to continue with this significant work.

Reducing Board size

Most board members expressed support on the proposed reduction in board size noting that a smaller board is more nimble. Also, best practice leans towards smaller boards with greater public participation. A few Board members voiced out their concerns including: distribution between elected and appointed members, potential shortage in public representation in committees and the distribution between dentists and CDAs. A Board member clarified that public members on committees don’t necessarily have to be board members. Dr. Lobb also explained that the Bylaw Working Group will come up with their recommendation on the distribution/breakdown.

Vote results: YES – 18, NO – 1, Abstain - 1

**MOTION: Coil/Holben**

That the number of elected Board members be reduced for more efficient and effective governance.

Carried

One CDA on the Board

There was considerable discussion regarding the proposed reduction of CDA representation on the Board from the current two (2) to one (1).

Some board members expressed their confusion regarding the motion that was originally put forward, thinking that the intention of the proposed motion is to add a CDA board member to the Bylaw Working Group. Dr. Lobb clarified that the motion is meant to confirm that there will only be one CDA as part of the reduced board size.

Since there are significantly more CDAs than dentists, there were concerns that having just one CDA on the board may disproportionately represent the certificants. On the other hand, some argue that a more important consideration is to ensure that the board has the competencies necessary to protect the public.
While elected Board members are not representing their professions at the board table but are there to protect the public, another argument raised is that CDAs have more public/patient interface and as such, their skills, experience and perspective is crucial at the board table.

A board member suggested that the President change his motion from “That the Bylaw Working Group work with one CDA elected Board member as part of its recommendation to reduce Board size.” to “There will only be one CDA as part of the reduced Board size” for clarity, if that was the intention of the motion.

The Board agreed to remove the original motion.

Vote results: YES - 12, NO – 8

**MOTION: Hunter/Spitz**

*That there will only be one CDA on the Board as part of a reduced Board size*

*Carried*

Number of Public Board Members

Dr. Lobb explained that the proposed motion on the number of appointed board members will give the College more flexibility. As long as the Board does not go below the required 1/3 public representation, it is considered properly constituted.

Vote results: YES – 19, NO – 1

**MOTION: Larson/Battrum**

*That the number of Appointed (public) Board members be based on a policy of “more than one third and up to fifty percent of the Board.”*

*Carried*

Election of Board Officers

Vote Results: YES – 12, No - 8
MOTION: Doyle/Jennings

That the Board Officers are elected annually from the Board (rather than at large from the dentist registrants) and that all Board members are eligible for election.

Carried

Dr. Lobb concluded this item by thanking everyone for their candor during the discussion and for giving the Bylaw Working Group some direction.

10. Canadian Dental Regulatory Authorities Federation (CDRAF) - Update

Dr. Hacker provided a background about the CDRAF and the RCDC for the benefit of new Board members.

Last June, the RCDC came to the CDRAF with a services agreement on running the specialist examinations, which will be brought to the Board of DRAs for ratification. Shortly after that, the RCDC informed the CDRAF that their 2019 budget shows a potential significant deficit. RCDC is looking at ways to reduce cost, for instance, changing the oral exam process. As an immediate step to address the shortfall, the NDSE examination fees will be increased significantly.

There was a comment from a Board member that raising the fees may present obstacles in registering more specialists.

Dr. Lobb shared that the Dental Regulatory Authorities (DRAs) will each contribute towards a contingency fund proportionate to the number of dentists in each province. By February, there will be a clear direction on how to address the financial issues and help ensure that there is a viable specialist examination process in place.

11. BC Centre for Disease Control - Update

A study undertaken by the BC Centre for Disease Control (BCCDC) revealed that there has been an increase in dentists prescribing antibiotics. To address this issue, the BCCDC initiated a campaign aimed primarily at the public which the BCDA supported.
The BCCDC requested inclusion of the CDSBC logo on their campaign materials which the College Board didn’t have sufficient time to consider. Since the College depends on BCCDC for relevant data, it is important to maintain the good relationship we have built. The College will organize a panel in March at the Pacific Dental Conference (PDC) around best practices in prescribing antibiotics and opioids which the BCCDC will help with and provide the data.

The Acting Registrar was happy to report that College’s relationship with the BCCDC remains strong.

12. Volunteer Recognition Program (attachments)

Dr. Peter Lobb introduced this item by explaining the functions of the Nominations Committee, one of which is to carry out the awards program for College volunteers. The discussion has been around whether a regulator should be recognizing its volunteers. There is consensus as to the value of recognizing volunteers. It allows us to publicly acknowledge their contributions and show that the time spent by these volunteers with the College is valued.

There have traditionally been two events that provide recognition for College volunteers: the volunteer recognition night after the November Board meeting and the awards ceremony at the PDC. The Committee is in support of continuing this tradition with some changes. They recommended to combine the two functions and to schedule it in March since most of the registrants and certificants will be in town for the PDC.

The Awards Ceremony that happens during the Pacific Dental Conference (PDC) will be renamed “College Volunteer Recognition Evening” while the reception in November will be called President’s Holiday Reception and will just be a social event with no formal recognition of volunteers.

The Committee indicated their proposed changes to the awards policy:

1. Broadening the purpose of the awards program as follows: “To recognize and show appreciation for individuals and/or groups who as volunteers have made significant contributions to support and enhance the regulation of dentistry in B.C. This may include volunteers who have served with the College of Dental Surgeons of BC or with other organizations supporting the College’s mandate to serve and protect the public.”
2. Requiring committee support for Certificate of Appreciation winners.

3. Making the immediate past president ineligible to receive an award in any category.

4. Increasing the minimum amount of time after which a volunteer will be automatically considered for an award from two years to three years.

5. Renaming the Nominations Committee as the “Volunteer Recognition Committee.”

Regarding the proposed change in the name of the committee, a suggestion was put forward to keep the name the same. There is a conflict in that the Governance Manual indicates that the Governance Committee does the nominations while the bylaws specify that function to be under the Nominations Committee. As the College moves towards Board membership based on competencies, there will be a need for a Nominations Committee to play a significant role.

**MOTION: Busse/Chow**

*That the changes to the CDSBC Awards Policy as submitted by the Nominations Committee be approved*

Carried

13. Governance Committee – Update

Dr. Patricia Hunter, Chair of the Governance Committee, provided a summary of the work that they are currently doing:

- Creation of a “Board only” portal where minutes and motions during “Board Only” In Camera sessions will be stored
- Development of a process for the appointment of Governance Committee members
- Review of the College’s Safe and Respectful Workplace policy
- Review of expense policy for volunteers
- Review of section 25 of the Governance Manual which will include the declaration of interests, including publishing bios of Board members on the website which has all their affiliations, so the public will know where their interest lies
• Discussing the development of a Patient’s Bill of Rights; this is pending because BCHR is working on a similar project.

**Action:** Ms. Joyce Johner to provide an update on where BCHR is at on the Patient’s Bill of Rights initiative.

14. Executive Limitation Reports

CDSBC Governance policy requires that the CEO report regularly on matters identified by the Board through a series of Executive Limitations policies. This is one of the ways the Board discharges its oversight obligations without delving into operational issues. The CEO routinely submits these reports to the Board.

- EL2: Treatment of Public *(attachment)*
- EL3: Registration, Certification and Monitoring *(attachment)*
- EL5: Financial Planning/Budgeting *(attachment)*
- EL6: Financial Condition and Activities *(attachment)*
- Registration, Certification & Monitoring, Quarterly Report *(attachment)*

Dr. Hunter noted that the Governance Committee has determined to assess the validity of this style of reporting as it relates to a previous governance model of risk assessment.

Responding to a query, the Acting Registrar assured the Board that there is nothing in these reports that would be a cause for concern.

15. Management Report

Dr. Hacker informed the Board that an In Camera Management Report is on the board portal and assured the Board that they will be informed of anything that comes up that might be of interest. Staff continues to update as time allows. With strategic planning and the Harry Cayton review ongoing, content has been less than normal.

16. Report from Acting Director of Professional Practice *(attachment)*

The Acting Director of Professional Practice gave a summary of complaint statistics and informed the Board that included in the Complaints Team Report is the Health
Professions Review Board (HPRB) Annual Report. Dr. Moores noted that the HPRB Annual Report outlines the review and adjudication process which might be of interest to the Board.

She also highlighted that staff has embarked on an in-depth analysis of the monitoring files with the preliminary work included in the Board package.

Dr. Moores responded to various questions from the board pertaining to chart reviews, health files, advertising and promotions submissions, among others.

With regards to the backlog in complaint files, a Board member asked what resources are needed to clear the backlog. Dr. Lobb informed the Board to expect an increase in budget at the November Board meeting primarily to deal with complaints.

Ms. Joyce Johner informed the board about a recent citation that was issued but not yet public. The College has been unable to locate or serve the citation on the registrant. The College held a pre-hearing management meeting with the Discipline panel about this issue and the Discipline Committee ordered substituted service including publishing a notice of the hearing on our website in advance of the four-week timeframe in the Public Notification Policy.

17. Radiography Designation Review (attachment)

Ms. Leslie Riva outlined the issues related to the issuance of dental radiography certificates to dental assistants. As part of the College’s mandate to protect the public, it is prudent that a review of the existing policies and processes be undertaken. Staff is seeking direction from the board on whether to:

- Continue recognizing the designation even for non-registrants and noncertificants
- Implement limitations in the exposure of dental radiographs as an activity that should only be undertaken by registrants and certificants

One of the concerns raised relative to limiting performance of the activity only by CDAs is access to care. On the other hand, allowing non-certificants may put the public at risk particularly if the dental assistant is not current. A Board member suggested that a policy may need to be developed to hold dentists supervising the dental assistant accountable for ensuring that they are current and competent in exposing radiographs.
After some discussion, Dr. Hacker suggested that staff will delve into this issue further and consult with a Committee if need be.

**Action:** Staff to dig deeper into the issue, consult with Committee if necessary and bring back for more specific recommendations

**Agenda item 20 – BCHR Health Regulators – For Information**

This item was moved from In Camera to the open portion of the meeting and discussed after Item 17 – Radiography Designation Review.

Dr. Chris Hacker explained what the BCHR’s role is. He summarized the key points in the MOH presentation on BCHR Regulatory Models and Practices. He then provided an overview of the Ministry’s request for the BCHR to look into the transformation of professional regulation and what the future of regulation might look like.

The Acting Registrar mentioned about the Quality Assurance Program Framework developed by a BCHR working group which was intended to be a guiding document to support a consistent approach to implementing quality assurance programs in each of the colleges. He informed the board that a copy of the framework will be provided as soon as it is available.

**Action:** Staff will provide the Board and the Quality Assurance Committee with a copy of the framework as soon as the document is received.

**Agenda item 23 – Electronic storage of motions and minutes from “board only” sessions**

This agenda item was moved from In Camera to the open portion.

Dr. Hunter informed the board that the College IT consultant will create the “Board only” portal where motions and minutes of “Board only” In camera session will be stored. The IT Consultant will train a Board member who will be in charge of uploading and accessing the confidential files. Whoever will be tasked to manage the “Board only” portal also needs to train the next person on the Board who will take on the role the following year.
This concludes the open portion of the meeting. The meeting ended at 2:05pm.

The remainder of the meeting will be held in camera, per Section 2.15 (9) of the College Bylaws under the *Health Professions Act*. 
Committee Name: Audit Committee and Finance & Audit Working Group

Submitted by: Mr. Gurdeep Bains, Chair

Submitted on: November 14, 2018

Meeting Frequency:
- May 8, 2018
- October 17, 2018
- November 1, 2018
- January 29, 2019
- May 15, 2019

Matters Under Consideration:
The Committee/Working Group continues to review the expense claims of the Registrar and Board members at each meeting.

Committee/Working Group Objective For 2018-2019:
- Draft of Proposed Budget for 2019-2020 was recommended for Board approval at the November 1, 2018 Audit Committee and Finance & Audit Working Group meeting.
- Continue to work with the Bylaws Working Group on the Bylaws revision project with respect to financial oversight and the Audit and Finance committees.
- Review and update the Executive Limitations reports relating to accounting and finance.
- As the Committee determined at its November meeting that the current auditors be retained for the 2018-2019 fiscal year, consideration of appointing a new auditor is deferred until next year.

Progress and Timeline to Completion:
Within the 2019-2020 fiscal year.

Challenges to Timeline:
The Bylaws Working Group is currently focusing on other areas of the bylaws.

Work in Progress:
None.
### CDSBC Committee Report to Board
For Public Agenda

<table>
<thead>
<tr>
<th>Committee Name</th>
<th>CDA Advisory Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submitted by</td>
<td>Ms. Wendy Forrieter, Chair</td>
</tr>
<tr>
<td>Submitted on</td>
<td>30 November 2018</td>
</tr>
<tr>
<td>Meeting Frequency</td>
<td>This Committee has not met since the last Board meeting.</td>
</tr>
</tbody>
</table>

**Matters Under Consideration**

- CDA Bylaw review

**Statistics/Report**

**Future Trends**

**Progress and Timeline to Completion:**
CDSBC Committee Report to Board
For Public Agenda

Committee Name: CDA Certification Committee
Submitted by: Ms. Bev Davis, Chair
Submitted on: 30 November 2018
Meeting Frequency: This Committee met on 29 October

Matters Under Consideration: The committee reviewed two applications for guided mentorships along with an application for reinstatement. The committee had a discussion about the temporary certification and complaints processes.

Statistics/Report

Future Trends

Progress and Timeline to Completion:
CDSBC Committee Report to Board
For Public Agenda

Committee Name: Ethics Committee
Submitted by: Dr. Reza Nouri, Chair
Submitted on: November 14, 2018
Meeting Frequency: May 16, 2018
October 24, 2018
January 30, 2019 (TBC)

Matters Under Consideration:

- **Ethics Committee: Bylaws Review**
  The Committee continues to await further instructions from the Bylaws Working Group on its earlier recommendations with respect to title and terms of reference.

- **Dental Corporations and Share Structures**
  Unless otherwise directed by the Board, the Committee will continue to focus on the dentist-patient interface, rather than making an attempt to analyze corporate share structure. Early data analysis was not productive.

Committee Objective For 2018-2019:
Review and update of the documents under the Committee’s mandate.

Progress and Timeline to Completion:
3 months for document review.

Challenges to Timeline:
None.
CDSBC Committee Report to Board
For Public Agenda

Committee Name: Governance Committee
Submitted by: Dr. Patricia Hunter, Chair
Submitted on: November 2018
Meeting Frequency: Since the last reporting, the committee has met on September 6th and October 25, 2018

Completed Tasks:
The Governance Committee is pleased to report completion of the following tasks:

• Storage of Registrar’s employment documents; Mr. Marburg’s file has been updated and a new file has been opened for Dr. Hacker;

• Board-only portal for storage of board-only minutes is finalized and Drs. Hunter and Conn will be trained to upload documents to this portal; documents for this portal from past years has been collected by Dr. Lobb;

• Addition of comment boxes to the board self-evaluation survey.

Matters in Progress/Under Consideration:
The Committee discussed the need for more of an overall Governance function with a strategic focus. The next meeting will focus on a discussion to advance the strategic plan and the mandate of the College.

Development of a new Conflict of Interest Declaration for Board and Committee members;

Staff development of a new “Safe and Respectful Workplace Policy”

Review of Expense Policy for Volunteers by the Governance Sub-committee

The committee discussed concerns raised by a Board member regarding Board and Staff relations, and is considering the need for a facilitated workshop to provide role clarity between Board and Staff.

Regulating dentistry in the public interest
The Committee has determined the Patient Bill of Rights matter is not within their mandate. The Registrar will determine which committee should address this.

**Timeline to Completion:** By Board year-end (June 2019)
CDSBC Committee Report to Board
For Public Agenda

Committee Name: Inquiry Committee
Submitted by: Dr. Greg Card, Chair
Submitted on: 14 November 2018
Meeting Frequency:

From 01 August 2018, the date of the last report, until 31 October 2018, the Inquiry Committee as a whole met on the following dates:

- 14 August 2018
- 21 September 2018
- 30 October 2018

Inquiry Committee Panels met on the following dates:

- 23 August 2018
- 12 September 2018
- 17 September 2018
- 24 September 2018
- 25 September 2018
- 28 September 2018

In addition, a Panel of the Inquiry Committee meets weekly electronically to review new complaints received and direct how each new file is to be handled (normally through investigation or early resolution).

Matters Under Consideration:
Between 01 August 2018 and 31 October 2018, Inquiry Committee Panels received information and gave directions regarding files involving 32 dentists and 1 certified dental assistant under review. The files had been referred to a Panel because they were complex; the registrant has asked to meet with a Panel; the registrant is a member of or related to a member of the CDSBC Board, Committee, or staff; or for consideration of proposals from registrants regarding complaint dispositions.

Statistics/Report:
53 files were opened and 26 files were closed between 01 August 2018 and 31 October 2018.
It appears that the number and complexity of complaints received over the past two years has increased. This has resulted in the number of complaints received being greater than those files closed. Two new part-time complaint investigators have recently been appointed inspectors by the Inquiry Committee which we anticipate will continue to reduce the extended time it can take to reach a consensus resolution and direct the file closed.
Committee Name: Nominations Committee

Submitted by: Dr. Don Anderson, Chair

Submitted on: 8 November 2018

Meeting Frequency: The Committee met by teleconference on 23 October 2018

Matters Under Consideration: The awards ceremony has been renamed the “College Volunteer Recognition Evening” to reflect its broader focus on volunteer recognition. A formal recognition of all volunteers will take place as well as the presentation of the annual awards. It will be held on Thursday, 7 March 2019 at 6 pm at the Fairmont Waterfront Hotel, Mackenzie Ballroom. Board members are strongly encouraged to attend the ceremony to meet and celebrate the award recipients as well as acknowledge the many individuals who lend their expertise in supporting the College’s mandate to serve and protect the public.

The Committee reviewed the submitted list of volunteers eligible for awards and the list of recommended award winners was finalized. The Committee is pleased to submit its recommendations to the Board for your consideration.

Statistics/Report: N/A

Future Trends: None

Progress and Timeline to Completion: N/A

*The role of the Nominations Committee is to administer the College’s awards program; this is done on an annual cycle. The Committee’s list of recommended award winners is submitted to the Board for approval at the last meeting of the calendar year and is included here. The awards are presented at a formal ceremony each March.*
**CDSBC Committee Report to Board**  
*For Public Agenda*

<table>
<thead>
<tr>
<th>Committee Name</th>
<th>Quality Assurance CE Subcommittee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submitted by</td>
<td>Dr. Ash Varma, Chair</td>
</tr>
<tr>
<td>Submitted on</td>
<td>30 November 2018</td>
</tr>
<tr>
<td>Meeting Frequency</td>
<td>Has not met since last Board meeting.</td>
</tr>
</tbody>
</table>

**Connection to Strategic Plan**

**Future Trends**
CDSBC Committee Report to Board
For Public Agenda

Committee Name: Quality Assurance Committee

Submitted by: Dr. Ash Varma, Chair

Submitted on: 30 November 2018

Meeting Frequency:
The QA Committee met 22 November 2018
The QA Working Group met 23 November 2018.

Matters Under Consideration:
Matters discussed at the 22 November QA Committee meeting included:
PDC course review; update on the revision of the Early Detection Oral Cancer document; RCDSO Implant Guidelines were re-visited at the request of the Board; Board request to Committee to comment on the BCHR Quality Assurance Principles.

Matters discussed at the 23 November QAWG included reviewing feedback from the consultation period for the draft QA program and next steps.

Statistics/Report: n/a

Future Trends: n/a

Progress and Timeline to Completion:
Final draft program will be sent to the Board for consideration for the February 2019 meeting.

Quality Assurance Working Group consists of:
Mr. Paul Durose
Dr. Alex Hird
Dr. Andrea Esteves
Dr. Ash Varma, Chair
Dr. David Vogt
CDSBC Committee Report to Board
For Public Agenda

Committee Name: Registration Committee
Submitted by: Dr. Alexander Hird (Chair)
Submitted on: 30 November 2018
Meeting Frequency: 20 September 2018

Matters Under Consideration

Statistics/Report: One request for transfer from non-practising to full registration from a registrant who has insufficient continuous practice hours: approved. Until such time that registrant achieves his/her required continuous practice hours, he/she may only practise dentistry when there is another dentist with current CDSBC full registration present.

Future Trends

Progress and Timeline to Completion

Regulating dentistry in the public interest
CDSBC Committee Report to Board
For Public Agenda

Committee Name: Sedation and General Anaesthetic Services Committee

Submitted by: Dr. Tobin Bellamy, Chair

Submitted on: November 9, 2018

Meeting Frequency: 4-5 times per year
Last Meeting: 17 September 2018
Next Meeting: 19 November 2018

Matters Under Consideration

Standards and Guidelines
The Sedation and Anaesthesia Committee continues to develop the Standards and Guidelines for the delivery of minimal, moderate, and deep sedation, and for general anaesthesia. The work on updating the minimal and moderate sedation document is complete. Work on the Deep Sedation and General Anaesthesia standard and guideline is almost complete. Work will soon begin on the development of a single document that incorporates and integrates the content of both Standards.

The Sedation and General Anaesthetic Services Committee has revised the wording pertaining to the requirement of emergency equipment and drugs for the Minimal and Moderate Sedation, Deep Sedation, and General Anaesthetic Standards and Guidelines. The current standards and guidelines require facilities to have all the necessary equipment and drugs in their office, and the shared provision of emergency equipment and drugs is prohibited. Clinics must meet these requirements in order to obtain authorization to provide sedation and general anaesthetic services. Facility inspectors expressed concerns that although offices may pass inspections because they have the required items, the items themselves can be disorganized and difficult to locate during emergency situations, delaying response to emergencies. Wording has been altered to revise the current standards and guidelines to specify each facility must have a well-organized, self-contained, centralized emergency mobile unit (cart of kit).

The existing principle remains the same.

Updates to the current deep sedation (December 2016 addendum) and general anaesthetic (March 2016 and December 2016 addendum) drug lists are in progress.

Scope of Practice for Certified Dental Assistants
During this process, the Committee has recognized that the desired activity level of Certified Dental Assistants (CDAs) to support the delivery of dentistry using sedation and anaesthesia may not be contemplated by the existing Bylaw (8.01 – 8.11). The committee will need to choose whether to recommend a rewrite of the standard to conform to the existing Bylaw, or whether to propose wording for a new Bylaw. At the moment, the committee favours the latter approach, though alternatives may exist (consultations with counsel are to be initiated).
Training and Recognition of Enhanced Skill Sets

The Committee relies on two programs to teach and train the additional knowledge and skills that a CDA is required to have in order to support the delivery of sedation and anaesthesia services. The programs are:

1. **DAANCE – Dental Anesthesia Assistant National Certification Examination** sponsored by the American Association of Oral and Maxillofacial Surgeons. This course is taught entirely online, and is considered by oral maxillofacial surgeons to be the “gold standard”. Hands-on training is provided in the office of the sponsoring dentist.

2. **CDAAC – The Canadian Dental Anaesthesia Assistant Course** sponsored by Dental Ed / Sea-to-Sky Continuing Education of Brackendale, BC. This course is very similar to DAANCE as it includes an online program, but also includes classroom, and hands-on activity. The latter is considered by the Committee to be an important component.

The Committee has developed no consistent ability to credential the content of any course, the faculty that provide the course, the facility in which the course may be provided, or the examination that determines eligibility for certification. Instead, the Committee relies on remote oversight of course content. The two named courses have an excellent reputation with the users of those programs.

There are other programs that seek the approval of this College before advertising their programs as being eligible for credit. The Committee has reviewed the proposed course content of one such program, but has delayed a decision pending the development of greater clarity on CDSBC credentialing requirements in the face of a perceived deficiency in the submitted course description. The Committee recommends that CDSBC explore through CDRAF the possibility of engaging CDAC to perform the function of credentialing continuing education programs that lead to certification in the delivery of sedation and anaesthesia. In the meantime, the Committee will develop checklists to assist in determining the sufficiency of programs that already exist or are similar to DAANCE/OMAAP.

The Committee is exploring whether such programs might usefully be recognized as “modules”, in line with the existing orthodontic, prosthodontic, and radiography modules. *(Bylaws 8.09 – 8.11).*

The first phase of self-inspection of offices that undertake moderate intra-venous sedation is due to be initiated in the Spring of 2019. The geographic mapping of dental facilities that undertake sedation will facilitate the efficient inspection of offices in a cost-efficient manner with the intention of beginning these additional inspections after 2020.

Statistics/Report

Since the last Board Meeting, the Committee has reviewed and approved the following:

<table>
<thead>
<tr>
<th>Inspections</th>
<th>Deep Sedation Facilities</th>
<th>General Anaesthesia Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tri-Annual</td>
<td>In-Progress</td>
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<tr>
<td></td>
<td>2</td>
<td>6</td>
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Registration of Qualifications

<table>
<thead>
<tr>
<th>Received</th>
<th>Approved</th>
<th>Pending Approval at Next Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>4</td>
<td>5</td>
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</table>

Annual Self-Assessments are sent to rotas of the Committee for approval:

<table>
<thead>
<tr>
<th>Approved</th>
<th>Reviewed, Pending Rectifications</th>
<th>In-Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>9</td>
<td>8</td>
</tr>
</tbody>
</table>

Recommendation:

1. That the Board support a request to the Commission on Dental Accreditation of Canada for the credentialing of certified dental assistant programs in sedation and anaesthesia.

Attachments:

1) Minimal and Moderate Sedation Section 6. Responsibilities of Facility Owner
2) Minimal and Moderate Sedation – Appendix C
3) Minimal and Moderate Sedation – Appendix D
4) Deep Sedation Section F. Emergency Armamentarium
5) General Anaesthesia Section F. Emergency Armamentarium
<table>
<thead>
<tr>
<th>CDSBC</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDSBC offices are accessible only to staff who require access. Premises are alarmed and monitored. Keypads are maintained for main office and Suite 103 entry.</td>
<td>Privacy</td>
</tr>
<tr>
<td>Forms collect only the information required.</td>
<td>Policy</td>
</tr>
<tr>
<td>Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:</td>
<td>Policy</td>
</tr>
<tr>
<td>- Use methods of collecting, transmitting, or storing information that fail to protect against improper access.</td>
<td>2</td>
</tr>
<tr>
<td>- Use forms that collect information for which there is no clear necessity.</td>
<td>1</td>
</tr>
<tr>
<td>- Fail to operate facilities with appropriate accessibility and fail to operate facilities with the material which.</td>
<td>3</td>
</tr>
<tr>
<td>- Use forms that collect information.</td>
<td>4</td>
</tr>
</tbody>
</table>

**Policy EL 2: Treatment of the Public**
and in our newsletters.

They experience with the complaint process. The results are published to the website.

We are in the third year of an exit survey that asks complainants and registrants about

complainants about your information we need from them when they submit a complaint.

can now submit a complaint entirely online. The new form provides clarity to

investigating complaints has been added to the site.

A public-friendly BC Health Regulators video that explains how health colleges

the home page, a complaint form, and a detailed description of the complaints process.

information about complaints, including a designated public protection "news feed" on

the process and the outcome of our processes. The CDSCB website contains helpful

"departments," this leads to information about the concerns to which the college will respond.

We invite anyone who has concerns or questions about a registrant to contact us.

We also listed at the board meeting by the acting director of professional practice.

Acting Registrar reports complaints. Details are included in complaints and discipline

Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:

unreasonable or disrespectful.

With respect to interactions with the public, the Registrar shall not cause or allow conditions, procedures or decisions which are unfair.
<table>
<thead>
<tr>
<th>Response/Report</th>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall to employ alternative dispute resolution where appropriate.</td>
<td>7</td>
</tr>
<tr>
<td>Fall to deal with public inquiries as quickly as possible.</td>
<td>6</td>
</tr>
<tr>
<td>Fall to deal with public inquiries as expeditiously as possible.</td>
<td>6</td>
</tr>
<tr>
<td>Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:</td>
<td></td>
</tr>
<tr>
<td>unreasonable or disrespectful in his or her interactions with the public. The Register shall not cause or allow conditions, procedures or decisions which are unfair.</td>
<td></td>
</tr>
</tbody>
</table>
POLICY EL 3: TREATMENT OF REGISTRANTS

With respect to interactions with registrants, the Registrar shall not cause or allow conditions, procedures, or decisions which are unfair, unreasonable or disrespectful.

Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:

<table>
<thead>
<tr>
<th>Policy</th>
<th>Response/Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Use forms that elicit information for which there is no clear necessity.</td>
<td>Forms (both paper and electronic) collect only relevant/statutory information needed for registration. Personal assurance of registration staff and review of Registrar/CEO are evidence of compliance.</td>
</tr>
<tr>
<td>2 Use methods of collecting, reviewing, transmitting, or storing information that fail to protect against improper access to the material elicited.</td>
<td>CDSBC database is secured with password protection and is located on internal servers behind firewall and industry standard end-point protection. Access to the database is restricted to only those persons requiring access. Physical files are kept in locked cabinets wherever personal or sensitive information is present. Registrant files are kept electronically, storing the paper version on-site for one year.</td>
</tr>
<tr>
<td>3 Fail to register applicants as expeditiously as possible.</td>
<td>Application process generally is completed within 2-3 weeks unless extenuating circumstances present. An online registration/application process was launched in March 2018 for General Dentists and CDAs (temporary and practicing).</td>
</tr>
<tr>
<td>4 Fail to establish with registrants a clear understanding of what may be expected and what may not be expected from the College, including the processes it employs in adjudication of public complaints.</td>
<td>The College communicates its expectations for registrants in a variety of ways, such as publications (electronic and print), through courses and presentations. Work on the development of a joint course with the BCDA for new registrants has been paused for a few months due to other priorities and we hope to be able to continue work on it before the end of the year. There are now 450 anonymous summaries complaint files in which the registrant was asked to take action to improve their practice on the website.</td>
</tr>
</tbody>
</table>
POLICY EL 3: TREATMENT OF REGISTRANTS

With respect to interactions with registrants, the Registrar shall not cause or allow conditions, procedures, or decisions which are unfair, unreasonable or disrespectful.

Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:

<table>
<thead>
<tr>
<th>Policy</th>
<th>Response/Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Fail to adjudicate complaints as expeditiously as possible. The College is currently opening more files than we are closing due to complexity of files, and limited human resources. We are in the third year of an exit survey pilot project for registrants and complainants. The results will be used to improve the complaints process and a summary of the results for the first two years have been communicated to registrants.</td>
</tr>
<tr>
<td>6</td>
<td>Fail to employ alternative dispute resolution where appropriate. The Complaints team facilitates remediation directed by the Inquiry Committee on files where concerns have been identified.</td>
</tr>
<tr>
<td>7</td>
<td>Fail to respond to registrants' inquiries as expeditiously as possible. All inquiries, whether from registrants or members of the public, are responded to promptly. When a prompt response is not possible, persons are informed of this fact and advised when a response may be expected.</td>
</tr>
<tr>
<td>8</td>
<td>Fail to develop a College communication strategy. Communications materials support the strategic plan and makes use of new communications tools where appropriate. Although most communication with registrants is electronic, the College also makes use of print, face-to-face and virtual tools, such as webinars. To improve transparency, we have added a forum to the website to share comments from registrants and the public in response to public consultations. The College is responsive to trends or issues as they arise.</td>
</tr>
</tbody>
</table>
POLICY EL 3: TREATMENT OF REGISTRANTS

With respect to interactions with registrants, the Registrar shall not cause or allow conditions, procedures, or decisions which are unfair, unreasonable or disrespectful.

Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:

<table>
<thead>
<tr>
<th>Policy</th>
<th>Response/Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 Propose registration fees to the Board without a clear rationale.</td>
<td>All registration fees are tied to budget and budgeting process over which the Board has oversight and through which the Board and Audit/Finance Committee are consulted.</td>
</tr>
</tbody>
</table>

Respectfully Submitted By:

[Signature]

Dr. Chris Hacker
Acting Registrar

Date: 14 November 2016
**POLICY EL 5: FINANCIAL PLANNING/BUDGETING**

**Due Date:** Quarterly - May, Sep, Dec, Feb

Financial planning for any fiscal year shall not deviate materially from Board's Ends priorities, risk fiscal jeopardy, or fail to be derived from a business plan.

Further, without limiting the scope of the foregoing by this enumeration, the Acting Registrar shall not plan in a manner that:

<table>
<thead>
<tr>
<th>Policy</th>
<th>Response/Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Risks the organization incurring those situations or conditions described as unacceptable in the Board's policy Financial Condition and Activities. Acting Registrar reports compliance per EL 6 report.</td>
</tr>
<tr>
<td>2</td>
<td>Fails to include credible projection of revenues and expenses, separation of capital and operational items, cash flow, and disclosure of planning assumptions. Monthly financial statements, forecast, and Budget are evidence of compliance.</td>
</tr>
<tr>
<td>3</td>
<td>Fail to maintain a contingency reserve. Acting Registrar reports compliance per EL 6 report, and as evidenced in financial statements.</td>
</tr>
</tbody>
</table>

Respectfully Submitted By:

Chris Hacker  
Acting Registrar  

Date: **Nov 6 2018**
POLICY EL 6: FINANCIAL CONDITIONS AND ACTIVITIES

Due Date: Quarterly - May, Sep, Dec, Feb

With respect to ongoing financial condition and activities, the Acting Registrar shall not cause or allow the development of fiscal jeopardy or a material deviation of actual expenditures from Board priorities established in Ends policies.

Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:

<table>
<thead>
<tr>
<th>Policy</th>
<th>Response/Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Expend more funds than have been received in the fiscal year to date unless the debt guideline (see 2 below) is met. CDSBC does not debt finance. Financial statements reported monthly show that expenditures do not exceed revenues.</td>
</tr>
<tr>
<td>2</td>
<td>Indebt the organization in an amount greater than 5% of the annual revenue. CDSBC does not debt finance.</td>
</tr>
<tr>
<td>3</td>
<td>Use any contingency reserves except as authorized by an extraordinary motion of the full Board. No transfers are undertaken without a Board motion. No contingency reserves have been utilized since last report.</td>
</tr>
<tr>
<td>4</td>
<td>Fail to report to Board at the earliest opportunity the amount by which any item in the approved operating or capital budget is forecasted to exceed the budget for a category. Monthly financial statements are shared with the Audit Committee and Finance &amp; Audit Working Group, and the latest financial statements are received at each Audit Committee and Finance &amp; Audit Working Group meeting. Financial statements are tabled at each Board meeting showing performance against budget. Staff report any item in the approved operating or capital budget that is forecasted to exceed the budget of any category, in the notes to the variances or verbally at the Board meeting.</td>
</tr>
</tbody>
</table>
POLICY EL 6: FINANCIAL CONDITIONS AND ACTIVITIES

Due Date: Quarterly - May, Sep, Dec, Feb

With respect to ongoing financial condition and activities, the Acting Registrar shall not cause or allow the development of fiscal jeopardy or a material deviation of actual expenditures from Board priorities established in Ends policies.

Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:

<table>
<thead>
<tr>
<th>Policy</th>
<th>Response/Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Authorize the payment of any item that was included in the approved operating or capital budget in an amount that will exceed the approved budget for that category by more than $50,000.</td>
</tr>
<tr>
<td></td>
<td>Acting Registrar reports compliance.</td>
</tr>
<tr>
<td>6</td>
<td>Fail to obtain authorization from Board before committing the College to any operating or capital expenditure not included in the approved operating or capital budget that exceeds $25,000 or that creates or increases a cash flow deficiency for the current fiscal year.</td>
</tr>
<tr>
<td></td>
<td>Acting Registrar reports compliance.</td>
</tr>
<tr>
<td>7</td>
<td>Fail to settle payroll and debts in a timely manner.</td>
</tr>
<tr>
<td></td>
<td>Acting Registrar reports compliance. All payroll obligations are being met.</td>
</tr>
</tbody>
</table>
POLICY EL 6: FINANCIAL CONDITIONS AND ACTIVITIES

Due Date: Quarterly - May, Sep, Dec, Feb

With respect to ongoing financial condition and activities, the Acting Registrar shall not cause or allow the development of fiscal jeopardy or a material deviation of actual expenditures from Board priorities established in Ends policies.

Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:

<table>
<thead>
<tr>
<th>Policy</th>
<th>Response/Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Allow tax payments or other government ordered payments or filings to be overdue or inaccurately filed. Acting Registrar reports compliance.</td>
</tr>
<tr>
<td>9</td>
<td>Acquire, further encumber or dispose of real property. Acting Registrar reports compliance.</td>
</tr>
<tr>
<td>10</td>
<td>Fail to aggressively pursue receivables after a reasonable grace period. All receivables are recovered in a timely manner. CDSBC continues to have one outstanding debt owed to it from a former registrant arising from Discipline case/cost/disbursements, and one new outstanding debit owed to it from a current registrant. While we continue to pursue collections, the financial situation of the former registrant may make collection difficult.</td>
</tr>
</tbody>
</table>

Respectfully Submitted By:

[Signature]
Chris Hacker
Acting Registrar

Date: Nov. 6, 2015
POLICY EL 8: ASSET PROTECTION

Due Date: Annually - December

The Acting Registrar shall not allow the College's assets to be unprotected, inadequately maintained or unnecessarily risked.

Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:

<table>
<thead>
<tr>
<th>Policy</th>
<th>Response/Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Acting Registrar reports compliance. Following is a general summary of the main policies in place. In addition, all CI's carry required CDSPI insurance.</strong>&lt;br&gt;&lt;br&gt;Theft - The property policy protects against theft (property coverage is on a replacement cost basis). There is also crime coverage in place that would cover against theft as well. The distinction between the two: the crime policy is designed to cover against theft of money (currency, cheques, money orders etc.) and securities.&lt;br&gt;&lt;br&gt;Casualty - the commercial general liability policy protects the Board, staff (including volunteers) and the organization from liability arising from bodily injury or property damage to a third party.&lt;br&gt;&lt;br&gt;The commercial general liability policy protects against liabilities arising out of bodily injury and property damage. There is also the non-profit organization liability policy that protects the liabilities of the Board, staff (including volunteers) and the organization itself. This is more commonly referred to as the Directors and Officers policy and offers protection for the following:&lt;br&gt;&lt;br&gt;Directors and Officers Liability: Covers liabilities arising out of the activities of governing the organization.&lt;br&gt;&lt;br&gt;Employment Practices Liability: Covers liabilities from employment related claims (wrongful dismissal, sexual harassment, failure to promote, etc.).&lt;br&gt;&lt;br&gt;Professional Liability: covers negligent act, negligent error or negligent omission committed or alleged to have been committed by the insured in the performance of Professional Services (regulatory activities).</td>
</tr>
<tr>
<td>2</td>
<td><strong>All equipment is on appropriate maintenance schedules. Staff are made aware of proper use and care expectations.</strong></td>
</tr>
<tr>
<td>3</td>
<td><strong>Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:</strong></td>
</tr>
<tr>
<td>4</td>
<td><strong>Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:</strong></td>
</tr>
</tbody>
</table>
## POLICY EL 8: ASSET PROTECTION

**Due Date:** Annually - December

The Acting Registrar shall not allow the College's assets to be unprotected, inadequately maintained or unnecessarily risked. Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:

<table>
<thead>
<tr>
<th>Policy</th>
<th>Response/Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Unnecessarily expose the organization, its Board or staff to claims of liability. Acting Registrar reports compliance.</td>
</tr>
<tr>
<td>4</td>
<td>Make any purchases or award any contract: (a) wherein normally prudent protection has not been given against conflict of interest; (b) of over $25,000 without having obtained comparative prices and quality. Orders shall not be split to avoid these criteria. Acting Registrar reports compliance.</td>
</tr>
<tr>
<td>5</td>
<td>Fail to take reasonable steps to protect intellectual property, information and files from loss or significant damage. CDSBC secures all physical files. All electronic files are routinely backed up, with historical tape backups spanning multiple years held off-site. Critical files and configuration parameters are backed up and stored off-site as well. IT systems have built-in redundancies and daily local backups to disk.</td>
</tr>
<tr>
<td>6</td>
<td>Fail to implement the auditor's recommendations with respect to financial internal controls. Acting Registrar reports compliance.</td>
</tr>
</tbody>
</table>
POLICY EL 8: ASSET PROTECTION

Due Date: Annually - December

The Acting Registrar shall not allow the College’s assets to be unprotected, inadequately maintained or unnecessarily risked.

Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:

<table>
<thead>
<tr>
<th>Policy</th>
<th>Response/Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Fail to ensure the following cheque signing authorities: A) two signatures for cheques up to $25,000 from the following: President, Vice-President, Treasurer, Acting Registrar, Director of Registration and HR, Director of Communications, S. Mgr: CDA Certification and QA, General Counsel. B) two signatures for: (i) cheques over $50,000 of a budgeted item - one from each of the following two groups: i) President, Vice-President or Treasurer; ii) Acting Registrar, Director of Registration and HR, Director of Communications, Sr. Mgr: CDA Certification and QA, General Counsel. (ii) cheques over $25,000 of an unbudgeted item - two signatures from the following: President, Vice-President, Treasurer, Acting Registrar, Director of Registration and HR, Director of Communications, Sr. Mgr: CDA Certification and QA, General Counsel. With the exceptions that: ii) The Acting Registrar, Director of Registration and HR, Director of Communications, Sr. Mgr: CDA Certification and QA, or General Counsel, shall not act as a signing officer for an expense that they have approved. iii) No individual shall be a signing officer for a cheque of which they are the payee.</td>
</tr>
</tbody>
</table>
# POLICY EL 8: ASSET PROTECTION

**Due Date:** Annually - December

The Acting Registrar shall not allow the College's assets to be unprotected, inadequately maintained or unnecessarily risked.

Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:

<table>
<thead>
<tr>
<th>Policy</th>
<th>Response/Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td><strong>Invest or hold operating capital in insecure instruments or bonds of less than AA rating at any time, or in non interest-bearing accounts except where necessary to facilitate ease in operational transactions.</strong></td>
</tr>
<tr>
<td>9</td>
<td><strong>Fail to establish appropriate procedures governing the confidentiality, disclosure, safekeeping and eventual disposition of all records over which the Board has jurisdiction.</strong></td>
</tr>
<tr>
<td>10</td>
<td><strong>Fail to protect title and ownership of the College building and equipment.</strong></td>
</tr>
</tbody>
</table>

Respectfully Submitted By:

[Signature]

Chris Hacker  
Acting Registrar

Date: **Nov. 6, 2018**
Quarterly Report

Registration and Certification

1 August 2018 – 31 October 2018

Prepared for the Board
Overview

The Registration/Certification Team, consisting of the Director of Registration & HR, the Senior Manager, CDA Certification and Quality Assurance and four support staff, are responsible for all aspects of registration of dentists and certification of certified dental assistants. It is also responsible for the CDA Certification Committee, CDA Advisory Committee, Registration Committee, Quality Assurance Committee and the Quality Assurance CE Subcommittee.

The following represents a statistical breakdown of the activity in these areas for the period 1 August 2018 – 31 October 2018 inclusive.

Where available, the previous year’s statistics for the same period (1 August 2017 – 31 October 2017) are provided in brackets.

**Continuing Education**
**Dentists & Certified Dental Assistants**

Continuing education credit submissions are received electronically and by mail and applied to each registrant’s Transcript of Continuing Education. Of the more than 10,000 registrants, 3693 have their three-year cycle ending 31 December 2018.

In late October, transcripts were e-mailed to all registrants with unfulfilled cycles ending that year.
# DENTIST STATISTICS

Practising Dentists - 3712

## NEW REGISTRATIONS

<table>
<thead>
<tr>
<th></th>
<th>1 August 2018 - 31 October 2018</th>
<th>1 August 2017 - 31 October 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Registrations issued (includes Specialists)</td>
<td>35</td>
<td>41</td>
</tr>
<tr>
<td>Restricted to Specialty Registrations issued</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Academic Registrations issued</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>Limited Registrations issued:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Armed services or government</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>• Education</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>• Post-graduate</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>• Research</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>• Student practitioner</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>• Volunteer</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Temporary Registrations issued</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Non-practising Registrations issued</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

## GENERAL

<table>
<thead>
<tr>
<th></th>
<th>1 August 2018 - 31 October 2018</th>
<th>1 August 2017 - 31 October 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfers from Non-practising to Practising</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>Transfers from Practising to Non-practising</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Lapsed</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Reinstated</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Resigned/Retired</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Deceased</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
### CDA STATISTICS

**Practising CDAs - 6081**

#### NEW CERTIFICATIONS

<table>
<thead>
<tr>
<th></th>
<th>1 August 2018 – 31 October 2018</th>
<th>1 August 2017 – 31 October 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practising Certifications issued</td>
<td>46</td>
<td>65</td>
</tr>
<tr>
<td>Temporary Certifications issued</td>
<td>34</td>
<td>36</td>
</tr>
<tr>
<td>Temporary-Provisional Certifications issued</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Limited Certifications issued</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Non-practising Certifications issued</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

#### GENERAL

<table>
<thead>
<tr>
<th>Transfer Type</th>
<th>1 August 2018 – 31 October 2018</th>
<th>1 August 2017 – 31 October 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfers from Non-practising to Practising</td>
<td>10</td>
<td>16</td>
</tr>
<tr>
<td>Transfers from Temporary to Practising</td>
<td>128</td>
<td>148</td>
</tr>
<tr>
<td>Transfers from Temporary-Provisional to Practising</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Transfers from Limited to Practising</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Lapsed</td>
<td>54</td>
<td>32</td>
</tr>
<tr>
<td>Reinstated</td>
<td>46</td>
<td>15</td>
</tr>
<tr>
<td>Resigned/Retired</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Deceased</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

---

**Module designations granted**

Orthodontic Module – 2 (4)
Prosthodontic Module – 2 (4)
Dental Radiography Module 14 (15)

**CDA Assessments**

Initiated assessments:
- 14 (17)

Certification issued as a result of assessment:
- 9 (12)
## The College of Dental Surgeons of British Columbia
### Consolidated Statement of Revenues and Expenses

**For the Period ending September 30, 2018**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Certification &amp; Registration Fees</td>
<td>1</td>
<td>6,711,346</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>6,711,346</td>
<td>6,391,254</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Application Fees</td>
<td></td>
<td>567,551</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>567,551</td>
<td>511,424</td>
</tr>
<tr>
<td>3</td>
<td>Assessments</td>
<td></td>
<td>3,746</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3,746</td>
<td>3,285</td>
</tr>
<tr>
<td>4</td>
<td>Reimbursement &amp; Miscellaneous Fees</td>
<td></td>
<td>53,063</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>53,063</td>
<td>54,099</td>
</tr>
<tr>
<td>5</td>
<td>Other Revenue</td>
<td></td>
<td>397,022</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>397,022</td>
<td>353,932</td>
</tr>
<tr>
<td>6</td>
<td>Cost Recovery Items - Revenues</td>
<td></td>
<td>96,702</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>96,702</td>
<td>105,457</td>
</tr>
<tr>
<td>7</td>
<td>Interest Credited to Contingency Reserve</td>
<td></td>
<td>-</td>
<td>15,813</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>15,813</td>
<td>13,269</td>
</tr>
<tr>
<td>8</td>
<td>Income - JV</td>
<td></td>
<td>-</td>
<td>-</td>
<td>369,182</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>369,182</td>
<td>373,416</td>
</tr>
<tr>
<td>9</td>
<td>Less Dues &amp; Grants</td>
<td></td>
<td>(3,201,388)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(3,201,388)</td>
<td>(3,147,390)</td>
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<td>369,182</td>
<td>-</td>
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<td>-</td>
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<td>5,013,038</td>
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<td></td>
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<tr>
<td>10</td>
<td>Amortization of Capital Assets</td>
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<td>-</td>
<td>-</td>
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<td>78,569</td>
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<tr>
<td>11</td>
<td>IRF Capital Expenditures</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>(49,264)</td>
<td>-</td>
<td>-</td>
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<td>-</td>
<td>-</td>
<td>(49,264)</td>
<td>-</td>
</tr>
<tr>
<td>12</td>
<td>Gain/Loss on Disposal of Assets</td>
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<td>-</td>
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<td>-</td>
<td>-</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>13</td>
<td>Wellness Program Expenses</td>
<td></td>
<td>7</td>
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<td>-</td>
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<td>14</td>
<td>Office Reno. Expenses</td>
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<td>15</td>
<td>IT Project Expenses</td>
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<td>16</td>
<td>Disc. Hearing/Unauthorized Practice/Judicial Review</td>
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<td>-</td>
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<td>-</td>
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<td>141,084</td>
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</tr>
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<td>17</td>
<td>Building Occupancy Costs</td>
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<td>-</td>
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<td>570</td>
<td>587</td>
</tr>
<tr>
<td>18</td>
<td>Expenses - JV</td>
<td></td>
<td>-</td>
<td>-</td>
<td>329,179</td>
<td>-</td>
<td>-</td>
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<td>-</td>
<td>-</td>
<td>329,179</td>
<td>318,420</td>
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<tr>
<td>19</td>
<td>Committees</td>
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<td>42,293</td>
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<td>42,293</td>
<td>38,875</td>
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<tr>
<td>20</td>
<td>Cost Recovery Items - Expenditures</td>
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<td>102,055</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>102,055</td>
<td>109,055</td>
</tr>
<tr>
<td>21</td>
<td>Consulting Fees</td>
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<td>147,068</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>147,068</td>
<td>151,976</td>
</tr>
<tr>
<td>22</td>
<td>General and Administrative</td>
<td></td>
<td>401,372</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<td>-</td>
<td>401,372</td>
<td>379,975</td>
</tr>
<tr>
<td>23</td>
<td>Honorarium/Table Officers Fees</td>
<td></td>
<td>110,825</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>110,825</td>
<td>103,030</td>
</tr>
<tr>
<td>24</td>
<td>Interest and Bank Charges</td>
<td></td>
<td>2,597</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2,597</td>
<td>2,325</td>
</tr>
<tr>
<td>25</td>
<td>Legal Costs</td>
<td></td>
<td>177,807</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>177,807</td>
<td>52,739</td>
</tr>
<tr>
<td>26</td>
<td>Meeting and Travel Costs</td>
<td></td>
<td>164,854</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>164,854</td>
<td>182,182</td>
</tr>
<tr>
<td>27</td>
<td>Salaries and Benefits</td>
<td></td>
<td>2,968,160</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2,968,160</td>
<td>2,346,570</td>
</tr>
<tr>
<td>28</td>
<td>Total Expenditures (b)</td>
<td></td>
<td>4,117,302</td>
<td>-</td>
<td>329,179</td>
<td>33,137</td>
<td>-</td>
<td>6,130</td>
<td>50,508</td>
<td>22,492</td>
<td>141,084</td>
<td>4,699,832</td>
<td>3,890,344</td>
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<tr>
<td>Excess (Deficiency) of Revenues over Expenses (a-b)</td>
<td></td>
<td>510,741</td>
<td>15,813</td>
<td>40,004</td>
<td>(33,137)</td>
<td>-</td>
<td>(6,130)</td>
<td>(50,508)</td>
<td>(22,492)</td>
<td>(141,084)</td>
<td>313,207</td>
<td>768,398</td>
<td></td>
</tr>
<tr>
<td>Fund Balances, Beginning</td>
<td></td>
<td>3,015,943</td>
<td>1,935,802</td>
<td>3,694,113</td>
<td>594,336</td>
<td>204,399</td>
<td>133,982</td>
<td>-</td>
<td>126,956</td>
<td>1,614,807</td>
<td>11,320,238</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interfund transfers</td>
<td></td>
<td>28</td>
<td>Excess (Deficiency) of Revenues over Expenses</td>
<td></td>
<td>510,741</td>
<td>15,813</td>
<td>40,004</td>
<td>(33,137)</td>
<td>-</td>
<td>(6,130)</td>
<td>(50,508)</td>
<td>(22,492)</td>
<td>(141,084)</td>
</tr>
<tr>
<td>29</td>
<td>Capital Expenditures</td>
<td></td>
<td>(28,257)</td>
<td>-</td>
<td>-</td>
<td>28,257</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<td></td>
</tr>
<tr>
<td>30</td>
<td>Interfund transfers</td>
<td></td>
<td>3,9</td>
<td>(789,213)</td>
<td>-</td>
<td>104,610</td>
<td>-</td>
<td>(54,999)</td>
<td>(23,962)</td>
<td>425,000</td>
<td>128,590</td>
<td>473,957</td>
<td>55,343</td>
</tr>
<tr>
<td>31</td>
<td>Capital adjustment - Due from CPBC</td>
<td></td>
<td>-</td>
<td>-</td>
<td>8,077</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>8,077</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Distributions from JV</td>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fund Balances, Ending</td>
<td></td>
<td>2,709,214</td>
<td>1,951,615</td>
<td>3,637,583</td>
<td>589,456</td>
<td>150,000</td>
<td>103,869</td>
<td>374,492</td>
<td>232,954</td>
<td>1,947,681</td>
<td>11,696,864</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Notes to the Financial Statements

1 The registration & certification fees are paid in advance at the beginning of the fiscal year; these are being amortized monthly over the fiscal year of the College and the unamortized balance is shown as prepaid registration & certification fees under current liabilities on the statement of financial position. The total registration & certification fees for fiscal year 2018/19 received to the end of September 2018 is $11,617,263; the total budget for registration & certification fees for fiscal year 2018/19 is $11,555,495.

2 Along with the registration & certification fees, the dues & grants are also being amortized on a monthly basis over the fiscal year of the College; the prepaid balance of the dues & grants is shown as prepaid dues & grants under current assets. The total dues & grants paid to the end of September 2018 amount to $5,539,420; the total budget for the fiscal year 2018/19 is $5,529,420.

3 The IT Internally Restricted Fund was set up at the end of February 2008; the Office Renovations & Furniture Internally Restricted Fund was set up at the end of February 2010 and was dissolved in June 2015; the Disciplinary Hearing Internally Restricted Fund (renamed to HPA Enforcement Legal Fund in September 2013) was set up at the end of May 2011; and the College Place Preservation Fund was set up at the end of May 2013.

4 In May 2009 the Board approved a budget of up to $2,000,000 from its unrestricted net assets and from the Contingency Reserve Fund into a building fund to cover the costs of repairs and renovations carried out on the building. The total costs incurred amount to $1,679,734. In October 2011 the Board approved a transfer of the building fund surplus of $320,266 to unrestricted net assets.

5 The Contingency Reserve Fund was established in 2006 for unanticipated or unbudgeted expenses which are consistent with the objectives of CDSBC. Any disbursements from the Contingency Reserve Fund requires a special resolution of the Board.

6 In September 2013, the Board approved renaming the Disciplinary Hearing Internally Restricted Fund to HPA Enforcement Legal Internally Restricted Fund. In June 2016, the fund policy was modified to include all expenses for disciplinary hearings, unauthorized practice, judicial reviews and registration related legal expenses.

7 In November 2016, the Board approved to set up an Internally Restricted Wellness Fund in the 2017/18 fiscal year.

8 In February 2018 the Board approved the set up of an Internally Restricted Office Renovation Fund in the 2018/19 fiscal year. In the same meeting, the Board also approved a transfer of $25,000 from Unrestricted Net Assets to the Internally Restricted Office Renovation Fund in the 2018/19 fiscal year to cover any expenses for preparing a business case on the BCDA Learning Centre office space.

9 In June 2018, the Board approved a transfer of $54,399 from the College Place Preservation Fund to Unrestricted Net Assets, a transfer of $23,982 from the Internally Restricted Wellness Fund to Unrestricted Net Assets, a transfer of $400,000 from Unrestricted Net Assets to the Internally Restricted Office Renovation Fund, a transfer of $128,590 from Unrestricted Net Assets to the Internally Restricted IT Fund, and a transfer of $473,957 from Unrestricted Net Assets to the Internally Restricted HPA Enforcement Legal Fund.
## The College of Dental Surgeons of British Columbia
### Consolidated Statement of Financial Position
#### As at September 30, 2018

<table>
<thead>
<tr>
<th>Assets</th>
<th>September 30, 2018</th>
<th>September 30, 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash</td>
<td>$803,489</td>
<td>$1,321,506</td>
</tr>
<tr>
<td>Temporary Investments</td>
<td>9,343,262</td>
<td>8,239,394</td>
</tr>
<tr>
<td>Accounts Receivable</td>
<td>69,873</td>
<td>75,731</td>
</tr>
<tr>
<td>Prepaid Expenses</td>
<td>104,020</td>
<td>100,851</td>
</tr>
<tr>
<td>Prepaid Dues and Grants</td>
<td>2</td>
<td>2,338,032</td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td>12,658,675</td>
<td>12,039,631</td>
</tr>
<tr>
<td><strong>Long Term Accounts Receivable</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accrued Long Term Accounts Receivable</td>
<td>9,000</td>
<td>40,891</td>
</tr>
<tr>
<td></td>
<td>9,000</td>
<td>40,891</td>
</tr>
<tr>
<td><strong>Capital Assets - Net</strong></td>
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<td></td>
</tr>
<tr>
<td>IT Equipment</td>
<td>81,109</td>
<td>115,842</td>
</tr>
<tr>
<td>Equipment &amp; Furniture</td>
<td>197,417</td>
<td>185,033</td>
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<tr>
<td>Office Renovation</td>
<td>310,929</td>
<td>352,745</td>
</tr>
<tr>
<td><strong>Total Capital Assets</strong></td>
<td>589,456</td>
<td>653,620</td>
</tr>
<tr>
<td><strong>Investment in 1765 West 8th Holdings Ltd.</strong></td>
<td>3,723,101</td>
<td>3,907,576</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td>16,980,232</td>
<td>16,641,718</td>
</tr>
</tbody>
</table>

The College of Dental Surgeons of British Columbia
Consolidated Statement of Financial Position
As at September 30, 2018
## The College of Dental Surgeons of British Columbia
### Consolidated Statement of Financial Position
#### As at September 30, 2018

<table>
<thead>
<tr>
<th>Liabilities and Net Assets</th>
<th>September 30, 2018</th>
<th>September 30, 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts Payable and Accrued Liabilities</td>
<td>$ 235,973</td>
<td>$ 240,468</td>
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<tr>
<td>Prepaid Certification and Registration Fees</td>
<td>1</td>
<td>4,905,917</td>
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<tr>
<td>Prepaid Criminal Record Check Fees</td>
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<td>31,527</td>
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<tr>
<td>Prepaid Publication Sale and Remedial Education Fees</td>
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<td>24,432</td>
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<tr>
<td><strong>Total Current Liabilities</strong></td>
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<td>5,197,849</td>
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<td><strong>Liabilities - JV</strong></td>
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<td>85,518</td>
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<tr>
<td><strong>Net Assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Assets Invested in Capital Assets</td>
<td></td>
<td>589,456</td>
</tr>
<tr>
<td>Net Investment in Joint Venture</td>
<td></td>
<td>3,597,579</td>
</tr>
<tr>
<td>Contingency Reserve Fund</td>
<td>5</td>
<td>1,951,615</td>
</tr>
<tr>
<td>College Place Preservation Fund</td>
<td>3</td>
<td>150,000</td>
</tr>
<tr>
<td>Internally Restricted Net Assets - Wellness</td>
<td>7</td>
<td>103,869</td>
</tr>
<tr>
<td>Internally Restricted Net Assets - Office Renovations</td>
<td>8</td>
<td>374,492</td>
</tr>
<tr>
<td>Internally Restricted Net Assets - Information Technology</td>
<td>3</td>
<td>232,954</td>
</tr>
<tr>
<td>Internally Restricted Net Assets - HPA Enforcement Legal</td>
<td>3</td>
<td>1,947,681</td>
</tr>
<tr>
<td>Unrestricted Net Assets</td>
<td></td>
<td>2,198,473</td>
</tr>
<tr>
<td>Excess of Revenues over Expenses for the Period - JV</td>
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<td>40,004</td>
</tr>
<tr>
<td>Excess of Revenues over Expenses for the Period - CDSBC</td>
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<td>510,741</td>
</tr>
<tr>
<td><strong>Total Net Assets</strong></td>
<td></td>
<td>11,696,864</td>
</tr>
<tr>
<td><strong>Total Liabilities and Net Assets</strong></td>
<td></td>
<td><strong>$ 16,980,232</strong></td>
</tr>
</tbody>
</table>
Complaints Team Report

01 August 2018 – 31 October 2018

Regulating dentistry in the public interest
Overview

As at 31 October 2018, the Complaints Team was handling 297 active files. The Chart at Tab A captures the breakdown by age of the open complaint files as of that date.

For this reporting period the following table compares the number of files that are over one year of age:

<table>
<thead>
<tr>
<th>Date</th>
<th>Number of Files</th>
</tr>
</thead>
<tbody>
<tr>
<td>31 December 2017</td>
<td>57 files</td>
</tr>
<tr>
<td>30 April 2018</td>
<td>64 files</td>
</tr>
<tr>
<td>31 July 2018</td>
<td>80 files</td>
</tr>
<tr>
<td>31 October 2018</td>
<td>96 files</td>
</tr>
</tbody>
</table>

The following table compares files over two years of age:

<table>
<thead>
<tr>
<th>Date</th>
<th>Number of Files</th>
</tr>
</thead>
<tbody>
<tr>
<td>31 December 2017</td>
<td>4 files</td>
</tr>
<tr>
<td>30 April 2018</td>
<td>5 files</td>
</tr>
<tr>
<td>31 July 2018</td>
<td>9 files</td>
</tr>
<tr>
<td>31 October 2018</td>
<td>17 files</td>
</tr>
</tbody>
</table>

The Chart at Tab A indicates the average file age of the open files is 303 days. The following table compares the average file age of open files:

<table>
<thead>
<tr>
<th>Date</th>
<th>Average File Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>31 December 2017</td>
<td>257 days</td>
</tr>
<tr>
<td>30 April 2018</td>
<td>283 days</td>
</tr>
<tr>
<td>31 July 2018</td>
<td>278 days</td>
</tr>
<tr>
<td>31 October 2018</td>
<td>303 days</td>
</tr>
</tbody>
</table>

Telephone Calls

Between 01 August 2018 and 31 October 2018, the complaints support staff received:

- 62 calls from members of the public inquiring about making a complaint regarding their dentist;
- 21 calls from dentists and dental office staff regarding complaint issues;
- 32 calls from registrants and complainants regarding their open files; and
- 32 miscellaneous inquiries.

Long-standing Complaints

There are many reasons a file may take an extended period of time to resolve, including:

- difficulty in obtaining reports and records;
- multiple patients involved;
- complexity of the issues;
- the registrant’s health;
- staff resources available;
- the involvement of legal counsel; and
- legal proceedings.

Complaints Received

Between 01 August 2018 and 31 October 2018, the College opened 53 complaints. In the same three-month period in the previous fiscal year, the College opened 46 complaints.

The Chart at Tab B includes the number of complaint files opened and closed by month for 01 August 2018 to 31 October 2018.

The Chart at Tab C includes files opened by month so far this fiscal year over last fiscal year. 152 files were opened from 01 March 2018 to 31 October 2018, compared to 123 files this time last fiscal year.

Of the 53 complaints received between 01 August 2018 and 31 October 2018, 29 (55%) were from patients or family members of a patient.

Closed Complaints

The Complaints Team continues to target the older files in the system.

The Chart at Tab D sets out the age of files on closing between 01 August 2018 and 31 October 2018. The College closed 26 files during that period. 11 files were closed in under a year. Between 01 August 2017 and 31 October 2017, the College closed 23 files, 14 of which were closed in under a year.
The majority of files are closed because the allegations are unsubstantiated or can be resolved by agreement. The most common issues found on closing are:

- diagnosis and treatment planning (20%)
- informed consent (17%)
- recordkeeping (15%)

Complaints to the Ombudsperson

The Ombudsperson for the Province of British Columbia accepts complaints/inquiries regarding professional associations and regulators, including CDSBC.

The College has not received the Ombudsperson's report for this reporting period.

Monitoring Files

Monitoring files consist of confidential health files and files opened to track compliance, completion and assessment of consensual remedial agreements.

The assessment of these agreements is determined through chart reviews initiated at predetermined intervals after successful completion of the remedial education.

The increase in complaint file closures and the number of closing issues over the last 2-3 years, has resulted in an expected and significant increase in the number of monitoring files opened.

College staff have embarked on an in-depth analysis of the existing monitoring files. The following Tab E represents the preliminary work that has been done and are being presented for the first time. It is hoped that the reporting will become more in depth as the sophistication of the analysis increases.

Health Professions Review Board

Under the Health Professions Act (HPA), a complainant or respondent may write to the Health Professions Review Board (HPRB) for a review regarding the timeliness of an investigation. After a complaint is closed, a complainant can apply for a review of the adequacy of the investigation and/or the reasonableness of the decision.

For the period 1 August 2018 to 31 October 2018, the College received no new delayed investigation applications. There are no current delayed investigation applications at this time.
For the period 1 August 2018 to 31 October 2018, the College received three new disposition review applications, which the HPRB has directed into the Stage 1 review stream, which requires the Complainants to provide a Statement of Points. We continue to await the HPRB’s consideration of time extension requests on two other files in which the complainant sought a review of the disposition outside the 30 day time limit prescribed. There are currently five open disposition applications in total.

Of the five open disposition applications, we are awaiting receipt of the Complainants’ Statement of Points on three of them and the HPRB’s decision on time extension requests on two others, as referenced in the preceding paragraph. In each case, the College has taken no position with respect to the time extension request. In all other cases, the investigation records have been provided to the HPRB and we are awaiting further direction.

Four disposition review applications were closed during the same time period. Three were closed on the basis the College’s investigation was adequate and the disposition reasonable. The fourth was resolved through a mediation held by HPRB’s which resulted in the Complainant withdrawing his Application for Review after all parties agreed to the following: (1) Recognition the dental treatments provided to the patient in this case were complex and protracted; (2) acknowledgement there was confusion over a second radiograph that did not exist; (3) apology for any stress caused by the complaint investigation process; (4) a commitment on the part of the College to sensitivity about complainant concerns in future; and (5) commitment on the part of the College to an ongoing review of the College’s complaint process.

Out of a total of 146 disposition review applications received since the College came under the HPA in 2009, there are currently five active applications.

We note that in June 2016, the HPRB amended its practice directive regarding mediation and stated its long-held preference that mediation be attempted in the majority of reviews. We expected that the majority of reviews would proceed in this fashion going forward; however, with the exception of the file noted above, none of the current applications have been directed into the mediation stream. Most have been directed into the Stage 1 review stream requiring only the Complainant to make written submissions.

HPRB matters are managed by our general counsel, Joyce Johner, and complaints paralegal, Julie Boyce.

The chart at Tab B indicates the number of applications taken to the HPRB by month for the relevant period. The chart includes the applications for the timeliness reviews as well as the applications for review of the Inquiry Committee’s disposition of a complaint. It should be noted, however, that the chart only indicates those files where the HPRB has acknowledged receipt of the new applications – it does not include applications which have been submitted but for which the HPRB has not yet notified us.
Open Files Aging Report

As of October 31, 2018
Average File Age (days): 303

<table>
<thead>
<tr>
<th>Age</th>
<th>File #</th>
<th>Opened</th>
<th>Days</th>
<th>Dentist/CDA</th>
<th>Complainant</th>
<th>Investigator</th>
<th>Type</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 3M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>53</td>
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<tr>
<td>3 - 6M</td>
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<td>25</td>
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<td>24 - 36M</td>
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<td></td>
<td></td>
<td></td>
<td>14</td>
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<tr>
<td>&gt; 36M</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
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<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>297</td>
</tr>
</tbody>
</table>
TAB B
File Breakdown By Month
01-Aug-2018 to 31-Oct-2018

<table>
<thead>
<tr>
<th>Month</th>
<th>Opened</th>
<th>Closed</th>
<th>HPRB Disposition</th>
</tr>
</thead>
<tbody>
<tr>
<td>August</td>
<td>21</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>September</td>
<td>16</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>October</td>
<td>16</td>
<td>10</td>
<td>0</td>
</tr>
</tbody>
</table>

Legend:
- Opened - 53
- Closed - 26
- HPRB Disposition - 3

Printed: Thursday, November 08, 2018
TAB C
Age of Files on Closing

Files Closed between 01-Aug-2018 and 31-Oct-2018

<table>
<thead>
<tr>
<th>Age of Files (Days)</th>
<th>Number of Files</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 90</td>
<td>2</td>
</tr>
<tr>
<td>91 - 225</td>
<td>2</td>
</tr>
<tr>
<td>226 - 365</td>
<td>7</td>
</tr>
<tr>
<td>365+</td>
<td>15</td>
</tr>
</tbody>
</table>

Average age of closed files during this period: **452**
Monitoring Report 2018

**Total Number of Files in Monitoring**
There are currently 213 monitoring files open, 152 complaints monitoring files and 61 health files.

![Bar chart showing total open files, complaints monitoring, and health files]

**Current Chart Review – Status**
There are currently 123 monitoring files that have a requirement for a chart review under the terms of the MAU. 31 files are ready for the chart review to be conducted. There are 10 files which have insurance remittance summary statements or explanation of benefits (EOBs) received and are awaiting patient selection. There are 3 files awaiting the Patient Charts already requested from the Registrant.

**Files Awaiting Patient Selection – Status**
For the oldest file awaiting patient selection, the information was received June 2018.

**Files Ready for Chart Review – Status**
The records for 3 out of the 31 files were received in 2016.
- The chart review for 2 of these files are nearing completion.
- The third file is next in line for review.

Of the remaining 28 files, the records for the oldest file were received August 2017.
Chart Review Outcomes for August – October 2018

Within the August - October 2018 period, 3 chart reviews were deemed successful, 9 were deemed unsuccessful with the possibly of 1 of those being referred to an Intake Panel depending on the outcome of the meeting with the Registrant.
Unsuccessful Chart Reviews – Status
7 of the 9 unsuccessful chart reviews were asked to provide the College with a written response to the concerns identified in the review. In addition, arrangements have been made for 4 of the Registrants to attend a meeting at the College to discuss the results of their chart review.

Successful Chart Reviews – Status
2 of the 3 files with successful chart reviews have now been closed as all requirements of the MAU have been completed. The remaining file will proceed to the next chart review.
Health Report 2018

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Open</td>
<td>14</td>
<td>12</td>
<td>11</td>
<td>8</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Closed</td>
<td>8</td>
<td>3</td>
<td>2</td>
<td>6</td>
<td>2</td>
<td>5</td>
</tr>
</tbody>
</table>

*up to and including 31 October 2018

Breakdown of Current Health Files

Total 61
- Substance Dependence: 25, 41%
- Blood Borne Pathogens: 9, 15%
- Other: 27, 44%

Breakdown of Substance Dependence Category

- Alcohol, 8, 32%
- Opioids, 6, 24%
- Polysubstance, 11, 44%
Breakdown of Blood Borne Pathogens Category

- HIV: 11%
- Hep B: 89%

Breakdown of ‘Other’ Category

- Psychological: 9, 33%
- Neurological: 7, 26%
- Physical: 11, 41%

- Neurological (e.g. stroke, epilepsy)
- Physical (e.g. musculoskeletal, MVA)
- Psychological (e.g. depression, anxiety)
Memo

TO:         CDSBC Board
FROM:      Dr. Chris Hacker – Acting Registrar
DATE:      November 30, 2018
SUBJECT:  Canadian Dental Regulatory Authorities Federation Update

Background

The Canadian Dental Regulatory Authorities Federation (CDRAF) is the national forum and collective voice of provincial and territorial dental regulatory authorities (DRAs) which identifies and discusses regulatory strategies and trends both nationally and internationally. It was created by Letters Patent issued in 2004 under the Federal Ministry of Industry.

CDRAF has gone through a number of governance models since 2004 evolving to a board comprised of the ten provincial registrars. While having no real authority itself, as regulation is overseen at the provincial level, CDRAF facilitates and maintains relationships with national accreditation bodies and allows collaboration amongst the provincial DRAs in setting national standards for accreditation, registration and certification allowing increased labour mobility across the country.

Historically, the College of Dental Surgeons of BC (CDSBC) has participated in CDRAF since its inception and the Acting Registrar (AR) currently sits on the Board. Aside from attending regularly scheduled meetings of the Board, the AR also contributes to the work of CDRAF through participation in three specific working groups.

Issues before the Board currently include development of a new application for recognition of new dental specialties in Canada, improved specialty certification process and a review and development of national competency standards for the new graduate dentist.
**Specialty Recognition Process**

CDSBC’s AR along with Dr. Jack Gerrow, Executive Director of CDRAF, will be looking into improving the existing pathway for application for national recognition of a new dental specialty. The most recent version of the process was approved by the Board in February 2018 but concerns were almost immediately identified. This new process had replaced the existing one developed by CDRAF in 2011 which in turn had substituted for an earlier model overseen by the Canadian Dental Association (CDA).

Work will initiate in early 2019 and will allow a draft to be presented to the CDRAF Board in February of that year. Once approved, it will be brought back for consideration by the CDSBC and potential ratification. At that time thought will need to be given to some form of consultation with stakeholders as this process will have ramifications both for registrants and the public.

**Specialty Certification**

CDRAF was hoping to be able to recommend a new third party services agreement with the Royal College of Dentists (Canada) (RCD(C)) to the provincial DRAs for specialty certification. The agreement would allow RCD(C) to continue to provide specialty examinations for dental specialists wanting to practice in Canada.

Due to ongoing problems within RCDC, CDRAF has determined to look elsewhere for an acceptable model of certification. Working groups have been established to compare the efficacy of individual DRAs providing mentorships for graduates of accredited post-graduate specialty programs with identifying third parties capable of providing psychometrically approved examinations. The work is continuing and more information may be available before CDSBC’s next Board meeting in February.

**National Competencies for General Dentists**

In 2005, the DRAs, National Dental Examining Board of Canada (NDEB) and the Association of Canadian Faculties in Dentistry (ACFD) were involved in developing a national competency document. Since that time, NDEB and ACFD have both developed their own resource documents to guide their own specific activities.

CDRAF has determined the existing document needs to be updated to better capture and define the competencies that define the new graduate general dentist. A working group has been struck and through two meetings to date, June and November, has consulted
and worked with representatives of stakeholder groups and educators with content expertise to begin creation of a new draft document.

Work will continue through the spring with the hopes of the document being presented to CDRAF for adoption in 2019. CDRAF will then request that the document be used as part of national accreditation standards for the assessment of dental education facilities across the country. The document will also help inform provincial DRA process as it relates to entry-level and ongoing competencies of their registrants.

Respectfully Submitted

Dr. Chris Hacker
Acting Registrar
TAB 4 i.

Deep & GA Standards & Guidelines

For information

Attached:

- Minimal & Moderate Sedation Standards & Guidelines,
  Section 6, Appendix C and D
- Deep Sedation Standards & Guidelines
- General Anaesthetic Services Standards & Guidelines

(Revised and clean versions of these documents are attached)
6. Responsibilities of the Facility Owner

The facility owner is responsible for ensuring that any visiting dentist or physician who provides sedation has the appropriate qualifications and credentials, as outlined in these Standards.

Any visiting dentist/physician may only administer moderate sedation in a facility that has been inspected and approved by CDSBC. In the event that a visiting dentist/physician brings their own monitoring equipment, the facility owner must ensure that the equipment has been inspected at least annually and serviced and/or maintained as required. All devices must comply with original performance specifications and meet appropriate CSA standards.

The facility owner is responsible for ensuring all emergency equipment and emergency drugs are on site prior to providing moderate sedation.

All emergency equipment and drugs must be provided by either the facility owner or the visiting dentist/anaesthetist. Emergency equipment and drugs must be consolidated and stored in a well-organized, self-contained, mobile unit (cart or kit) at a centralized location that is readily available at all times. Drugs must be current and readily identifiable. The emergency cart or kit will contain all drugs and equipment necessary to perform emergency procedures. An emergency cart or kit must be present in each facility before any procedure is commenced. Emergency carts or kits must not be shared with other facilities when sedations are performed. The emergency cart or kit must be present until the patient is discharged from the facility.

Note: The BC safety authority recognizes certification bodies other than CSA. The bodies acceptable to the BCSA must be accredited by the Standards Council of Canada and have medical and/or hospital equipment within their scope of practice. See: https://www.scc.ca/en/accreditation/product-process-and-service-certification/directory-of-accredited-clients.
Appendix C

Emergency Medications Required for Minimal Sedation

<table>
<thead>
<tr>
<th>Drug</th>
<th>Amount on Hand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxygen</td>
<td>One (1) Full “E” Cylinder</td>
</tr>
<tr>
<td>Epinephrine or EpiPens</td>
<td>Two (2) amps of 1:1000 or 1 EpiPen</td>
</tr>
<tr>
<td>Nitroglycerin</td>
<td>One (1) spraypump</td>
</tr>
<tr>
<td>Diphenhydramine or Chlorpheniramine</td>
<td>One (1) vial of 50mg</td>
</tr>
<tr>
<td>Salbutamol Inhalation Aerosol</td>
<td>One (1) inhaler</td>
</tr>
<tr>
<td>ASA</td>
<td>One (1) small bottle</td>
</tr>
<tr>
<td>Flumazenil*</td>
<td>One (1) vial</td>
</tr>
<tr>
<td>Naloxone**</td>
<td>Two (2) amps</td>
</tr>
<tr>
<td>Supplemental glucose for oral use</td>
<td>One (1) source</td>
</tr>
</tbody>
</table>

Notes:
1. These are the minimum requirements for emergency medications. Practitioners may wish to have additional medications available.
2. The portable oxygen cylinder must be a dedicated emergency supply and have a regulator/flowmeter/wrench and administration supplies continuously connected.
3. Salbutamol is best administered with an Aerosol chamber/spacer.
4. Appropriate syringes/needles to draw/dilute/administer medications should be stored with the emergency medications.
5. Emergency equipment and drugs must be consolidated and stored in a well-organized, self-contained, mobile unit (cart or kit) at a centralized location that is readily available at all times. Drugs must be current and readily identifiable. The emergency cart or kit will contain all drugs and equipment necessary to perform emergency procedures. An emergency cart or kit must be present in each facility before any procedure is commenced. Emergency carts or kits must not be shared with other facilities when sedations are performed. The emergency cart or kit must be present until the patient is discharged from the facility.
*Flumazenil is only required if benzodiazepines are used.

**Naloxone is only required if opioids are used.
## Emergency Medications Required for Moderate Sedation

<table>
<thead>
<tr>
<th>Drug</th>
<th>Amount on Hand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxygen</td>
<td>One (1) Full “E” Cylinder</td>
</tr>
<tr>
<td>Epinephrine</td>
<td>Six (6) amps of 1:1000</td>
</tr>
<tr>
<td>Nitroglycerin</td>
<td>One (1) spraypump</td>
</tr>
<tr>
<td>Diphenhydramine or Chlorpheniramine</td>
<td>Two (2) vials of 50mg</td>
</tr>
<tr>
<td>Salbutamol Inhalation Aerosol</td>
<td>One (1) inhaler</td>
</tr>
<tr>
<td>ASA</td>
<td>One (1) small bottle</td>
</tr>
<tr>
<td>Flumazenil*</td>
<td>One (1) vial</td>
</tr>
<tr>
<td>Naloxone**</td>
<td>Two (2) amps</td>
</tr>
<tr>
<td>Atropine</td>
<td>Two (2) amps of 0.6mg</td>
</tr>
<tr>
<td>Hydrocortisone Succinate</td>
<td>Two (2) vials of 100mg</td>
</tr>
<tr>
<td>Supplemental glucose for oral use</td>
<td>Two (2) sources</td>
</tr>
</tbody>
</table>

**Notes:**

1. These are the minimum requirements for emergency medications. Practitioners may wish to have additional medications available.
2. The practitioner may wish to have additional vials of atropine and epinephrine on hand.
3. The portable oxygen cylinder must be a dedicated emergency supply and have a regulator/flowmeter/wrench and administration supplies continuously connected.
4. Salbutamol is best administered with an Aerocambr/ spacer.
5. Appropriate syringes/needles to draw/dilute/administer medications should be stored with the emergency medications.

6. Emergency equipment and drugs must be consolidated and stored in a well-organized, self-contained, mobile unit (cart or kit) at a centralized location that is readily available at all times. Drugs must be current and readily identifiable. The emergency cart or kit will contain all drugs and equipment necessary to perform emergency procedures. An emergency cart or kit must be present in each facility before any procedure is commenced. Emergency carts or kits must not be shared with other facilities when sedations are performed. The emergency cart or kit must be present until the patient is discharged from the facility.
*Flumazenil is only required if benzodiazepines are used.

**Naloxone is only required if opioids are used.
- Stylettes that will fit tracheal tube.
- Forceps (Magill).
- Emergency airway adjuncts (difficult intubation kit), which must include tracheotomy or cricothyrotomy sets.

(Note: At the discretion of the practitioner administering the deep sedation, the intubation equipment may include laryngeal mask and lighted stylette.)

E. **DEEP SEDATION DRUGS AND SUPPLIES**

1. **Sedative Drugs**

The choice of sedative drugs must be determined by the practitioner administering the deep sedation, who must ensure that all drugs are current and stored appropriately.

The prescribing and dispensing of drugs should comply with CDSBC Policy on that subject.

2. **Venipuncture**

Intravenous equipment and supplies must include the following:

- Cannulas (needles).
- Catheters.
- Administration sets (adult/pediatric/mini-drip).
- Intravenous stand.
- Intravenous solutions (choice to be determined by practitioner administering the deep sedation).

3. **Other Supplies**

Accessory equipment and supplies such as the following must be available and stored appropriately:

- Needles (various types/sizes).
- Syringes (various sizes).
- ECG leads and electrodes.
- Defibrillation paste or pads.
- Sponges, tape, etc.
- Throat packs.
- Lubricants.
- Disposal container for sharps.
- Padding (e.g., pillow) to help in head positioning.

F. **EMERGENCY ARMAMENTARIUM**

Emergency equipment and drugs must be readily available at all times. Drugs must be current and stored in readily identifiable, labeled trays or
bags. Space permitting, a "crash cart" is an ideal vehicle for storage and conveyance, but other appropriate containers may also be used. Emergency equipment and drugs must be consolidated and stored in a well-organized, self-contained, mobile unit (cart or kit) at a centralized location that is readily available at all times. Drugs must be current and readily identifiable. The emergency cart or kit will contain all drugs and equipment necessary to perform emergency procedures. An emergency cart or kit must be present in each facility before any procedure is commenced. Emergency carts or kits must not be shared with other facilities when sedations are performed. The emergency cart or kit must be present until the patient is discharged from the facility.

1. Emergency Equipment
   a. Airway Adjuncts (see item D, Essential Airway Equipment)
   b. Intravenous Equipment (see item E2, Venipuncture)
   c. Defibrillator

Each facility must have a defibrillator that conforms to CSA standards. It must be tested bi-monthly by appropriately trained personnel, and, as previously noted, records of testing and maintenance must be kept in an appropriate logbook.

*Note:* The equipment required for long-term cardiac life support is not essential in an out-patient deep sedation facility, because there is a low likelihood of it being used, and also because attempts to initiate its use would likely delay hospital transfer.

2. Emergency Drugs
   **A. Essential Emergency Drugs**
   There must be a minimum of two ampoules, except as noted, of the following essential emergency drugs:
   - Adenosine
   - Atropine
   - Benadryl
   - Dantrolene sodium (8 - 12 ampoules, enough for 2 mg/kg dose), if a triggering agent is used
   - Epinephrine
   - Flumazenil, if benzodiazepines are being used
   - Hydrocortisone or Solumedrol
   - Lidocaine
   - Naloxone, if narcotics are being used
   - Nitroglycerine
   - Succinycholine
   - Ventolin

   **B. Highly Recommended Emergency Drugs**
   It is highly recommended that the following emergency drugs also be kept on hand:
E. GENERAL ANAESTHETIC DRUGS AND SUPPLIES

1. Anaesthetic Drugs

The choice of anaesthetic drugs is determined by the anaesthetist who must ensure that all drugs are current and have been stored appropriately. There must be a drug inventory record and a periodic inspection by staff to ensure that used drugs have been restocked and out-dated drugs have been replaced.

2. Venipuncture

Intravenous access must be established in all cases. Intravenous equipment and supplies must include the following:
- Cannulas (needles)
- Catheters
- Administration sets (adult/pediatric)
- For smaller children, mini-drip sets (60 drops/cc) with burettes
- Intravenous stand
- Intravenous solutions (choice to be determined by anaesthetist)

3. Other Supplies

Accessory equipment and supplies such as the following must be available and stored appropriately:
- Needles (various types/sizes)
- Syringes (various sizes)
- ECG leads and electrodes
- Defibrillation paste or pads
- Sponges, tape, etc.
- Throat packs
- Lubricants
- Disposal container for sharps
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## Appendix C

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<td>Nitroglycerin</td>
<td>One (1) spraypump</td>
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<tr>
<td>Diphenhydramine or Chlorpheniramine</td>
<td>One (1) vial of 50mg</td>
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<td>ASA</td>
<td>One (1) small bottle</td>
</tr>
<tr>
<td>Flumazenil*</td>
<td>One (1) vial</td>
</tr>
<tr>
<td>Naloxone**</td>
<td>Two (2) amps</td>
</tr>
<tr>
<td>Supplemental glucose for oral use</td>
<td>One (1) source</td>
</tr>
</tbody>
</table>

Notes:

1. These are the minimum requirements for emergency medications. Practitioners may wish to have additional medications available.

2. The portable oxygen cylinder must be a dedicated emergency supply and have a regulator/flowmeter/wrench and administration supplies continuously connected.

3. Salbutamol is best administered with an Aerocambr/pace.

4. Appropriate syringes/needles to draw/dilute/administer medications should be stored with the emergency medications.

5. Emergency equipment and drugs must be consolidated and stored in a well-organized, self-contained, mobile unit (cart or kit) at a centralized location that is readily available at all times. Drugs must be current and readily identifiable. The emergency cart or kit will contain all drugs and equipment necessary to perform emergency procedures. An emergency cart or kit must be present in each facility before any procedure is commenced. Emergency carts or kits must not be shared with other facilities when sedations are performed. The emergency cart or kit must be present until the patient is discharged from the facility.

*Flumazenil is only required if benzodiazepines are used.

**Naloxone is only required if opioids are used.
## Appendix D

### Emergency Medications Required for Moderate Sedation

<table>
<thead>
<tr>
<th>Drug</th>
<th>Amount on Hand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxygen</td>
<td>One (1) Full “E” Cylinder</td>
</tr>
<tr>
<td>Epinephrine</td>
<td>Six (6) amps of 1:1000</td>
</tr>
<tr>
<td>Nitroglycerin</td>
<td>One (1) spraypump</td>
</tr>
<tr>
<td>Diphenhydramine or Chlorpheniramine</td>
<td>Two (2) vials of 50mg</td>
</tr>
<tr>
<td>Salbutamol Inhalation Aerosol</td>
<td>One (1) inhaler</td>
</tr>
<tr>
<td>ASA</td>
<td>One (1) small bottle</td>
</tr>
<tr>
<td>Flumazenil*</td>
<td>One (1) vial</td>
</tr>
<tr>
<td>Naloxone**</td>
<td>Two (2) amps</td>
</tr>
<tr>
<td>Atropine</td>
<td>Two (2) amps of 0.6mg</td>
</tr>
<tr>
<td>Hydrocortisone Succinate</td>
<td>Two (2) vials of 100mg</td>
</tr>
<tr>
<td>Supplemental glucose for oral use</td>
<td>Two (2) sources</td>
</tr>
</tbody>
</table>

Notes:

1. These are the minimum requirements for emergency medications. Practitioners may wish to have additional medications available.

2. The practitioner may wish to have additional vials of atropine and epinephrine on hand.

3. The portable oxygen cylinder must be a dedicated emergency supply and have a regulator/flowmeter/wrench and administration supplies continuously connected.

4. Salbutamol is best administered with an Aerochamber/spacer.

5. Appropriate syringes/needles to draw/dilute/administer medications should be stored with the emergency medications.

6. Emergency equipment and drugs must be consolidated and stored in a well-organized, self-contained, mobile unit (cart or kit) at a centralized location that is readily available at all times. Drugs must be current and readily identifiable. The emergency cart or kit will contain all drugs and equipment necessary to perform emergency procedures. An emergency cart or kit must be present in each facility before any procedure is commenced. Emergency carts or kits must not be shared with other facilities when sedations are performed. The emergency cart or kit must be present until the patient is discharged from the facility.

*Flumazenil is only required if benzodiazepines are used.

**Naloxone is only required if opioids are used.
- Stylettes that will fit tracheal tube.
- Forceps (Magill).
- Emergency airway adjuncts (difficult intubation kit), which must include tracheotomy or cricothyrotomy sets.
(Note: At the discretion of the practitioner administering the deep sedation, the intubation equipment may include laryngeal mask and lighted sylette.)

E. DEEP SEDATION DRUGS AND SUPPLIES

1. Sedative Drugs

The choice of sedative drugs must be determined by the practitioner administering the deep sedation, who must ensure that all drugs are current and stored appropriately.

The prescribing and dispensing of drugs should comply with CDSBC Policy on that subject.

2. Venipuncture

Intravenous equipment and supplies must include the following:
- Cannulas (needles).
- Catheters.
- Administration sets (adult/pediatric/mini-drip).
- Intravenous stand.
- Intravenous solutions (choice to be determined by practitioner administering the deep sedation).

3. Other Supplies

Accessory equipment and supplies such as the following must be available and stored appropriately:
- Needles (various types/sizes).
- Syringes (various sizes).
- ECG leads and electrodes.
- Defibrillation paste or pads.
- Sponges, tape, etc.
- Throat packs.
- Lubricants.
- Disposal container for sharps.
- Padding (e.g., pillow) to help in head positioning.

F. EMERGENCY ARMAMENTARIUM

Emergency equipment and drugs must be consolidated and stored in a well-organized, self-contained, mobile unit (cart or kit) at a centralized location that is readily available at all times. Drugs must be current and readily identifiable. The emergency cart or kit will contain all drugs and equipment necessary to perform emergency
procedures. An emergency cart or kit must be present in each facility before any procedure is commenced. Emergency carts or kits must not be shared with other facilities when sedations are performed. The emergency cart or kit must be present until the patient is discharged from the facility.

1. Emergency Equipment

   a. Airway Adjuncts (see item D, Essential Airway Equipment)
   b. Intravenous Equipment (see item E2, Venipuncture)
   c. Defibrillator

Each facility must have a defibrillator that conforms to CSA standards. It must be tested bi-monthly by appropriately trained personnel, and, as previously noted, records of testing and maintenance must be kept in an appropriate logbook.

*Note:* The equipment required for long-term cardiac life support is not essential in an out-patient deep sedation facility, because there is a low likelihood of it being used, and also because attempts to initiate its use would likely delay hospital transfer.

2. Emergency Drugs

   A. Essential Emergency Drugs

   There must be a minimum of two ampoules, except as noted, of the following essential emergency drugs:

   - Adenosine
   - Atropine
   - Benadryl
   - Dantrolene sodium (8 - 12 ampoules, enough for 2 mg/kg dose), if a triggering agent is used
   - Epinephrine
   - Flumazenil, if benzodiazepines are being used
   - Hydrocortisone or Solumedrol
   - Lidocaine
   - Naloxone, if narcotics are being used
   - Nitroglycerine
   - Succinylcholine
   - Ventolin

   B. Highly Recommended Emergency Drugs

   It is highly recommended that the following emergency drugs also be kept on hand:

   - Amiodarone
   - Digoxin
   - Ephedrine
   - Furosemide
   - Hydralazine
   - Isoproterenol
   - Labetalol hydrochloride
   - Morphine
E. GENERAL ANAESTHETIC DRUGS AND SUPPLIES

1. Anaesthetic Drugs

   The choice of anaesthetic drugs is determined by the anaesthetist who must ensure that all drugs are current and have been stored appropriately. There must be a drug inventory record and a periodic inspection by staff to ensure that used drugs have been restocked and out-dated drugs have been replaced.

2. Venipuncture

   Intravenous access must be established in all cases. Intravenous equipment and supplies must include the following:
   - Cannulas (needles)
   - Catheters
   - Administration sets (adult/pediatric)
   - For smaller children, mini-drip sets (60 drops/cc) with burettes
   - Intravenous stand
   - Intravenous solutions (choice to be determined by anaesthetist)

3. Other Supplies

   Accessory equipment and supplies such as the following must be available and stored appropriately:
   - Needles (various types/sizes)
   - Syringes (various sizes)
   - ECG leads and electrodes
   - Defibrillation paste or pads
   - Sponges, tape, etc.
   - Throat packs
   - Lubricants
   - Disposal container for sharps
   - Padding (e.g., pillow) to help in head positioning

F. EMERGENCY ARMAMENTARIUM

   Emergency equipment and drugs must be consolidated and stored in a well-organized, self-contained, mobile unit (cart or kit) at a centralized location that is readily available at all times. Drugs must be current and readily identifiable. The emergency cart or kit will contain all drugs and equipment necessary to perform emergency procedures. An emergency cart or kit must be present in each facility before any procedure is commenced. Emergency carts or kits must not be shared with other facilities when sedations are performed. The emergency cart of kit must be present until the patient is discharged from the facility.
Meeting the Challenge of Access to Care

Dr. Ray Grewal, President
Ms. Jocelyn Johnston, Executive Director
Since the BCDA Began 19 years ago

- **Administered $7.1M** in government funding
- **Fundraised $1.3M** through the Toothfairy Gala for dental treatment and research
- **Save A Smile** has provided just under **$1M** for urgent dental care of young children
Constitution: to serve & protect the interests of its members

a) promoting the **integrity and honour of the dental profession**

b) advancing the **scientific, educational, professional, and economic interests** of the dentists of British Columbia

c) preparing and distributing **fee guides and negotiating fee schedules** with government bodies, as necessary

d) collecting and preserving archives and artifacts of the society

e) **recognizing outstanding contribution and service** to the dental profession
BCDA Member Services

- SecureSend
- Mediation Program
- DPAP Counselling
- O.A.S.I.S.
- Fee Guide
- iTRANS
- Practice Resources & Policy Templates
- X-ray Inspection Program - CBCT
- Annual Wage Survey
- Advocacy
- PLAN Mapping Tool
- FREE CE and Training for Dentists & Staff
- YourDentalHealth Campaign
Constitution: to serve the public interest in...

a) **advancing** the art and **science** of dentistry

b) **providing continuing education programs** to advance the education of dentists and dental professionals in Canada and elsewhere

c) **promoting oral health**

d) facilitating and promoting **access to dental care**

e) developing and promoting **quality standards**

f) **promoting and facilitating relations between dentists and their patients**

g) **liaising with government, insurance providers, health care providers and other stakeholders** regarding the delivery of oral care services

h) to **provide assistance to individuals or groups who have purposes similar or beneficial to the society’s purposes.**
Continuing Education & Quality Standards

Silver Tsunami
Crystal Meth
Oral Cancer
Responsible Antibiotic Use
Medical Emergencies
Bisphosphonates
The First Dental Visit
Oral Health Outreach

Patient Information Bulletin: Direct-To-Consumer Dentistry: Is It Right for You?

Talk to Your Dentist.
Advances in technology offer dental patients more treatment options and promise shorter treatment times. Before you bypass the dental office, be informed:

1. ARE YOU A GOOD CANDIDATE?
Your dental and health history and oral condition will determine if you have any issues which may need to be addressed before considering any procedures.

2. ARE YOU AWARE OF ALL YOUR OPTIONS?
Some dental procedures offer a cost-effective option for dental care. Ask your dentist if any options are available and if a particular option is being recommended to you. Understand the benefits and risks of each before choosing what is best for you.

3. ARE YOU IN HEALTHY BODY?
If you have oral or systemic issues, you may not be a good candidate for procedures that involve your teeth. The suspension of use of breath fresheners, toothbrushes, mouthwash, and dental care can only be determined by your doctor.

Patient Information Bulletin: Cannabis & Dental Procedures

Whether you smoke it, vape, or use edibles, cannabis (marijuana) can negatively impact your dental appointment.

1. STAY GATE: TALK TO YOUR DENTIST
Tell your dentist and your lifestyle before your appointment. You can use cannabis, although it is not recommended. The dentist will be able to have a clear dialogue about your dental appointment.

2. CANNABIS CAN ALTER THE EFFECTIVENESS OF NON-SYMPHOMATIC MEDICATION
Cannabis can interact with medications that you are currently using, including painkillers, blood thinners, and antibiotics. Talk to your dentist before your appointment.

3. INCREASED HIRING
Cannabis use can cause an increased risk of infection, which can lead to more pain during and after dental procedures.

4. CANNABIS EFFECTS VARY
Cannabis can cause a delay in your recovery time, which can lead to oral pain. It can also cause increased bleeding, which can lead to problems with your dentures or crowns.

5. PLAN AHEAD: AVOID CANNABIS BEFORE YOUR APPOINTMENT
Cannabis can cause a delay in your recovery time, which can lead to oral pain. It can also cause increased bleeding, which can lead to problems with your dentures or crowns.
BC Oral Health Challenges

Decayed Teeth

Filled Teeth
Access to Care Challenges

Medically Supported Dentistry
- Cancer / Transplant
- Genetic Conditions
- Facial Trauma

Socio-Economically Vulnerable Patients
- Low Income
- Seniors
- First Nations

Early Childhood Caries
- Persons with Disability

Dental Conditions Requiring Medical Support
Medically Supported Dentistry

Medical Services Plan

$8 million a year for trauma, severe infection or disease including the surgical and orthodontic support for cleft lip and palate patients

Specialized Programs

BC Children’s Hospital

• Specialized dental care, including interim prosthetics & orthodontic care
• Final prosthetic once patient has reach maturity

BC Cancer Agency

• Access to necessary dental treatment prior cancer therapy
• Prosthodontic care, especially for oral cancer survivors
BCDA Support

Advocated for increase program funding for both oral Cancer survivors, (BC Cancer) and facial anomalies, (BCCH) patients ($100K annually combined)

Advocating for funding

• Program for Prosthodontic Excellence at BC Cancer to provide specialized prosthodontic care to oral cancer survivors and facial anomalies patients

Fundraise through the Toothfairy Gala; childhood survivors of cancer & oral cancer research ($140K)

Administer two prosthodontic programs on behalf of government

• Cleft Lip and Palate Prosthodontic program ($50K annually)
• Prosthodontic Management of Severe Dental Program ($50K annually)
Dental Conditions Requiring Medical Support in BC

10,000 dental patients are treated under GA annually

Children
- Approx. 50% under the age of 9
- Early Childhood Caries: most common reason a child receives a GA
- Dental disease is preventable

Adults
- Predominantly Persons with Disability and/or seniors
- Many are Ministry of Social Development and Poverty Reduction
- Treatment is for dental disease, though some is for preventive case
BCDA Support

Advocate and Collaborate with Ministry of Health

• Decreasing waitlist for dental surgery (increase of 900 surgeries)

Administer the Complex Medical Dental Pilot

• Ensure access to necessary dental care prior to medical treatment, i.e. organ transplant
• $50,000 initial funding

Advocate for Improved coverage under MSDPR programs

Health Promotion Campaigns and Initiatives

• First Nations Health Authority & Public Dental Health

Administer the Save A Smile Program

• $70,000 annually
Socio-Economic Vulnerable Patients

**Low income individuals**, especially those without a dental plan

**Seniors**, especially those in long term care

**First Nations

Refugees**
BCDA Support

Support BC’s 20 Not for Profit Clinics Treating 45,000 patients annually

- Advocating for additional NFP funding; current grant of $800k over 3 years
- Fund annual workshop for education and networking

Seniors

- Advocating for a Low Income Seniors Dental/ Long Term care coverage
- Funded UBC research on improving access to care in LTC homes
- Developed online course for caregivers
- Public Health campaigns
BCDA Support

First Nations

- Collaborate on Terrace pilot to reduce ECC hospitalizations
- Co-hosting a First Nations Dental Clinic workshop planned for 2019

Refugees

- Provided Dental Screenings to 900 Syrian Refugees in 2016 in collaboration with public health with oral health kits
- Provided health promotion material in Arabic
Develop a Prosthodontic program of excellence within PHSA

Ensure Dentistry’s voice within the government

Improve Ministry coverage for vulnerable patients:
- Persons with Disability & Income Assistance Dental Coverage
- Seniors Dental plan
- Funding for NFP Clinics

Dentists’ Access to Pharmanet
Government is Engaged

MSDPR Consultation on Poverty Reduction Report

Even people receiving income or disability assistance with supplemental health coverage were being forced to go without because of gaps in their coverage. They highlighted dental services, in particular, as not meeting their needs.

2018 Budget Finance Recommendation #9

Create a low-income senior’s dental plan, similar to the Healthy Kids Program, and integrate dental coordinator positions into long-term care facilities.

2019 Budget Finance Recommendation #44

Provide funding to not-for-profit dental clinics, and incentives to support dentists who provide charitable dentistry.
Questions?
November 14, 2018

Dr. Peter Lobb, President
College of Dental Surgeons of BC
500 – 1765 West 8th Avenue
Vancouver, BC V6J 5C6

Dear Dr. Lobb,

Thank you for the invitation to speak to the College Board on November 30, 2018.

In preparation for the meeting, please find enclosed the BCDA report, *A path to addressing critical gaps in dental healthcare*, along with the Association’s submission to the provincial government’s Consultation on Poverty Reduction. These documents provide an overview of the BCDA’s Access to Care activities and policy direction, working together with stakeholders such as government, the profession, UBC and patient groups.

I, along with our Executive Director Jocelyn Johnston, are happy to provide a high-level view on these important issues.

Warm regards,

Ray Grewal
President

Enclosures:  
- A path to addressing critical gaps in dental healthcare
- BCDA Submission to Poverty Reduction Consultation
A path to addressing critical gaps in dental healthcare

A stakeholder solutions preliminary report prepared by the BC Dental Association

August 2017
The British Columbia Dental Association would like to recognize the members of the Medically Supported Dental Care Task Force for their time and dedication to this important initiative.

A special thank you to:

Dr. Raymon Grewal (Chair)
Dr. Mark Casafrancisco
Dr. Debbie Fonseca
Dr. Anita Gartner
Dr. Tony Nadolski
Dr. Samson Ng
Dr. Tony Rea
Executive Summary

While most British Columbians enjoy optimal oral health, growing segments of the population in British Columbia face unique challenges in preventing and treating dental health issues.

Accessing dental care can be especially challenging for medically complex patients who are traditionally viewed as being outside the public healthcare system. This includes persons with a disability, young children with severe dental disease, seniors in long-term care, and adults with facial anomalies. According to the provincial Surgical Waitlist site, more than 2,200 dental patients are awaiting dental surgery, and in the case of pediatrics, a quarter of waitlisted patients require dental care.

Without improvements and new solutions to reduce the demands on the overall healthcare system in this province, the oral and general health of these vulnerable groups will continue to deteriorate.

Using a collaborative and solutions-focused approach, the BC Dental Association’s Medically Supported Dental Care Task Force initiated a consultation process in early 2016 to better understand the issues surrounding access to dental care. The Task Force heard from stakeholders and patient groups, as well as medical and dental healthcare professionals.

The first step is to recognize the importance of dental health as part of overall health, especially for these vulnerable populations. The next step is to recognize that dental disease is preventable. Ensuring access to preventive dental services, early intervention and support for medically complex patients will reduce the burden on the healthcare system and improve the quality of life for these patients. Finally, it’s important to recognize the short- and longer-term efficiencies that can be gained through collaboration and co-operation among health professions, Health Authorities and provincial government ministries.
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14: Expand Section 19 of the Medical and Health Care Services Regulation to allow Health Authorities to contract with private general anaesthesia facilities accredited by the College of Dental Surgeons of BC.  

15: Expand the Community Partners Program or develop a similar program to expand the number of available general anaesthetic facilities beyond the Lower Mainland.  

Persons with a disability (PWD)  

16: The agreement between Community Living BC, Ministry of Health and the Health Authorities, Guidelines for Collaborative Service Delivery for Adults with Developmental Disabilities, be updated and clarified with respect to Appendix 4.  

17: Modernize the Ministry of Social Development & Social Innovation’s dental plan to meet the needs of vulnerable patient groups to preserve dentition and functionality along with preventing pain and infection:  

1. Undertake research to determine what patients with different disabilities require, and ensure the plan provides sufficient coverage.  

2. Ensure that artificial annual limits are not a barrier to necessary treatment.  

3. Set fees that reflect the time and cost required to provide care for this complex group of patients and to reduce the incidence of balance billing, which can be a barrier to care.  

18: Ministry of Health and Ministry of Social Development & Social Innovation to coordinate resources to ensure programs and resources for persons with a disability and low-income children are effective and used to maximum efficiency.  

19: Ministry of Health and Ministry of Social Development & Social Innovation to develop a continuum of community sedation options ranging from nitrous oxide, oral to intravenous, to general anaesthesia.  

20: Develop support for healthcare providers responsible for the dental needs of medically complex patients, to facilitate patient care.  

21: Hospitals to encourage the coordination of general anaesthesia sessions for patients with disabilities so that dental exams, x-rays and care can be provided when a patient is receiving medical exams or other diagnostic treatment.  

22: The Province and Health Authorities should create community-based clinics as part of the healthcare (hospital) system for vulnerable patients such as persons with a disability, with access to advance sedation.  

23: Include hospital-based dental practice locations as teaching sites for the Faculty of Dentistry – modelled on the Seattle Special Care Dentistry Clinic.
24: Foster better access of community-based dentists to hospital-based programs to promote a dental home, which has been shown to improve care in terms of follow-up, and can reduce repeat sedations. .......................................................................................................................................... 29

Pediatric dental patients, including ECC patients

25: Develop a program to facilitate access to a province-wide accessible fluoride varnish program to reduce the incidence of early childhood caries. ................................................................. 36

26: Dental healthcare providers should promote the use of diamine fluoride, which has been shown to be effective in arresting decay ........................................................................................................... 36

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29: Develop education for healthcare providers around eligibility and services related to public dental coverage: Medical Services Plan, First Nations Health Authority, Healthy Kids and Ministry of Children and Family Development .......................................................................................................................... 37

30: Seek options to allow more community pediatric dentists to treat at BC Children’s Hospital’s operating room, to ensure continuity of care for their patients, improve care in terms of follow-up and reduce repeat general anaesthetics. .......................................................................................................................... 38

31: Improve the transition of young adults (17-19) from BC Children’s Hospital to dentists in the community. ........................................................................................................................................ 38

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Frail seniors and geriatric dental care

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34: Develop integrated models of care within long-term care facilities that ensure communications and co-operation with respect to dental care ........................................................................................................................................... 39

35: Ensure long-term care residents receive an annual dental examination by a dentist .......................................................................................................................... 39

36: The provincial government should provide a basic dental plan for low-income seniors and for all long-term care residents, to alleviate financial barriers to receiving basic care ........................................................................................................... 39

37: Fund and support Dental Care Coordinator positions in long-term care to assist care aides in providing care and assist dental professionals providing in-facility care. ......................................................................................... 40
38: Develop support and training for healthcare providers who work with dental clients who have special needs or care requirements. ................................................................. 40

Patients with facial anomalies due to congenital birth defects or disease

39: Educate professionals about the long-term dental needs of people with facial differences. Creating courses for post-grads, continuing education for professionals, and certification will go a long way toward building confidence for these patients. ................................................................. 41

40: Create an online referral system for patients seeking certified professionals. ......................... 41

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Introduction

A growing number of patients require medical support for their dental care, either due to the nature of their medical condition or to the extent of dental treatment required. This may be no more than a consultation between the patient’s dentist and physician to determine the risks for dental treatment. On the other end of the spectrum are patients with a congenital birth defect that necessitates co-treatment by a team of medical and dental specialists, including oral and maxillofacial surgeons, orthodontists, and maxillofacial prosthodontists, along with plastic surgeons, ENT specialists, etc.

Access to care can be very challenging for patients who require sedation and/or a hospital setting for their dental care (e.g., children with extensive dental decay, a condition referred to as Early Childhood Caries [ECC], persons with a disability and frail seniors). It’s important to realize that, left untreated, dental decay is progressive and the patient can suffer pain, infection and bleeding. If the appropriate dental treatment is delayed, the condition is managed through pain medication and antibiotics but can still pose a risk to the patient.

The scarcity of public healthcare resources increases the challenge for these patients, who are traditionally viewed as being outside the public system. According to the provincial Surgical Waitlist site, more than 2,200 dental patients are awaiting dental surgery, and in the case of pediatrics, a quarter of waitlisted patients require dental care.

Without some foreseeable resolution to reducing the demands on the overall healthcare system, the situation will only deteriorate. The increasing number of seniors in the population and rising rates of disability suggest the number of people who require medical support for their dental care is trending upward. The first step is to recognize the importance of dental health as part of overall health, especially for these vulnerable populations. Second, recognize that dental disease is preventable. Ensuring access to preventive services, early intervention and support will not only reduce the impact on the healthcare system, but also improve the quality of life for these patients. Third, short- and longer-term efficiencies can be gained through collaboration and co-operation by health professions, the Health Authority and provincial government ministries.

The comments received recognize that medical and dental communities frequently collaborate. That said, the ongoing demands on the healthcare system inadvertently marginalize dental patients. This is further complicated by the mix of funding sources, regulations and responsibilities shared among various ministries, Health Authorities, private insurers and patients themselves.

The intent of this report is to have dental and medical healthcare providers, as well as stakeholder groups, identify the barriers and suggest solutions. From these responses, supplemented with background information, the issues and recommendations are laid out within the following structure:

1. **Inter-professional & multi-disciplinary care:** There is a continuum of interaction between the dental community and other health providers, ranging from a relatively
simple consultation to a large multi-practitioners group focused on medically complex patients.

2. **Medically complex patient groups:** Due to their medical conditions or extent of their dental needs, certain patient groups are challenged in receiving necessary dental/medical care:

- Persons with a disability, both adults and children
- Young children with severe dental disease (EEC)
- Seniors in long-term care facilities
- Adults with facial anomalies

Please note: in the interest of practicality and time, the stakeholder suggestions/issues identified in this report have been curated based on their viability in the near term by the British Columbia Dental Association (BCDA) Medically Supported Dental Care Task Force, staff and Board of Directors.

This report will be shared with those who were part of the consultative process and made available to the public via the BCDA’s website, bcdental.org. The intent of the report is to raise awareness of the issues that medically or dentally complex patients are facing and what options exist to improve their oral and overall health. While some recommendations may be easily adopted, the majority will require collaboration for success. We believe this will open the door to greater teamwork among healthcare providers, government and patients.

**Methodology**

Between February and April 2016, a letter from Dr. Raymon Grewal, Chair of BCDA’s Medically Supported Dental Care Task Force, was sent to a broad range of stakeholders:

- ABOUTFACE Craniofacial Family Society
- Autism BC
- BC Anesthetists Society
- BC Dental Hygienists’ Association
- BC Pediatric Society
- BC Pharmacy Association
- Certified Dental Assistants of BC
- Child Health BC
- College of Dental Hygiene of BC
- College of Dental Surgeons of BC
- College of Physicians and Surgeons of BC
- Doctors of BC
- Inclusion BC
- Lower Mainland Down Syndrome Society
- Members of the BC Dental Association
- BC Ministry of Children and Family Development
- BC Ministry of Health
- BC Ministry of Social Development and Social Innovation
- Parents of patients with disabilities
- Provincial Health Authorities:
  - Vancouver Island Health Authority
  - Interior Health Authority
  - Fraser Health Authority
  - Vancouver Coastal Health
  - Northern Health Authority
- Provincial Health Officer – Dr. Perry Kendall
These stakeholders were asked for their input/insights on the following questions:

1. What, if any, are the barriers to care that exist, or have been encountered in relation to collaboration/co-operation with dental professionals for medical or dental treatment of common patients?

2. What workable solutions would your organization suggest to address these issues or concerns?

3. With the exception of the above, are there any other concerns? If so, what are they and what suggestions do you have to address them?

Comments were received from many providers and stakeholders, from which we identified patient groups, their issues and potential solutions. Upon reviewing the comments and supplemental research to better define the issues, the Task Force arrived at a set of recommendations that could be broken down into two areas: Inter-Professional and Multi-Disciplinary Care and Medically Complex Patient Groups.

With regard to the latter, recommendations focused on:

- Persons with a disability (PWD)
- Pediatric Dental Care (including children with Early Childhood Caries)
- Frail Seniors and Geriatric Care
- Patients with Facial Anomalies

This report will be shared with stakeholders, including professional organizations and those who contributed to the report, to improve understanding of where the most serious gaps lie and lay the groundwork to address them so that we may better meet the dental healthcare needs of these vulnerable populations.
Inter-Professional and Multi-Disciplinary Care
Most dental patients are treated safely within dental offices every day. But medical conditions and/or medications can affect treatment options. An example is the care required for a patient who needs an extraction after cancer treatment involving bisphosphonates, due to the risk of bone necrosis. Or the patient who requires co-management within a hospital setting by dentists and other healthcare providers to ensure any risk of complications is minimized. Facial trauma or patients born with a facial anomaly will require complex care from different providers to ensure that whatever medical treatment is provided, the patient’s dentition is optimally restored to improve the patient’s quality of life.

Inter-professional communications

Most interactions between dental and other health professionals are dealt with through inter-professional communications that can take the form of a letter and/or telephone call. In more complicated cases, such as an endocarditis patient, a dentist may be asked for a consultation to determine if the source of infection is due to dental disease.

The College of Physicians and Surgeons of BC (CPSBC), individual dentists and the Doctors of BC (DOBC) agree that inter-professional communications between dentists and medical physicians are positive. That said, there is merit in developing protocols to facilitate this process.

Collaborating further, dental, medical and other health professions can improve communication to enhance patient care, including agreeing on a definition for a ‘medically complex’ dental patient.

1: The BC Dental Association, in conjunction with other health professions, should develop communications and educational material regarding the various aspects of dental care and the medically complex patient.

Having access to diagnostic services and prescribing rights facilitates patient care and reduces the reliance of dentists to refer patients to their GP physician. Like physicians and midwives, dentists have the ability to order lab tests and write prescriptions for both schedule 1 and 2 drugs. Unlike physicians and pharmacists, dentists do not have access to PharmaNet, despite being the second-largest prescribing group after physicians. Expanding access to include dentists would ensure dentists have current drug histories, which facilitates treatment and ensures all communications between professionals is accurate.

2: The BC Ministry of Health should initiate the process to expand PharmaNet access to include dentists.

Dental practitioners provided more than 3,000 hospital-related consultations in 2016.
Standardized treatment guidelines and protocols

Where a condition or potential infection has been associated with dental treatment, the use of agreed-upon guidelines has enhanced patient care by ensuring a common approach between medical and dental practitioners.

An excellent example is the current guideline for patients with heart conditions. It identifies which heart conditions require the prophylactic use of antibiotics prior to dental treatment and is prepared by the American Heart Associationiii.

An emerging area of concern is Xerostomia, or dry mouth, which can arise from some medical conditions or medications. The lack of saliva can increase the risk of dental decay and additional care must be taken. Xerostomia is associated with anti-psychotic medications and medications used for cardiac transplant and valve replacement patients, as well as cancer, Parkinson’s and dementia patients. These conditions are also associated with frail seniors who need additional support for their daily oral care.

3: The dental and medical communities should develop a program to raise awareness among practitioners of the risk of Xerostomia and its potential effect on patients.

Dentistry’s roles within multi-disciplinary healthcare teams

Many of the comments received recognize the roles medical and dental professionals can have as part of multi-disciplinary health teams. Several successful examples exist throughout the province:

- BC Cancer Agency’s Oral Cancer team has oral and maxillofacial surgeons, oral medicine specialists, prosthodontists and dentists working alongside oncologists, ENT and plastic surgeons to provide treatment and post-treatment support, including facial and dental reconstruction for oral cancer patients. Dentists will also provide advice and treatment in advance of radiation therapy to minimize the risk of infection.

- BC Children’s Hospital’s Cleft Palate & Craniofacial Disorders Clinic includes oral and maxillofacial surgeons, pediatric dentists, orthodontists and prosthodontists to provide and support surgical and orthodontic care for children with facial anomalies.

- Hospital dental departments that provide emergency support for facial and dental trauma, as well as consultations and medically necessary dental treatment for hospitalized patients.

- Long-term care facilities where dental professionals, including dental hygienists and denturists, provide both preventive therapeutic and rehabilitative care, as required (see section on frail seniors and long-term care residents).
Examples of co-management

- Open-heart surgical patients who are at risk of endocarditis
- Diabetic or patients on dialysis who are at risk for infection from possible dental abscesses
- Psychiatric patients with unknown facial or head pain
- Emergency room patients with serious abscesses requiring hospitalizations
- Patients who need organ transplants should have dental consultations (heart, liver, lungs, etc.)
- Patients whose teeth are broken during emergency intubations
- Patients with an infection of an unknown source
- Patients who are bleeding from the mouth due to blood thinners
- Patients who have a dental abscess or swelling
- Patients who’ve suffered trauma or dental trauma

In smaller communities, teams may develop informally through necessity. In Prince George there is a longstanding arrangement between the city’s dentists and the hospital to ensure there is Emergency Room (ER) coverage as well as advanced sedation services available for dental patients.

Including dentists and other dental health professionals can improve patient care in some cases through:

1. Ensuring a comprehensive diagnosis and treatment is arrived at faster.
2. Making it easier for patients to visit one facility for assessment and treatment.
3. Improving health outcomes in terms of creating centres of expertise and knowledge through cross-discipline care.

Not only will this “team” approach improve care, but also the healthcare system will benefit through efficiencies gained. For the more formalized teams, these collaborations most often reside in teaching hospitals or regional centres where medical and dental specialists can easily come together, generally in larger urban areas.

While there is common agreement that this is an excellent approach, several factors impede teamwork, such as treatment funding and professional and healthcare legislation.

These barriers can be traced back to the Canada Health Act and how it has influenced dentistry’s role in the public healthcare system. The Act defines what basic services are covered by the public healthcare system, including dental services. Specifically, ‘insured surgical-dental services means any medically or dentally required surgical-dental procedures performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedures’.

From this definition, the current state of hospital-based dental services evolved with respect to provincial funding, hospital legislation/regulation and availability of services, and barriers to care evolved with it.

Funding for hospital-based dental services

Compared to medicine, relatively few dental or oral surgical services are covered under MSP. Those covered range from complex extractions and biopsies to facial trauma and rehabilitation.
For some procedures, coverage is contingent upon certain conditions being met, the primary one being that the active treatment is provided in hospital. MSP also covers the professional fees for anaesthetists providing services for dental care in both hospital and private facilities, provided the conditions meet those under agreed-upon policy terms. If not, the anaesthetist can charge directly for their services.

Some emergency care is covered in hospital ERs, generally facial trauma or dental infections. As well, dentists and dental specialists are eligible for call-out fees and after hour premiums. Unlike their medical colleagues, dentists are neither eligible for on-call nor telephone consultations fees.

...barrier that was identified is that some dentists are unwilling to participate in a call schedule for emergency dental patients, which results in ERs providing “Band-Aid care” over weekends and holidays.

— BC Physician

Non-MSP services can be provided in hospital and these are generally restorative procedures such as fillings or root canals. These procedures are the responsibility of the patient, though dental coverage, either private or government, pays all or some of the fees.

The majority of funding for dentistry comes from private dental plans and patients themselves. Approximately 60-65% of British Columbians have private dental coverage. Major sources of government funding are:

- Ministry of Social Development and Social Innovation (MSDSI) for clients on income assistance, including PWD and low-income children through the Healthy Kids Program.
- Ministry of Children and Family Development (MCFD) for foster children and for children under the At Home program, provided they meet certain conditions.
- First Nations Health Authority, through buy-back from Healthy Canada’s NIHB program.
- Federal Veterans Affairs dental plan for veterans.

Each plan is unique with its own set of adjudication rules, remuneration and financial limits. It is often very difficult for patients, practitioners and caregivers to navigate through the system. Treatment not covered becomes the responsibility of the patient or the patient’s family (see following table.)

**New Funding for Children’s Oral Health**

On March 22, 2017, the Ministry of Social Development and Social Innovation (MSDSI) announced an additional $5 million per year would be allocated to improve existing dental plans for children. BCDA is currently working with MSDSI to implement the increase for September 2017.
<table>
<thead>
<tr>
<th>Who is covered?</th>
<th>Government Administrator</th>
<th>Eligibility</th>
<th>$ Limits</th>
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| Ministry of Social Development and Social Innovation (MSDSI) | MSDSI | • Based on asset/income criteria  
• As above with the addition of medical criteria | Income Assistance: Emergency Services only  
PWD: Up to $1,000 per two years and emergency care when limit is exhausted |
| Healthy Kids | BC Ministry of Social Development & Social Innovation | • Parents qualify for MSDSI coverage  
• The family qualifies for MSP Premium Assistance | $1,400 per two years. Additional $1,000/year for treatment in hospital under general anaesthetic.  
Child whose parents are clients of MSDSI are eligible for ortho. |
| Ministry of Children and Family Development (MCFD) | MCFD | Children and Youth in Care  
• Youth Agreements  
• Status Aboriginal  
• Status Nisga’a  
• Children in the At Home program | Children and Youth: $700/year  
Aboriginal: $700/year ($100/year MCFD) with $600 from NIHB  
Ortho: $5,000 lifetime  
At Home Program: Dental Care is pre-authorized |
| First Nations Health Authority | Health Canada on behalf of the BC First Nations Health Authority (Non-Insured Health Benefits program) | Registered First Nations | Procedure-based limits. Limits by either number of procedures or a financial limit |
| Federal Veterans Affairs dental plan | Veterans Affairs Canada | Veteran | $1,500 for Category B |
| Employer-provided or purchased dental plans | Private insurance companies | Pay premium | Defined by plan |
Provincial health legislation and regulations

The BC Hospital Act and its regulation permits dentists access to operating room (OR) time and oral and maxillofacial surgeons access to admitting and discharge privileges. The range of dental services offered in hospitals varies across Health Authorities. While some offer OR time for dentists and dental specialists, not all have the necessary equipment for a full dental operatory or even inter-oral X-ray equipment within the OR.

On the other end of the spectrum, Vancouver General Hospital has a full dental clinic specifically intended for patients with medical conditions, which provides regular care and has access to OR time for patients who require it. Where specialized care is provided, such as by BC Children’s Hospital (BCCH) and the BC Cancer Agency, dental clinics are available with access to ORs.

As in the case of other healthcare professionals, dentists and dental specialists must apply for hospital privileges and approval is dependent upon whether the professional can meet the credentialling standards. While an oral surgeon’s advanced degree is sufficient, a general dentist or other specialist is often required to have completed a hospital residency, usually after completing a general dentistry degree.

As well, the professional must demonstrate that their experience is current, which generally means they’ve been maintaining their hospital practice. With limited access to OR time, appropriately educated dentists fall behind if they’re unable to regularly practice within a hospital. The concern is that when older dentists retire their hospital practices, qualified candidates may not be able to take over as they cannot meet the credentialling requirements, or else have built practices that cannot accommodate absences from their office.

4: Ensure hospitals establish clear accountabilities around who is the Most Responsible Provider for dental patients, to ensure patient safety.

5: Human resource planning at the community level should include dental professionals to ensure continuity of hospital dental services.

6: Explore the BC Loan Forgiveness Program and Health Match BC as a means of ensuring communities have access to hospital-based dental services.

7: The Ministry of Health and Health Authorities should encourage coordinated, multi-disciplinary care in hospital and institutional settings.

It is our suggestion that Health Authorities work with the BC Dental Association to re-evaluate the time allocation for these procedures.

– Michael Marchbank,
President and CEO,
Fraser Health Authority
8: For medical facilities that offer dental services, ensure dental professionals have the equipment and resources to efficiently deliver care in hospital- and community-based settings; e.g., radiology equipment, sterilization equipment, etc.

9: In rural settings with small populations, create multi-disciplinary offices that include dental care.

Lack of Hospital Access for Dental Professionals

Approximately 10,000 BC patients received dental treatment under the care of an anaesthetist, with over half of these patients being children under the age of 10.

BC’s surgical waitlists report approximately 1,000 adult patients, with 90% of those receiving care within 33.3 weeks. More concerning is that 25% of BC’s pediatric surgical waitlist, approximately 1,300 children, are awaiting dental care.

Expand dental coverage for these patients so most of their treatment may be looked after in either private practice or private general anesthetic facilities. These environments are able to provide care in a much more efficient and timely manner than the hospital clinic.

– Reza Nouri, Pediatric Specialist

There are approved dental facilities outside hospitals available to relieve this pressure and make these services available to waiting pediatric patients. Open contract bid opportunities to these facilities to provide MSP covered services for children.

– Kulminder Bahi, Oral and Maxillofacial Surgeon

Source: BC Ministry of Health, unpublished data
Patients most in need of advanced sedation, (PWD and young children), are MSDSI clients or covered under the Ministry's Healthy Kids program for children of low-income families.

Many comments focused on the lack of access to OR time as a major barrier to care but also recognized the public hospital system is overburdened, and that options are required to ease waitlists.

In rural areas (Interior Health [IH] region), barriers to medically supported dental care include dentists’ access to OR time as well as patients’ access to a dentist who has OR privileges. Only a select number of dentists have permission through IH to offer dental surgery in an OR.

– Chris Mazurkewich, President and CEO, Interior Health Authority

Most dental and oral surgeries are considered elective and are frequently given lower priority than other surgical medical procedures when demands on OR time outweigh supply. Dental concerns may not be properly considered as there is not a dental representative on the Provincial Surgical Committee of the Ministry of Health.

...there needs to be better availability of dentists for after-hours coverage and... dentists should be encouraged to apply for hospital privileges.

– BC Physician

Within the last decade, the number of dentists providing care in hospital has declined since it was not feasible to continue an OR schedule with decreased access to the OR. It is difficult to continue providing OR-based services when a dentist only has one OR day every six months, as patients would need to be managed for pain and infection while awaiting care. Instead the patients were referred to other dentists or dental specialists with OR time. Those dentists who continue with their hospital practice are often older practitioners. Without appropriate human resource planning, communities may find they are without dentists eligible to provide OR care as these dentists retire. In some areas of the province, patients need to travel to larger centres for care. For example, there are no GPs with hospital time in Nanaimo, requiring PWD patients to travel to Victoria for OR-based care.

10: Ensure that dentistry is represented on the Provincial Surgical Committee.

With the decline in dental OR time came a decline in the ER presence of dentists and dental specialists. In the past, there was quid pro quo; dentists who attended the ER and took call were granted OR time. This has proven frustrating for both physicians and patients. As the availability of OR time has diminished, so has the number of dentists who would take call. Unlike physicians who are paid to be on-call for a certain time period, dentists are only paid when they are called out. Also, a dentist may not be paid for the services rendered in the OR if the patient is referred out. Dentists are reluctant to be consultants for local ERs because unlike their medical colleagues, they cannot bill for telephone consultations but most attend the OR to be paid.
The culmination of these factors has limited the number of available dentists willing to take on a hospital practice.

11: Include MSP coverage for telephone consultations with hospital departments.

12: Explore – with the Ministry of Health, Doctors of BC and BC Dental Association – Medical Services Plan billing codes for supporting a dental patient in and out of hospital.

13: Replace the current call-out fee for dentists and dental specialists with a flat on-call rate to ensure emergency room coverage for dental emergencies.

Alternatives to hospital ORs

Some patients can be treated in private general anesthesia (GA) facilities throughout BC. However, those patients requiring hospital support, such as access to medical specialists and/or an ICU, are not appropriate candidates. Dental care provided in these clinics is outside of MSP; hence, patients are responsible for a facility fee unless there is available coverage through other programs. Clearly this will not be an option for low-income patients without available coverage. Many stakeholders recognized that access to private sedation and/or GA facilities is a viable option to reducing hospital waitlists and the demands on the public healthcare system. In fact, this was recognized by the Ministry of Health in its Discussion Paper, Future Directions for Surgical Services In British Columbia, which reported how the capacity of the public healthcare resources in Regina and Saskatoon increased their surgical and diagnostic capacity through the use of third-party facilities to offer day surgery for a number of services including dental. Patients consistently report high satisfaction ratings with this arrangement. The report suggested this could be an option for BC.

Both the College of Dental Surgeons of BC (CDSBC) and CPSBC have accreditation programs for facilities that offer sedation, including general anesthesia. In recognition of this option, the Ministry of Health amended Section 19 of the Medical and Health Care Services Regulation to allow a Health Authority to contract directly with private GA facilities to provide MSP-billable services outside of a hospital setting. The caveat is that only those facilities accredited by the CPSBC are eligible.

This places an undue limitation on feasible alternatives for expanding access to care, for at least some patients. CDSBC facilities are intended to provide only dental care while CPSBC facilities are often designed for broader medical service such as plastic surgery, etc. and may not be interested in providing care to dental patients. To date there is only one Health Authority that has contracted with private medical facilities for dental care.

14: Expand Section 19 of the Medical and Health Care Services Regulation to allow Health Authorities to contract with private general anaesthesia facilities accredited by the College of Dental Surgeons of BC.
Community Partners Program
The Provincial Health Services Authority, through BCCH, contracts with private GA facilities for pediatric dental and PWD patients who are covered under MSDSI dental plans. A $1-million fund was established in 2003 by MSDSI and contracts are in place with facilities accredited by both CDSBC and CPSBC. MSP dental services cannot be billed under this program. While initially the program had contracts at seven facilities across the province, today there are only four, all located in the Lower Mainland.

This program demonstrates that contracting for GA services is a viable option for children and PWDs to reduce waitlists, improve access to care and realize OR cost savings. In 2014/2015, the average cost per patient to CPP was under $1,000, whereas the cost of care within a hospital was $1,515x.

15: Expand the Community Partners Program or develop a similar program to expand the number of available general anaesthetic facilities beyond the Lower Mainland.

Our experience is that barriers to accessing dental care, particularly if a general anesthetic is required, are primarily cost… or very significant waitlists if dental care is delivered in a hospital setting… While there are opportunities to move some procedures to the private surgical sector through public private partnerships, cost and access are still very problematic.

– Heidi Oetter, MD, Registrar, BC College of Physicians and Surgeons

In 2014/2015, the program covered the facility fees for 1,023 patients, the majority of whom were children under the age of 10.
Medically Complex Patient Groups
Barriers facing vulnerable patient groups

Dental disease is preventable and there has been demonstrable improvement in the oral health of British Columbians over the past 30 years. This is a result of a lifetime of daily oral hygiene care and access to professional dental services. Unlike their parents, most adults are reaching retirement with most of their dentition and will not require dentures.

Despite this progress, some British Columbians are challenged in reaching their optimal oral health. There is considerable literature that links poor oral health to lower socio-economic factors. Generally speaking, dental treatment for these groups can be managed within a dental office and hence is not within the scope of this discussion paper. If care requires medical intervention, then these patients generally share the same concerns.

However, dental/medical conditions can pose a challenge in accessing care for PWD, young children and frail seniors. Contributing factors affecting the oral health of vulnerable patients are:

- Lack of access to fluoridated drinking water: unlike the rest of Canada, less than 3% of BC’s population has access to fluoridated water that reduces the incidence of dental decay. While other patients can compensate through proper diet and eating habits, and daily mouth care with fluoridated toothpaste and professional dental hygiene care, this may not be the case for all patients, especially those who are dependant on others.

- Patients’ medical conditions may not facilitate effective daily oral hygiene.

- Daily hygiene support is not always available for patients in hospital or an institutional setting.

- Patients may not be co-operative, especially seniors or small children.

- Caregivers may not understand the importance of or be capable of providing daily oral hygiene.

- Due to age or medical condition, patients may be non-verbal and unable to help identify the source of pain or infection.

- The patient’s medical condition may contribute to their dental issues.

Recognizing these challenges, dentists will endeavour to assist patients to reach their optimal oral health, with the priority of keeping the patient pain- and infection-free and maintaining functionality. This is not always possible, because:

- Dentists and their staff may not be able to adequately address a medically complex patient’s dental needs in their offices, and must refer the patient to the appropriate dental specialist or a GP dentist with advanced training.

- The recommended treatment plan requires sedation for safe and efficient care, which may require a referral to a practitioner who can access a private GA facility or hospital OR.
• The costs of establishing a CDSBC-accredited private GA facility is substantial.

• For a CPSBC-accredited dental facility, the cost is even higher due to the requirement for two on-staff physicians.

• While some patients may be able to be treated in a private sedation facility, the facility fee itself may be a barrier to care.

• Some hospitals do not have dental equipment available such as dental X-rays, etc. In the case of hand pieces or dental materials that are not stocked by a hospital, dentists are required to provide the equipment a day in advance so it can be sterilized to comply with the Ministry of Health infection control protocols.

• Rural practitioners have limited access to dental specialists or sedation facilities if hospital OR time is not available.

• Hospitals in smaller centres may not be able to support medically complex patients, requiring patients to travel to larger centres, such as the Lower Mainland.

Persons with a disability (PWD)

The range of barriers faced by PWD will vary depending on the nature of the disability and whether they are MSDSI clients. Generally speaking, patients who are able to communicate and manage their oral health face fewer challenges than those patients who are dependent upon others for their care.

Most adult PWD are clients of MSDSI and receive basic dental coverage. Children with disabilities (CWD) may receive coverage under MCFD, and if not, may be covered under Healthy Kids, which is an MSDSI program for low-income children (see Cost of Care, page 22).

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_It was suggested [by our members] that dental health benefits should be improved for certain patient populations including people with disabilities and those on MSP premium assistance. Some physicians also felt that emergency dental care should be considered a healthcare necessity with funding based upon ability to pay._

— BC Physician

MSDSI coverage is available for adults who:

• Have a severe physical or mental impairment that is expected to continue for more than two years.

• Are significantly restricted in their ability to perform daily-living activities and require assistance with daily living activities from another person, an assistive device or assistance animal.

• Have very limited assets and limited access to ongoing financial support.
As of April 2016, there were 93,506 cases identified as PWD, covering 111,390 individuals who are all entitled to medical and dental benefits. This represents 60% of all MSDSI clients, including those on Temporary Assistance. Since 2005, the number of PWD cases has increased by 60% and clients by 65%. (Cases include PWD clients and their dependents.)

**MSDSI program limitations**

MSDSI’s dental plan for PWD clients is very basic, covering preventive and restorative care as well as partial and full dentures. Patients are eligible for $1,000 of treatment every two years and there are annual procedure limits. If a patient exceeds either financial or annual limits, the patient is eligible only for emergency dental care, with no access to preventive or follow-up care.

Despite the dramatic increase in PWD clients since 2005, there has not been a program review to evaluate whether the Ministry’s plan is meeting its clients’ needs. For example, some patients could benefit from more preventive care than is allowed under the program. If a patient exceeds their financial limit due to the amount of treatment provided in a single hospital visit, they are only eligible for emergency care and must wait until the next two-year cycle for preventive care.

Except for the March 22, 2017 increase to children’s dental plans (details on page 17), the Ministry has not increased the fees since 2007 (except for some minor changes in 2010). Some fees, such as for partial dentures, are so low that in some cases they barely if at all cover the direct cost of the prosthetic. Though 90% of dentists bill the Ministry program, approximately half of these are estimated to charge additional fees to cover the cost of treatment. Given the limited resources available to Ministry clients, this can be a barrier to care, especially for preventive service.

MSDSI does not cover sedation services in dental offices and relies on hospital resources within the public healthcare system and those contracted under the Community Partners Program.

The Health Authorities, with the support of the Ministry of Health, work in conjunction with Community Living BC (CLBC) to support children and adults with developmental disabilities in achieving good oral health and accessing community dental care. A review of the agreement between the provincial government ministries and CLBC is required, at least with respect to dental care, since who is responsible for which services is unclear. For example, Appendix 4 relates specifically to dental care and includes the following: ‘Program direction, policies and standards will be provided by the Senior Dental Health Consultant in the Ministry of Health Services.’ What these standards are and how they are implemented is not evident.

16: The agreement between Community Living BC, Ministry of Health and the Health Authorities, *Guidelines for Collaborative Service Delivery for Adults with Developmental Disabilities*, be updated and clarified with respect to Appendix 4.
The frustration felt by the dental profession has been echoed in the comments from patient groups and the medical community. A number of physicians commented that a lack of dental coverage [under MSP] for certain groups of patients is a barrier to collaboration in that it is not even possible to communicate with a dentist in these cases. This is particularly the case for patients who use emergency departments as a substitute for seeing a primary care physician and for those with chronic mental illness.

– BC Physician

The Province is long overdue in reviewing and revising PWD, including the Dental Plan. The PWD Dental Plan was developed in 1982 and has not been revised in any significant way over the past 34 years and as such provides for far less than even the most basic dental care for people on PWD. The Plan coverage does not reflect best dental treatment practices and must be modernized and enhanced. As well, fees must reflect all the time and services that are required for people with disabilities, recognizing that added support and time may be necessary to ensure safe, respectful and quality dental care.

– Faith Bodnar, Executive Director, InclusionBC

17: Modernize the Ministry of Social Development & Social Innovation’s dental plan to meet the needs of vulnerable patient groups to preserve dentition and functionality along with preventing pain and infection:

1. Undertake research to determine what patients with different disabilities require, and ensure the plan provides sufficient coverage.

2. Ensure that artificial annual limits are not a barrier to necessary treatment.

3. Set fees that reflect the time and cost required to provide care for this complex group of patients and to reduce the incidence of balance billing, which can be a barrier to care.

18: Ministry of Health and Ministry of Social Development & Social Innovation to coordinate resources to ensure programs and resources for persons with a disability and low-income children are effective and used to maximum efficiency.

19: Ministry of Health and Ministry of Social Development & Social Innovation to develop a continuum of community sedation options ranging from nitrous oxide, oral to intravenous, to general anaesthesia.
20: Develop support for healthcare providers responsible for the dental needs of medically complex patients, to facilitate patient care.

21: Hospitals to encourage the coordination of general anaesthesia sessions for patients with disabilities so that dental exams, X-rays and care can be provided when a patient is receiving medical exams or other diagnostic treatment.

22: The Province and Health Authorities should create community-based clinics as part of the healthcare (hospital) system for vulnerable patients such as persons with a disability, with access to advance sedation.

23: Include hospital-based dental practice locations as teaching sites for the Faculty of Dentistry – modelled on the Seattle Special Care Dentistry Clinic.

24: Foster better access of community-based dentists to hospital-based programs to promote a dental home, which has been shown to improve care in terms of follow-up, and can reduce repeat sedations.

Pediatric dental patients, including ECC patients

Several comments were received regarding this patient group, with a focus on prevention strategies, funding and access to hospitals or other anaesthesia options. The comments are warranted given that while most BC children enjoy optimal oral health, the need for dental care under GA appears to be increasing. This reflects, in part, population growth, but there are growing numbers of young children with severe dental decay, sometimes referred to as Early Childhood Caries, ECC, who require GA for the efficient and safe delivery of their dental care.

Dental decay is preventable and reducing the incidence of dental disease will not only improve the quality of life for these patients, but also will reduce the demands on the healthcare system. Preventative strategies and broadening the options for access to anaesthesia are simultaneously required to ease demands in both the short and long term.

Status of oral health of BC’s children

In 2000, BC’s provincial dental officer cited the most common reason a child receives GA in BC is for dental care. Today, it vies with otolaryngology surgeries for first place. That said, only 11.2% of the BC pediatric surgical waitlist is for otolaryngology, while dentistry represents 26% as of Dec. 31, 2016. As previously noted, children under the age of four have the highest incidence of being treated under anaesthesia.
Rate by 1,000 Patients Receiving Dental Anaesthesia

<table>
<thead>
<tr>
<th>Age</th>
<th>Rate by 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4</td>
<td>15.3</td>
</tr>
<tr>
<td>5-9</td>
<td>12.0</td>
</tr>
<tr>
<td>10-15</td>
<td>2.4</td>
</tr>
<tr>
<td>Total</td>
<td>9.0</td>
</tr>
</tbody>
</table>


While the need for dental anaesthesia is increasing, the overall incidence of dental disease appears to be falling. Through kindergarten screenings over a seven-year period, the rate of children screened who are caries-free (without dental decay) has increased, while the rates of treated caries and untreated decay have both declined. In 2013, 67.3% of kindergarten-aged children were caries- or decay-free.

Similar data is not available for older children, but self-reported results of BC teens are encouraging in that most high school students (84%) had visited the dentist in the past 12 months, although 5% had last visited more than 24 months ago.

Of concern are the 2% who had never been to the dentist, and of those who had been to the dentist, the 8% who reported the reason for their visit was to address pain (9% of females vs. 8% of males). The longer it had been since the youth had gone to the dentist, the more likely it was that their last visit was for pain.
<table>
<thead>
<tr>
<th>Area</th>
<th>Visit Last 12 Mos</th>
<th>24 Mos</th>
<th>Never Been</th>
<th>Last Visit was for Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Columbia</td>
<td>84</td>
<td>5</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Central Vancouver Island</td>
<td>84</td>
<td>6</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>East Kootenay</td>
<td>86</td>
<td>4</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Fraser East</td>
<td>84</td>
<td>5</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Fraser North</td>
<td>84</td>
<td>5</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Fraser South</td>
<td>85</td>
<td>5</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Kootenay Boundary</td>
<td>84</td>
<td>5</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>North Shore/ Coast Garibaldi</td>
<td>86</td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>North Vancouver Island</td>
<td>82</td>
<td>7</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Northeast</td>
<td>82</td>
<td>6</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Northern Interior</td>
<td>85</td>
<td>5</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Northwest</td>
<td>85</td>
<td>4</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Okanagan</td>
<td>85</td>
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<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Richmond</td>
<td>84</td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>South Vancouver Island</td>
<td>84</td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Thompson Cariboo Shuswap</td>
<td>83</td>
<td>6</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Vancouver</td>
<td>85</td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
</tbody>
</table>

Dental health varies by region in British Columbia. The chart ‘Dental Health Indicators vs. BC Average by Region’ shows the six regions with the largest variation from the provincial average according to three measures of children’s oral health. The Northwest, Northern Interior and Northeast regions are the only three of 16 regions that perform worse than the provincial average on all three measures.

**Impact and Extent of ECC on British Columbia**

Left untreated, ECC can cause pain and infection, interfering with sleep, growth and learning, and it can be the cause of behavioural problems. When several teeth are affected, patients will likely require sedation, often GA, depending on their weight, age, the extent of treatment and other medical considerations.

The incidence of ECC is not distributed evenly across populations. In 2013, CIHI reported that day surgery rates in Canada:

- Were 8.6 times as high for children from neighbourhoods with big (versus small) Aboriginal populations.
- Were 3.9 times as high for children from the least (versus the most) affluent neighbourhoods.
- Were 3.1 times as high for children from rural (versus urban) neighbourhoods.

The highest rate of GA is for children under the age of four. Estimates have varied since 2000 from 10-15 per 1,000 children but with a
general trend upwards. Across the province, the rates vary considerably from 6.9 per 1,000 in East Fraser Health to as high as 52 per 1,000 in Northwest BC xv.

For ECC alone, the average annual cost in terms of hospital care was $3.5 million between 2010-2011 and 2011-2012. This did not include the cost of professional fees for the anaesthesia and dentistry provided, which could double this cost xvi.

Clearly prevention will not only improve the quality of life for these children but also could reduce the need for more extensive treatment later in life. It will also reduce the demands on the public healthcare system either by reducing costs and/or freeing resources for other medical treatment.

While prevention is a simple concept, implementing prevention strategies is far more complex. Commonly cited reasons for ECC are:

1. Parents and caregivers are unaware of the importance of baby teeth and the need for daily home care and visits to professional oral health providers for preventive treatments and early intervention.

2. Lack of access to pediatric dentists in smaller communities.

3. Lack of access to general dentists who will examine children under the age of three years.

4. Parents and caregivers lack the financial resources to seek care.

In addition to the above, some groups, such as children with disabilities (CWD) and First Nations, face additional challenges.

**Children with disabilities (CWD)**

Another high-risk group is CWD, especially those with multiple disabilities, as they are more likely to suffer dental infection or pain. While disabled children are affected in the same way as children without a disability, there is the added risk that medically necessary procedures, such as cardiac or other surgeries, can be delayed due to active dental disease.

In addition to the reasons noted above, CWD, especially those with complicated medical needs, face additional difficulties in accessing dentists who can provide appropriate care. In a survey of general practitioner dentists in BC, some of the problems identified were xvii:

- Lack of appropriate training.
- Dental fees do not reflect the additional time that is often required for treatment.
- Lack of access to GA for the appropriate delivery of care.
A dentist’s decision to refer or treat a CWD patient is based on several factors: procedure time, patient individuality, parent wishes, distance and travel time. Generally, referrals would be made to a pediatric dentist or BCCH.

“We recognize that providing adequate care for children with development disabilities requires collaboration between medical and dental professionals; however, the barriers that were raised (by social workers when asked) related primarily to the coordination and collaboration between dental professionals and MCFD staff.”

– Jonathan Barry, Executive Director, Provincial Services, MCFD

First Nations Children

It is clear that First Nations children have a considerably higher incidence of dental disease than other BC children. As identified in the BC’s First Nations and Aboriginal Oral Health Strategy, there are a number of barriers to good oral health:

- Remoteness of communities and lack of on-reserve oral health professionals.
- Lack of funding to support community programs.
- Lack of knowledge regarding food choices and infant feeding practices.
- Transiency.

The First Nations Health Authority (FNHA) is actively engaged in caries-prevention programs, especially those targeting young children. In addition to dentists, dental hygienists and dental therapists providing treatment, some communities have Children’s Oral Health Initiative workers who not only provide fluoride varnish to young children but also work with families on caries prevention education.

FHNA offers dental and other health benefits through a buy-back of services from Health Canada, which originally provided these benefits prior to the establishment of the Authority. The program’s administration has improved under FHNA’s administration.

![Provincial Kindergarten Dental Screening Results](image)

Aboriginal & Non-Aboriginal Children

- % Caries Free
- % Treated Caries
- % Visible Decay
Reducing the incidence of ECC through prevention

Governments and oral health professionals recognize the need for preventive strategies in both private dental offices and through public dental health programs.

The Canadian Dental Association recommends that children be taken to visit a dentist within six months of their first tooth erupting or by age one. In a survey of BC GPs, 64% encourage parents to bring their child in for their first dental visit by age one while 65% treat children under the age of three.xix

Public dental health providers, FHNA and BCDA, among others, have been actively involved in caries-prevention strategies.

In terms of public health initiatives, each Health Authority has dedicated dental health staff who are engaged in education activities as well as in providing assessment and preventive treatment. Programs are aimed at children at high risk for dental caries, as well as persons with a disability. To better target infants, many Health Authorities will attempt to coordinate their activities with vaccination schedules and continue past the age of two for children who are deemed high-risk. Staff will also refer patients to local dentists for care. BCDA works in conjunction with the public dental health staff to support urgent treatment for low-income families.

To complement this work, the Ministry of Health provides information on oral health to new mothers in several venues.

“...we should put handouts in the going-home-from hospital package telling parents how to care for teeth, how to avoid ECC and about fluoride prevention programs.”
– Katherine R. Gross, Pediatrician
(on behalf of BC Pediatrics)

BCDA is involved in several initiatives to educate and promote oral health, including several patient groups that contain young children. These include television and radio ad campaigns and multi-ethnic resources available online. In the case of children, the focus is on education and the importance of good oral health and how to take care of baby teeth, along with nutritional and diet information. Resources are also available to assist dental practitioners on best practices for examining pediatric patients.

One solution identified was the introduction of a universal fluoride varnish program for children under the age of five in the recent Lifetime Prevention Schedule For Children and Youthxx. The Ministry of Health, in conjunction with the Health Authorities and BCDA, is currently assessing the feasibility.

“From a public health perspective, primary prevention of caries and access to clinically proven preventative measures such as fluoride in drinking water and fluoride varnish are priorities.”
– P.R.W Kendall, OBC, MBBS, MHSc, FRCP, Provincial Health Officer
Another option that is broader in scope and employed in other provinces is fluoridated drinking water. However, as noted before, this is not a realistic goal.

25: Develop a program to facilitate access to a province-wide accessible fluoride varnish program to reduce the incidence of early childhood caries.

26: Dental healthcare providers should promote the use of diamine fluoride, which has been shown to be effective in arresting decay.

27: Ensure new parents’ in-hospital packages include advice on how to care for teeth and prevent early childhood caries – especially as not all families interact with public health.

Cost of dental care

As cited by the Canadian Dental Association, “there is a strong association between poverty and dental decay, and families of children at high-risk usually have low incomes among a myriad of other challenges”xxi. While dental costs are commonly cited as a barrier to care, most children have access to some form of dental coverage, especially low-income children.

Dental coverage within BC for private plans is estimated to be around 60%. Public plans also cover several high-risk groups:

- MSDSI offers coverage for children of low-income families that qualify for MSP Premium Assistance through the Healthy Kids program.
- FNHA covers pediatric dental care through the NIHB program.
- MCFD covers foster children and some CWD on the At Home Program. If the child does not qualify for the At Home program, the family can apply for Healthy Kids.
- Ministry of Health will cover medically necessary procedures, when provided in-hospital as per the MSP dental and dental specialist schedules.

That said, not all plans are equal, varying in terms of fees, coverage, financial and/or procedure limits and administration. As noted previously, MSDSI fees average around just 55% of the BCDA 2017 Fee Guide. This remains a challenge for dental offices and in some cases dentists will balance-bill some or part of the fee.

It is difficult for dental offices to ascertain coverage, especially for children covered under several plans such as MCFD and FHNA, as each program claims to be ‘payer of last resort’. For families or support workers, this is an even more daunting challenge to navigate.

Comments from staff within MCFD in particular express concern around this issue, as foster children fall within the Ministry’s responsibility. Concerns were expressed about the need for clarity around fees/dental coverage, and around engaging both birth parents and foster parents in the delivery of the child’s dental care. There is also confusion over coverage when a child...
leaves the Ministry’s responsibility or ages out of care.

**28:** Extend dental coverage and other benefits to a year past when a child leaves the Ministry of Children and Family Development’s care, to ensure planned treatment can be completed.

**29:** Develop education for healthcare providers around eligibility and services related to public dental coverage: Medical Services Plan, First Nations Health Authority, Healthy Kids and Ministry of Children and Family Development.

**Expanding access to pediatric dental sedations**

There are roughly 6,000 children who are treated under GA each year, split equally between the ages of under-four and five to nine. For the younger age group, the magnitude of the issue is greatest due to the need for pediatric specialists and facilities, especially for children under age three.

As noted earlier, access to hospital OR time is at a premium throughout the province, especially for young patients. There are considerable demands on BCCH as the tertiary pediatric hospital for the province and the primary hospital for Vancouver Coastal Health Authority’s pediatric dental cases. The focus of BCCH’s dental department is to treat medically complex children and children under the age of four. Due to safety concerns, children under the age of two are treated primarily at BCCH.

As a teaching hospital, it is also the site for UBC’s Pediatric Dental Speciality program, which has reduced the availability of OR time for the Lower Mainland pediatric dental specialists. Last year the nursing shortage directly affected availability of OR time. It is no surprise that of the pediatric waitlist, 390 patients were awaiting treatment at BCCH as of January 31, 2017.

While the CPP program can help in easing the waitlist, generally only children over age three can be treated in these facilities, and the program is restricted to patients covered under MSDSI.

There are few options for Lower Mainland pediatric dental specialists to access OR time for their patients; they must either refer patients to BCCH to be treated by the residents or, if the patient can be treated safely, take the patient to a private GA facility. In the case of the latter, if the child is not covered by a government program such as Healthy Kids, the family must cover the private GA facility fee, which could be $500-$1,000.

Older patients, or those with certain medical conditions, are treated in local hospitals provided there is available OR time. When there is not, patients are referred to larger regional hospitals, including BCCH.
30: Seek options to allow more community pediatric dentists to treat at BC Children’s Hospital’s operating room, to ensure continuity of care for their patients, improve care in terms of follow-up and reduce repeat general anaesthetics.

31: Improve the transition of young adults (17-19) from BC Children’s Hospital to dentists in the community.

32: Allow pediatric dentists to treat previous BC Children’s Hospital patients in community hospital operating rooms, including at Vancouver General Hospital, to ensure continuity of care for their patients.

Frail seniors and geriatric dental care

As a person ages, so does their dentition. Frailty, illness and even medications can contribute to the decline in seniors’ oral health. Today many seniors are entering long-term care (LTC) with most, if not all, of their natural teeth. At the same time, these individuals face multiple health issues and require support for many of their basic care needs (including brushing teeth). Their dental health can deteriorate rapidly, risking pain and infection, and contributing to the deterioration of their overall health.

The Regulations under the Community Care and Assisted Living Act are intended to ensure that LTC residents have access to ongoing dental care. It requires each resident to have an oral healthcare plan along with assistance for persons in care to maintain daily health and obtain professional dental care (Part 5-Operation, Division 2-General Care Requirements, 54-General Health and Hygiene).

- Despite this, patients face several challenges with respect to accessing both daily care and professional care.
- Some homes are unaware of their responsibilities under this regulation.
- Staff are pressed for time to assist or provide daily dental hygiene. In some cases, staff are not properly trained.

Ensuring the LTC homes are aware of their responsibilities under the regulation would assist residents to maintain their oral health.

33: Educate residential care facilities on the requirements for oral healthcare as outlined under the Care and Assisted Living Act: Residential Care Regulations, and ensure that resident oral health plans are in place and being implemented.

Oral health providers also face challenges in providing care:

- There is a limit to what professional dental care can be provided in a facility, and if the condition cannot be managed, the patient may need to travel to seek care.
- For dental professionals, it may be difficult to obtain consent from the person with the power of attorney.
Residents may not have the means to cover the cost of professional dental care.

There are some cost-effective models of care within BC that engage dental healthcare professionals within LTC facilities to support residents with their oral health. For example, in the Prince George Outreach Geriatric Dental Program, three dentists, two dental hygienists and a certified dental assistant (CDA) provide care for residents within six LTC facilities. The CDA is integral in coordinating care for the residents.

These dental professionals are engaged on a contract basis for monthly care and emergencies at a cost of approximately $21,600 annually; funding is provided by Northern Health. This program can serve as a model to expand care to LTC facilities throughout the province.

34: Develop integrated models of care within long-term care facilities that ensure communications and co-operation with respect to dental care.

35: Ensure long-term care residents receive an annual dental examination by a dentist.

A key factor of successful dental programs in LTC is supporting preventive care and timely access to dental exams and treatment. Most residents are responsible for professional dental care; however, not all have the means to cover the cost. A plan for low-income seniors, similar to the Healthy Kids program, would ensure that financially vulnerable seniors have access to basic care. Extending the program to all low-income seniors would also ensure that independent seniors would be able to maintain their oral health, thereby reducing the risk of compromising their overall health.

The inclusion of a basic dental plan, ensuring residents receive an exam, preventive and limited restorative care would ensure that any barriers related to cost are addressed. BCDA’s 2008 Report on Seniors’ Oral Health estimated that a basic dental plan for residents in LTC facilities would cost $6 million. Given the increase in the number of beds, current estimates would be closer to $10 million.

36: The provincial government should provide a basic dental plan for low-income seniors and for all long-term care residents, to alleviate financial barriers to receiving basic care.

A LTC dental plan would also encourage dental practitioners to treat in LTC homes, as often there is no guarantee of payment unless the home has made special arrangements. Practitioners also have several administrative tasks that take them away from providing care, such as obtaining consent and arranging access to the patient.

A dentally trained coordinator is a cost-effective means for a facility to integrate an effective preventive oral healthcare program. BCDA, in collaboration with the UBC Geriatric Dentistry Program, recently completed a year-long dental coordinator pilot project in Comox. A CDA was
hired to facilitate a dental healthcare program within the four regional facilities. Working between the facilities, the coordinator:

• Provided care staff with mouth care training, including hands-on support for challenging residents.

• Coordinated dental exams and care with dentists in the community—including confirming medication use, scheduling transportation and/or securing space for dentists to treat patients on-site.

• Secured the necessary consent for care with family members.

• Assisted in providing an oral care plan for each resident.

For the purpose of the pilot, all those participating were offered free dental exams; any follow-up care was based on a fee per service and was up to the individual patient and family to cover these costs. Hospital administrators, care staff, as well as the dental professionals were enthusiastic about the pilot and the value the coordinator role contributed to ensure all parties had the tools required to care for the residents.

37: Fund and support Dental Care Coordinator positions in long-term care to assist care aides in providing care and assist dental professionals providing in-facility care.

38: Develop support and training for healthcare providers who work with dental clients who have special needs or care requirements.

Patients with facial anomalies due to congenital birth defects or disease

The healthcare system offers medical support for patients with facial anomalies, but rehabilitation of the patient’s dentition varies in terms of coverage and how care is accessed.

When a child is identified with a facial anomaly, reconstructive surgery is available through the public healthcare system. For example, an infant born with a cleft and/or palate deformity is immediately assessed at birth and in some cases, surgical or other treatment will commence, such as having stents placed within their nostrils to help close the opening created. As well, orthodontic treatment is also available for children who qualify under MSP’s Cleft Lip and Palate program. When a child reaches maturity, there is limited government funding for a final prosthesis once all surgeries and orthodontic treatment have been completed.

“Many professionals have honestly said that the government compensation to treat children and youth with facial differences is too low and therefore they choose not to engage with this community.”

— Anna Pileggi,
Executive Director,
ABOUTFACE
While palatial birth defects are covered, there are other congenital problems that affect dentition, such as oligodontia. Young patients will require more treatment for the management of their dentition in terms of temporary prosthetics, orthodontics and possible oral surgery. Upon maturity, patients often require a prosthetic such as a full or partial denture; increasingly the preferred treatment is an implant-supported prosthetic, as it helps to stabilize the bone within the arch. This care often exceeds private and public coverage, and can place financial strain on the patient.

During their lifetime, these patients can encounter difficulties in accessing appropriate dental care, including rehabilitation:

1. Financial: For adults this is a major barrier because there is very little if any support for treatment for updating work and many people require additional medical support such as anaesthesia for certain procedures. For many the cost is prohibitive, especially in remote areas where travel and accommodation costs add to the financial burden.

2. Experience/training: Not many professionals feel they are adequately trained for this type of patient and are therefore unwilling to take the risk of treating them.

3. Trust: This is an enormously important factor for people with facial differences when they seek medical/dental treatment. Having to explain to new healthcare providers who may have very little exposure to their particular situation means they have to relive trauma.

39: Educate professionals about the long-term dental needs of people with facial differences. Creating courses for post-grads, continuing education for professionals, and certification will go a long way toward building confidence for these patients.

40: Create an online referral system for patients seeking certified professionals.

41: Collaborate with community agencies such as About Face to help educate patients about certified professionals.

42: Develop adequate funding sources, public or private, to cover basic care for rehabilitation and associated travel costs.
Conclusion

The interplay of dentistry and the medical professions is generally a straightforward division which, for the most part, is defined by the *Canada Health Act*. However, for those patients who require some form of medical support for their dental care, or alternatively, require dental support for their medical care, it can be a difficult road to navigate, not only for patients but for providers and caregivers as well. Initial efforts should focus on:

- Expanding sedation options for dental treatment, including general anaesthetic services, within the public healthcare system, to reduce the demands for in-hospital care.

- Increase the number of dental practitioners who have the resources and expertise to address the needs of patients with specific medical/dental conditions.

- Reduce structural barriers between dentistry and medicine to encourage collaborative care in terms of legislation, funding, etc.

- In some cases, expand access to preventive programs to reduce the need for more advanced care within the public healthcare system.

- Encourage governments to review dental programs to ensure they meet the needs of their clients, are appropriately funded and minimize administrative complexity.

Recognizing these barriers to dental care is a first step, but it will take a committed effort on the part of dental and medical professionals, governments, and patient support groups to improve access to care for medically vulnerable patients.
Endnotes


ii In addition to the benefits cited above, access to Pharmanet will reduce drug seeking behaviour of some patient.

iii American Heart Association, Infective Endocarditis, www.heart.org/HEARTORG/Conditions/CongenitalHeartDefects/TheImpactofCongenitalHeartDefects/Infective-Endocarditis_UCM_307108_Article.jsp#.V65EGq335lU, accessed August 12, 2016

iv Canada Health Act, R.S.C., 1985, c. C-6, Section, Interpretation

v The MSP schedules for dental practitioners outlines what medical conditions qualify for in-hospital care are listed in the preamble of each section of the schedules. To access the schedules, go to http://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/msp/dentists


viii BC Ministry of Health, FUTURE DIRECTIONS FOR SURGICAL SERVICES IN BRITISH COLUMBIA. BC Ministry of Health & the Provincial Surgical Executive Committee, Cross Sector, Policy Discussion Paper, 2015, p 50

ix BCDA letter to Mr. Wynne Powell, Chair, Provincial Health Authority, September 19, 2016

x GUIDELINES FOR COLLABORATIVE SERVICE DELIVERY FOR ADULTS WITH DEVELOPMENTAL DISABILITIES. Community living British Columbia, Regional and Provincial Health Authorities, Ministry of Health Services, Ministry of Housing and Social Development, Appendix 4: Dental Health Services for Persons with a Development Disability, January 2010


xiii McCreary Centre Society, From Hastong Street to Haida Gwaii, Provincial results of the 2013 BC Adolescent Health Survey, 2014, p 13
xiv  Canadian Health Institute for Health Information, Treatment of Preventable Dental Cavities in Preschoolers: A Focus on Day Surgery Under General Anaesthesia, p vii

xv  Canadian Health Institute for Health Information, Treatment of Preventable Dental Cavities in Preschoolers: A Focus on Day Surgery Under General Anaesthesia, p xvii

xvi  Canadian Health Institute for Health Information, Treatment of Preventable Dental Cavities in Preschoolers: A Focus on Day Surgery Under General Anaesthesia, Table 2: Hospital Cost of Day Surgery for ECC by Location of Residence, Selected Provinces/Territories, Children Age 1 to Younger Than 5, Two-Year Pooled (2010-2011 to 2011-2012), p xii

xvii K.R. Mathu-Muju, S. Sun & R Harrison, British Columbia General Dentists’ Ability to Provide Care to Children With Special Health Care Needs, UBC Dentistry, 2016 p13

xviii Healthy Smiles for Life: BC’s First Nations and Aboriginal Oral Health Strategy, Table 2, p 11

xix  BCDA 2016 Census Survey, unpublished data


xxi  Canadian Dental Association, ’Position Paper on Access to Oral Health Care for Canadians,’ 2010
http://www.cda-adc.ca/_files/position_statements/accessToCarePaper.pdf, p 6


The link between poverty and poor oral health is well recognized. As noted in the Canadian Academy of Health Sciences report,

*Poor oral health is also causally linked to chronic pain, poor nutrition, impaired learning, and persistent infection, and it is strongly associated with arthritis and dementia. People with poor oral health also suffer from reduced dignity, self respect, employability and social connectedness, all of which have major health implications. (p 50)*

This is demonstrated in a number of ways:

1. Approximately 1% of emergency room visits are for non-traumatic dental care for the 29 reporting hospitals in BC. Of these patient, 98% were seen and released without their dental condition being treated.
2. In Canada, day surgery rates to treat extensive dental decay for children under the age of 6 were 3.9 times higher for children in the least affluent versus most affluent neighbourhoods.
3. BC's 22 not-for-profit dental clinics provided over 45,000 patient visits in 2017, a growth of 36% since 2011.

What is less understood is how poor oral health contributes to poverty. Consider the following:

4. 29% of low income US adults in a self-reported study stated that 'the appearance of my mouth and teeth affects my ability to interview for a job', while 82% 'believe straight, bright teeth help you get ahead in life'.
5. In Canada, about 2.26 million school-days and 4.15 million working-days are lost every year due to dental visits or dental sick-days.
6. An Ontario study suggested that there is the potential for discrimination of the poor based on oral health.
7. Assuming access to fluoride leads to better oral health as an adult, a US study found that the earnings were approximately 2% higher for those with access to fluoridated water during childhood than those without. In the case of women, the rate was 4%.

Poor oral health is inextricably tied to poverty, both as a health care concern and as a contributor to poverty.

Further complicating the matter, unlike other provinces, BC has virtually no fluoridated drinking water. Over the years, British Columbians have voted against fluoridated water in municipal referendums which led to lower oral health measures, especially for vulnerable patient groups that may not readily access preventive care such as young children and frail seniors.

Looking forward, any proposed poverty reduction plan for BC must address improving oral health outcomes for financially vulnerable patients.
The BCDA recommends the government implement an Oral Health Strategy that engages government ministries and the health authorities to ensure that limited resources are efficiently employed with respect to effective public health promotion programs and to ensure that public dental plans assist vulnerable populations to reach their optimal oral health. To do so also requires the engagement of critical stakeholders such as the BC Dental Association, professional and patient advocacy groups, as well as others such as BC’s more than 20 not-for-profit clinics.

Discussion:
As part of the BCDA’s recommendations, the following statements not only answer the three questions posed by the consultation, but also illustrate the need for an overall approach to reducing oral diseases in BC and how this will contribute to the province’s Poverty Reduction Strategy.

1. **What does success look like in a BC Poverty Reduction Strategy?**

   From dentistry’s perspective, a measure of success would be that all British Columbians have optimal oral health: that their oral health does not deter or hinder their ability to speak, eat, work and socialize; and they are pain and infection free.

BC’s public and private dental care sectors have met the majority of British Columbians’ oral health needs:

- 70% of British Columbians visited the dentist in 2014, and among seniors, the rate was 64%.viii
- An estimated 65% of British Columbians have access to a dental planix.
- The province has the lowest population to dentist ratio in the countryx and is supported by other dental auxiliaries such as dental hygienists and denturists.
- Many vulnerable groups have access to public dental coverage: children from low income families, income assistance clients, persons with disability, foster children and First Nations.
- There are over 20 not-for-profit clinics providing care, either free of charge or at discounted rates, for vulnerable groups: children, the homeless and financially challenged, including seniors.
- There is an active dental public oral health department within the health authorities to support oral care for young children and persons with disability.

However, British Columbians do not enjoy the same level of dental health as other Canadians as illustrated in this comparison of decayed, missing and filled teeth (DMFT) index:

<table>
<thead>
<tr>
<th>Age</th>
<th>Decayed Teeth</th>
<th>Missing Teeth</th>
<th>Filled Teeth</th>
<th>Decayed, Missing &amp; Filled Teeth (DMFT)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BC</td>
<td>CDN</td>
<td>BC</td>
<td>CDN</td>
</tr>
<tr>
<td>20-39</td>
<td>1.16</td>
<td>0.81</td>
<td>0.60</td>
<td>0.39</td>
</tr>
<tr>
<td>40-59</td>
<td>0.53</td>
<td>0.45</td>
<td>2.45</td>
<td>2.42</td>
</tr>
<tr>
<td>60-79</td>
<td>0.33</td>
<td>0.37</td>
<td>5.85</td>
<td>5.57</td>
</tr>
</tbody>
</table>

Note: BC figures are from the 2006 Adult Dental Health Survey (adjusted to the CHMS age groups). Canadian figures are from the 2009 Community Health Measures Survey.
In part, this is attributed to the lack of fluoridated water. In Ontario and Alberta, 67.3% and 43.3% of the population, respectively, have access to fluoridated water, compared to under 3% in BC.

It is also important to note that the difference between the provincial and national DMFT rates is primarily the result of filled teeth and not decayed, indicating that British Columbians are receiving treatment for the most part.

Other contributing factors to poor oral health in BC include:

1. BC has the second highest rate of poverty in Canada, 13.2%.\textsuperscript{xii}
2. There is a large number of recent immigrants to Canada.
3. Not all dental coverage is equal, and patients must cover the co-pay and any procedures not covered.
4. Dental anxiety and phobias, estimated between 22% of the population, act as a deterrent to seeking care early.\textsuperscript{xii}
5. Remote areas are still challenged in obtaining dental care.

Some patient groups have poorer oral health as measured in different ways:

1. For low income patients, dental insurance reduces barriers to care, but does not eliminate them. These patients have fewer dental visits and poor oral health.\textsuperscript{xii} For example, First Nations have access to a robust dental plan, but poor oral health.\textsuperscript{xii}
2. Children under the age of 6 in BC who are treated in the operating room for dental surgery have a higher probability of coming from a lower income area.\textsuperscript{xv}
3. Approximately 45% of patients at not-for-profit clinics self reported ‘fair’ to ‘poor’ oral health. Though 63% reported ‘good to excellent’ oral health, over 95% reported at least one or more chronic medical conditions.\textsuperscript{xv}

2. What do you think are the best ways to reduce poverty in British Columbia?

The social determinates of health similarly impact oral health, specifically: lack of access to clean drinking water, lack of understanding of the need for ongoing preventive care (including the importance of primary teeth), lack of access to dental care, both restorative and preventive, as well as less healthy diets. Last, the role of dental phobia cannot be dismissed which is estimated to impact 20% of the population, often arising due to a traumatizing event, and not always associated with dental treatment.

Improving the social determinants of health, including oral health, is one of the best ways to reduce poverty.
3. **What can we do as a province, a community or as individuals to reduce poverty and contribute to economic and social inclusion?**

**Provincial Level:**

*Recommendation 1:* Undertake an oral health needs assessment for British Columbians taking into consideration at-risk groups:

1. Children
2. Low Income Seniors
3. Long Term Care and other vulnerable patients
4. Persons with Disability
5. Financially vulnerable groups – homeless, unemployed, low income working adults, etc.

*Recommendation 2:* Create an Oral Health Strategy for British Columbia engaging resources from the Ministries of Social Development & Poverty Reduction, Health and Family and Children along with the health authorities and stakeholders: dental professional and other associations, community not-for-profit dental clinics, dental education institutions and patient advocacy groups.

*Recommendation 3:* Encouraging all employers to offer extended health benefits including dental as a means of attracting and retaining employees and minimizing out of office time due to emergency dental needs for workers and their dependants.

*Recommendation 4:* Endorse as provincial government policy, support for fluoridated drinking water at the municipal level.

**Community Level:**

*Recommendation 5:* Ensure public health facilities can accommodate dental care:

a) Hospital emergency and operating rooms have access to dental equipment and personnel to meet the needs of dental patients.

b) For patients who require medical support for their dental needs, ensure systems are in place to allow for seamless communications and appropriate access to both necessary medical and dental care.

*Recommendation 6:* Create systems within long term care facilities to encourage dental care for residents such as creating a dental care coordinator position to assist with daily oral care and facilitate ongoing professional care.

*Recommendation 7:* In multi-disciplinary health centres ensure access to dental providers, including onsite access. Successful examples include the dental clinics at both the BC Cancer Agency and BC Children's Hospital.

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1. Canadian Academy of Health Sciences, *Improving Access to Oral Care*, 2014, Ottawa, Canada


Canadian Dental Association, unpublished data, 2017

Canadian Dental Association, unpublished data, 2017


David Locker, John Maggirias, Carlo Quinonez,


16 October 2018

Ms. Jocelyn Johnston - Executive Director
British Columbia Dental Association
400 – 1765 West 8th Avenue
Vancouver, BC V5J 5C6

Dear Ms. Johnston,

Re: Fee Collection Agreement between CDSBC and BCDA

This letter agreement is executed in accordance with Bylaw 3.10 of the College of Dental Surgeons of British Columbia (CDSBC).

CDSBC hereby agrees to collect BCDA’s Annual Fees understood to be in the amount of $1,600.00 (inclusive of GST) from each registered practising dentist in all registration classes except for limited, temporary and non-practising registration. CDSBC understands the final fee amount will be confirmed by BCDA in November, 2018.

CDSBC hereby agrees to remit such fees collected to the BCDA upon receipt and after first retaining the amount of $167,000 plus applicable taxes, representing reimbursement for: (1) the electronic transaction costs associated with collection of BCDA’s annual membership dues of $127,000 for this year; plus (2) administrative costs of $40,000.

For your convenience, we have included a worksheet detailing the estimates from which we have derived our numbers.

Please countersign this letter signifying our mutual agreement and understanding.

Yours truly,

Dr. Chris Hacker
Acting Registrar

Countersigned on this 14 day of November, 2018.

Ms. Jocelyn Johnston
Memo

TO: CDSBC Board
CC: 
FROM: Dr. Chris Hacker, Acting Registrar
DATE: November 16, 2018
SUBJECT: Consultation on the 2019-22 Strategic Plan

Following the Board’s approval of the draft 2019-22 Strategic Plan for consultation, staff published it for a four-week consultation period ending Oct 26. The invitation to comment was published on the website and distributed to stakeholders via email. Individuals and organizations had the option to submit their comments by email, mail or via the new online consultation forum.

You will recall that consultant Susanna Haas Lyons facilitated the September board workshop on the strategic plan; she also helped us craft the three questions we asked people to respond to:

1. In what ways might the goals and initiatives in the draft strategic plan impact you?
2. What would you like CDSBC to consider as we plan to take action on this draft strategic plan?
3. Do you have any other comments on the draft strategic plan?

The invitation to comment was sent to our regular stakeholder list, as well as to additional organizations that might have an interest in this topic:

- Other health regulators in BC
- Ministry of Health
- First Nations Health Authority
- Other provincial dental regulators
- British Columbia Dental Association
- Certified Dental Assistants of BC
- UBC Dentistry
- Patient Voices Network
- Two immigrant/refugee support organizations (SUCCESS)
- Mosaic
- Ms. Joan Rush (advocate for adults with developmental disabilities)
- BC Centre for Disease Control
- Dental component societies
- Dental Specialist Society of BC
- CDSPI
- Canadian Dental Regulatory Authorities Federation
- Academy of General Dentistry
- Commission on Dental Accreditation of Canada
- BC Seniors Advocate
- Professional Standards Authority
- Council on Licensure, Enforcement and Regulation (CLEAR)
- Executive Directors and Registrars Group (regulators and associations representing various professionals within and outside health)

We received five submissions via email and 11 posts to the online forum. Below are the draft version published for consultation, the feedback received from the consultation, and the final submission for your approval.
Draft 2019-22 Strategic Plan

Updated: 28 September 2018

Regulating dentistry in the public interest
**Our Vision**

Public protection  •  Regulatory excellence  •  Optimal health

**Our Mission**

The College of Dental Surgeons of BC protects the public and promotes health by regulating dentists, dental therapists and certified dental assistants. It does so by establishing, monitoring and enforcing the safe, competent and ethical practice of dentistry in B.C.

**Our Mandate**

The College of Dental Surgeons of BC serves and protects the public, regulating dentists, dental therapists, and certified dental assistants by:

- Setting requirements for certification, registration, standards of practice and ethics
- Establishing requirements for, and monitoring, continuous competency
- Investigating and resolving complaints

**Our Values**

The College of Dental Surgeons of BC demonstrates trustworthiness and promotes professional excellence by being:

- Ethical, open and transparent
- Fair and accountable
- Respectful and courteous
- Objective and evidence-informed
- Inclusive and embracing diversity
- Patient-centred and engaged with the public
## Our Goals and Initiatives

### Goal 1: Improve outcomes for the public through clearly stated standards of competence and conduct for dentists, dental therapists and certified dental assistants.

**Initiatives**

We will do this by:
- Developing and maintaining standards and guidance that are clear, consistent, enforceable and up to date.
- Establishing effective and timely Board review and oversight of standards and guidance.

### Goal 2: Identify and strengthen productive relationships with stakeholders.

**Initiatives**

We will do this by:
- Sharing information and consulting broadly with the public and other stakeholders.
- Actively engaging the public and patients in decision making while being mindful of equity and diversity.
- Ensuring that we provide relevant and timely information that the public needs to make informed decisions about their health care.
- Communicating and collaborating effectively with key organizations and stakeholders.

### Goal 3: Embrace leading regulatory practices to protect the public.

**Initiatives**

We will do this by:
- Using data and risk assessment to enhance regulatory effectiveness.
Using leading regulatory practices, such as the principles of right-touch regulation\(^1\), to guide strategic decision-making and improve processes

- Increasing organizational capacity to anticipate and respond to external forces and future challenges with agility, resilience and openness

- Updating and implementing a comprehensive mandatory quality assurance program so that the public is well-served by competent health professionals

### Goal 4: Strengthen and clarify governance to support our mandate

**Initiatives**

We will do this by:

- Initiating a governance review to improve our governance model and identifying and responding to gaps and opportunities

- Developing guidelines and procedures to sustain effective relationships within and between Board and staff

- Providing support for Board and staff to be knowledgeable and competent in all matters of professional regulation and good governance

- Developing and implementing an annual board workplan

---

Direct email responses

1. Dear CDSBC members,

Thank you for providing this opportunity to comment on your draft Strategic Plan.

The first goal of the CDSBC draft SP is to improve outcomes for the public through clearly stated standards of competence. Under the draft SP, you will do this by “Developing and maintaining standards and guidance that are clear, consistent, enforceable and up to date.” In my opinion, it would be beneficial if the CDSBC agreed to develop and maintain standards that adhere to, or reflect, dental best practices. The regulatory goal should also include ensuring that practitioners continuously work towards improving their practice to ensure dental best practices through ongoing relevant CDE. Compare, for example, the SP of the CPSBC on this issue: https://www.cpsbc.ca/about-us/strategic-plan-2018-2020

The draft SP does not mention the dental “social contract” with Canadians. Compare, for example, the Strategic Plan developed by the Faculty of Medicine, UBC (which is significantly more comprehensive than this brief 4-page S.P.): https://stratplan.med.ubc.ca/ If the dental regulator does not encourage dentists to adhere to the dental social contract, then there will be no incentive or encouragement for dentists to become trained to treat all members of society or to work towards ensuring equitable access to dental treatment.

The draft SP states that the CSDBC will work with (undefined) key organizations and stakeholders. In view of the need for medicine and dentistry to collaborate for the benefit of many patients, including patients with special needs who require treatment under GA, in-hospital patients who require dental treatment in connection with organ transplants, heart surgery or complications of cancer treatment, and patients who are trauma victims, there should be a specific goal of collaborating with other health care providers in the best interests of the public.

Similarly, the CDSBC should include the goal of working promptly and collaboratively with other dental regulatory bodies to consider and adopt regulatory changes that will benefit the public, or will achieve the goal of equitable access to dental treatment for all members of the public.

I look forward to seeing your final Strategic Plan.

2. Thank you for the opportunity to give feedback on your strategic plan. The goals and initiatives are well written and appropriate.

Goals 1 and 3 are linked to the role of the NDEB as the organization responsible for establishing and maintaining a national standard of competence of dentists in Canada. The NDEB will continue to support CDSBC in assessing the competence of their future and current members as needed. We are also hoping to build on the good relationships between CDSBC and NDEB to work on future projects of common interest.
3. CDSBC Board of Directors:

Thank you so much for allowing the Dental Technicians Association of BC [DTABC] to offer comments as you draft your new Strategic Plan 2019-2022.

Our response here will be brief in order to meet the October 26 deadline, however we will be more than happy to have a further conversation with you should the opportunity present itself.

To begin, I attach a copy of a letter that we [DTABC] sent to Mr. Harry Cayton in response to his current inquiry into the CDSBC. This letter summarizes our concerns as a Professional Association and as a profession as a whole [Registered Dental Technicians or RDTs].

While we appreciate that the issue we raise in the letter has been somewhat addressed in your document “Patient Centered Care and the Business of Dentistry”, it has not been to the level that we, as an association, would have hoped for.

The DTABC would prefer to ensure that an RDT is employed in a dentist owned laboratory to oversee all fabrication of dental prosthesis or appliances. Also the dentist should only be receiving fabricated dental prosthesis from a dental lab in Canada.

The education and licensing of an RDT in Canada is mandated by Colleges for the majority of provinces. This education and licensing was put in place for the safety of the public and there should not be any avenue in which this safety is compromised.

According to Chris Opitz, the President of the DTABC, “in the past, Dentists were all educated in prosthetic and appliance fabrication technology. Now that specific education is almost non-existent.

It makes sense for dentists to dedicate the time to new and emerging aspects of dentistry that did not exist in the past, implants to name one. They are no longer the educated professionals with the expertise in the manufacturing of dental prosthesis and appliances and therefore cannot oversee or supervise the manufacture thereof.”

There are many good reasons for employing the services of an RDT in British Columbia all in the best interest of the patient and patient safety and satisfaction. The goals and objectives of the CDSBC Strategic Plan will have significant effect on the future of dental technology, a future which in some respects is already in jeopardy. The DTABC would appreciate the CDSBC at least considering our position and perhaps, at the very least, an Interpretive Document, such as the one produced for your Bylaw 12 might go a long way in making our case.

We are more than willing as an association to engage with partners in an industry symposium about the future of dental technology and we look forward to further discussion with the CDSBC as your plan evolves.

4. Since the CDSBC regulates other professions (assisting, therapy), are those professions considered a stakeholder? I would suspect not, but perhaps the dentists/members are
considered a stakeholder? Are the licenced individuals considered a member of the College? When I read through, it seemed to me that Goal 2 offered an opportunity to address that relationship, whatever it is.

Goal 2:
Identify and strengthen productive relationships with stakeholders and licensees.

Initiatives

We will do this by:

- Sharing information and consulting broadly with the public and other stakeholders (licensees)
- Actively engaging the public and patients in decision making while being mindful of equity and diversity
- Ensuring that we provide relevant and timely information that the public needs to make informed decisions about their health care
- Communicating and collaborating effectively with key organizations and stakeholders

5. I offer the following suggestions.

Strategic Plan:
First Nations
The draft of the Strategic Plan does not appear to include any direct mention of “cultural safety and humility” to correspond with the declaration of commitment signed by the health regulators, including the College of Dental Surgeons, and representatives of First Nations in March 2017. Inclusion of a direct statement, perhaps under Goal 1, would reinforce the objective of undertaking activities in support of the declaration.

The closest reference in the Strategic Plan seems to be in Goal 2:

- “Actively engaging the public and patients in decision making while being mindful of equity and diversity”

The positioning of a statement under “Identify and strengthen productive relationships with stakeholders” that refers only to “diversity” is inadequate. If this statement is intended to delineate the College response to the Declaration, it is not appropriately positioned under Goal 2 as First Nations are not stakeholders in this context, but a part of our public, which is covered under Goal 1. The challenge of undertaking strategies that create the conditions under which First Nations clients can comfortably access health care is considerable, and steps to address the challenge are required under 16 (k)(iii) of the HFA.

- Fostering the development and delivery of programs of education, experience, and training that enhance the abilities of registrants to meet the needs of diverse members of the public with sensitivity and humility.
This general wording is suggested so as to embrace any group within the public that may have barriers to access to care that originate from cultural difference or life experience including First Nations.

Collaborations
The Health Professions Act speaks at Section 16(k) to the duty and objects of a College to promote and enhance collaborative relationships with other colleges, amongst other entities. In a legislative environment in which the number of regulatory colleges is being reduced, and common standards of practice are being adopted, there is opportunity to promote the intention of this College, and to recognize its responsibility in providing leadership to the dental professions at large (including the colleges of dental hygienists, dental technicians, and of denturists) in the interests of public service and safety. Perhaps the addition of a statement under Goal 3 provides this opportunity:

- Developing common standards of practice in collaboration with the registrants of other health colleges.

The intention is to develop an environment in which the dental colleges at large would work collaboratively rather than competitively.

Consultation forum responses (inserted pages 5-7)
Comments provided below will be reviewed in accordance with our posting guidelines. We will review and post comments in a timely fashion during regular working hours; however, there may be delays which prevent us from reviewing it right away.

Feedback is closed.

11 Responses

1. Dentist
   October 26, 2018 at 04:10 PM
   Thank you to the committee for the work put into drafting the document. One comment I hear often when I meet my peers at conferences or CE lectures is that a great majority of practicing dentists do follow and have the desire to follow standards of practice and college bylaws. However, from time to time, they seek guidelines and bylaws that are easy to follow and are effective. We do look to the College to provide and demonstrate leadership in practicing in a professional and ethical manner. Wouldn’t the public be better served if the College spend equal attention in establishing a culture of high standards of professionalism and ethics, as it does on the small percentage of registrants who do not abide by regulatory standards?
   Another comment I often hear from my peers is that a solely complaint-driven approach to regulation may fall well short of a truly successful mandate to protect the public because it is effective only against the "lowest common denominator".

2. Organization
   October 26, 2018 at 03:44 PM
   Thanks for providing us the opportunity to include our thoughts in this. To begin with, we must say that the draft plan is well thought out with two key values to note: inculcating a model of care with a patient/public driven approach and highlighting the focus towards improving oral health outcomes through both treatment and health promotion/public engagement.
   A few other thoughts are:
   - CDSBC creates "registration categories", would it be helpful to include wording around recognizing a wide range of roles for oral health professionals, including public health within the document somewhere?
   - Suggest that you may include strategies for communication with the remote communities- underserved population are less likely submit a written complaint, can the college include a provision for the communities to make a phone complaint? Or any other strategy for gathering their voices?
   - May be include a strategy so that the registrants can submit their voices to the board by replying to a specific email from the college.
   Thanks once again and we applaud the college for their great efforts made to ensure protection of the public, standards of practice by the oral health professionals and having a public-driven approach.

3. Certified Dental Assistant
   October 23, 2018 at 01:35 PM
   In what way might the goals and initiatives in the draft strategic plan impact you? The impact to CDAs is to be included and have the CDSBC be transparent. Our presence on committees and the Board brings a perspective unlike the other groups represented.
   What would you like the CDSBC to consider?
   How will the CDSBC accurately measure the success of this strategic plan? Realistically?
   I like the simplicity of the plan although there is much said we must remember that personalities must never interfere with good strategic planning.

4. Dentist
   October 22, 2018 at 02:48 PM
   Thank you for following the Policy development process to provide the opportunity for feedback. I am speaking from my experience on the College board.
   In Goal 4: Strengthen and clarify Governance to support our mandate.  Bullet 3: 'The word "management" would be more precise and more appropriately describe the separation of the two entities in the College structure rather than the Board and staff'. The reason is that often there were confusion when some one mentioned staff. There was confusion between the Board staff or management team staff. The board has one staff who is the Registrar/CEO. I think that it is better described as the head of the management division. The rest the staff are members of the management team. The board leads and the Management executes.

5. Dentist
   October 18, 2018 at 12:20 PM
   I agree with Dentist Oct 16th, the committees should have good geographic representation, fixed term limits and Dentists should be the majority.
6. Dentist  
**October 16, 2018 at 08:20 AM**

One objective should be to involve all the College membership, since most of college work is done by committees. College committees should have a good geographic representation, and membership should have term limits, like CDA and BCDA committees. It is also important that general dentists form the majority of every committee so that special interest groups do not dominate the committees point of view.

---

7. Dentist  
**October 16, 2018 at 07:55 AM**

In response to the comment by Lex V:

- c) evaluate if volunteer hours should be a requirement to renew licenses and provide a benefit if hours are reached.

I disagree wholeheartedly with this request. If this is indeed implemented then the task would be afool of the definition volunteer, which is:

- a person who does something, especially helping other people, willingly and without being forced or paid to do it.

Many of the points brought up by Lex are wonderful but requiring dentist to provide free labour is a bit of an overreach in my humble opinion.

---

8. Organization  
**October 04, 2018 at 08:54 AM**

This feedback comes from a Not For Profit perspective.

- encourage and/or find ways that dental suppliers can provide more support to not for profit dental clinics, either:
  - talking with CRA to provide better tax brackets
  - talking with the city hall to grant special lease or other benefits while supporting not for profit.
  - realizing that not for profit can provide tax receipts.
  - motive to help more low volume buyers / not for profit and provide special rates.

b) motivate dental professionals to volunteers

The volunteer license is great but there might be other options.

- give CE credits to dentists that volunteer X number of hours per year.
- give a discount rate to CDA that volunteer X number of hours per year.
- encourage dentists to sponsor local not for profits.

* either with S., supplies, etc
* not for profit can provide tax receipt if needed

c) evaluate if volunteer hours should be a requirement to renew licenses and provide a benefit if hours are reached.

d) encourage school to add more and more volunteer or practicum programs within the not for profit environment.

e) talk with dental labs to have a sponsoring program towards not for profits. Either with free lab work or others, this can increase the chances to have access to full mouth rehabilitation = better health = better oral habits in a long term.

As you know the East Side dental clinic is the only not for profit (beside Abbotsford) that operates with volunteer support.

Considering that currently we have ± dentists in BC. If everybody gives a day to volunteer at this office. We will be operational 365 days of the year.

If the other aspects are combined, we would be able to have a good not for profit that its aim to help the community and provide long lasting oral results.

That its my honest feedback for a 2019 - 22 strategic plan from our not for profit point of view.

Sincerely,

Lex V.

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9. Dentist  
**October 04, 2018 at 08:44 AM**

I like the simplicity and the clarity of the document. I would suggest one amendment be considered please. I suggest you explore the replacement of "patient-centred" with "person-centred" or something close to that.

I offer this link as providing some of the rationale for the suggestion:

Have just gone through an exercise examining where the societal expectations of the profession in future were anticipated. I believe that the relationship between society and the professions and the relationship between the individual caregiver and recipient of care are evolving.

During this exercise, we consulted with medical colleagues about this changing landscape. It seems to me that because not all citizens are currently patients, because regulatory authorities may be expected to take some action relating to improving access to care for marginalized and vulnerable groups, because the whole circumstances of the
care recipient need to be considered by the care provider, because we must move away from paternalistic care models and co-create treatment plans with care recipients, there is an opportunity in your document to show leadership by considering inserting more inclusive language in your document. Thank you for providing me the opportunity to have some input for your consideration.

Member of the Public

October 05, 2018 at 08:23 AM

Thank you for the posting re. multicultural aspect of care provision. I think it is very important to welcome everybody and show that from our government associations. It goes along with the Canadian origin written in the citizen application: Canada is a multicultural country.

It is important to denote that even when we embrace a multicultural language, we keep the two national language always present. If not we will have the cases like some cities where speaking other language is a requirement to get employment. That aspect goes against employment standard – it is not the national two languages in the country.

10. Organization

October 03, 2018 at 09:45 AM

While the primary role of a professional college is protection of the public, standards of practice, etc., perhaps there is also an opportunity to engage/inform the public.
Draft 2019-22 Strategic Plan

Updated: November 2018

Regulating dentistry in the public interest
Our Vision

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• Fair and accountable
• Respectful and courteous
• Objective and evidence-informed
• Inclusive and embracing diversity
• Patient-centred and engaged with the public
Our Goals and Initiatives

Goal 1: Improve outcomes for the public through clearly stated standards of competence and conduct for dentists, dental therapists and certified dental assistants.

Initiatives
We will do this by:

- Developing and maintaining patient-centred standards and guidance that are clear, consistent, enforceable and up to date
- Establishing effective and timely Board review and oversight of standards and guidance

Outcomes
- CDSBC has clear standards & guidance for registrants that address new and developing areas of practice and take into account stakeholders’ views and experiences and provincial, national and international regulatory trends
- Standards of competence and conduct are up-to-date, kept under review and reflect best practices

Goal 2: Identify and strengthen productive relationships with stakeholders.

Initiatives
We will do this by:

- Sharing information and consulting broadly with the public and other stakeholders
- Actively engaging the public and patients in decision making while being mindful of equity and diversity
- Ensuring that we provide relevant and timely information that the public needs to make informed decisions about their health care
- Communicating and collaborating effectively with key organizations and stakeholders
Outcomes
- CDSBC has clearly reported on its performance and on how it has addressed any identified concerns.
- Accurate and easily accessible information has been provided by CDSBC about its registrants, regulatory requirements, guidance, processes and decisions to the public and other stakeholders.
- CDSBC understands the diversity of its stakeholders.
- CDSBC has consulted and worked with regulators, the public and other stakeholders to identify and manage risks to the public with respect to its registrants across all of its functions.
- CDSBC has published and maintained an accurate register of those registrants who meet its requirements that includes any restrictions or limitations on their practice.

Goal 3: Embrace leading regulatory practices to protect the public.

Initiatives
We will do this by:
- Using data and risk assessment to enhance regulatory effectiveness
- Using leading regulatory practices, such as the principles of right-touch regulation\(^1\), to guide strategic decision-making and improve processes
- Increasing organizational capacity to anticipate and respond to external forces and future challenges with agility, resilience and openness
- Updating and implementing a comprehensive mandatory quality assurance program so that the public is well-served by competent health professionals

Outcomes
- CDSBC has ensured that anyone is able to raise a concern about a registrant.
- CDSBC has ensured that its processes do not impose inappropriate barriers or otherwise disadvantage people with protected characteristics.
- CDSBC is transparent in the way it conducts and reports on its business.
- CDSBC privacy and security policy meets the standards set in Canadian legislation and the EU’s General Data Protection Regulation (GDPR).
- CDSBC has ensured that it has a comprehensive mandatory quality assurance program.
- With respect to CDSBC policies, relevant learning from one area is applied to other areas.
- CDSBC has confirmed its understanding of the diversity of its registrant population.
- CDSBC has ensured proportionate requirements are in place to satisfy itself that registrants continue to be fit to practise.
- CDSBC is using a risk-based framework to prioritize complaints and uses interim orders where appropriate to ensure the safety of patients.
- CDSBC has ensured that its complaints process is proportionate and deals with individual files as quickly as is consistent with a fair resolution.
- Through CDSBC, everyone can easily access information about dentists, dental therapists and CDAs, except in relation to their health, including any existing limitations or conditions on their practice.
## Goal 4: Strengthen and clarify governance to support our mandate

### Initiatives

We will do this by:

- Initiating a governance review to improve our governance model and identifying and responding to gaps and opportunities
- Developing guidelines and procedures to sustain effective relationships within and between Board and staff
- Providing support for Board and staff to be knowledgeable and competent in all matters of professional regulation and good governance
- **Developing and implementing an annual board workplan**

### Outcomes

- CDSBC has clear governance policies that provide a framework within which decisions can be made transparently and in the interests of patients and the public. It has clear terms of reference for committees and working groups and effective reporting mechanisms.
- The Board has effective oversight of the work of the Registrar/CEO and the senior management.
- The Board works co-operatively, with an appropriate understanding of its role as a governing body and members’ individual responsibilities.

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Memo

TO: CDSBC Board
FROM: Joyce Johner, General Counsel
DATE: 16 November 2018
SUBJECT: Review of CDSBC Strategic Plan by Liability Insurer

Background

At the 15 September 2018 board meeting, a motion was made and passed directing General Counsel to ensure our liability insurer does not have any concerns with respect to our draft strategic plans.

Action

At present, CDSBC’s liability insurer is Encon Group Insurance. I had a telephone conference with Ms. Amy Mathurin, Claims Analyst at Encon on 20 September 2018 and advised Ms. Mathurin that the College had a draft strategic plan and we wanted to provide to Encon. Ms. Mathurin took my request and had discussions with representatives from the underwriting side of Encon.

Ms. Mathurin advised me on 15 October 2018 that she had corresponded with the underwriting team on this issue. In an email, Ms. Mathurin confirmed that in the end, Encon decided that they would not need to review our Strategic Plan.

Conclusion

The College’s liability insurer was asked to review our strategic plan and they responded that they did not need to review the strategic plan.
**Core regulatory functions to meet (80% of what we do)**

<table>
<thead>
<tr>
<th>1. Fulfill regulatory responsibilities in a fair and transparent manner</th>
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<tbody>
<tr>
<td>• Set entry-to-practice standards</td>
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<tr>
<td>• Participate in national requirements for accreditation/certification in keeping with federal/provincial labour mobility requirements</td>
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<td>• Process initial registrations and annual registration renewals for registrants</td>
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<td>• Investigate and resolve complaints about the conduct and competence of registrants (about 200/year)</td>
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<td>• Respond to applications to Health Professions Review Board</td>
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<td>• Publish complaints and discipline outcomes/practice limitations in accordance with BC Health Regulators Public Notification Framework</td>
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<tr>
<td>• Process applications for dental sedation, authorize sedation facilities, inspect deep and GA facilities</td>
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<td>• Investigate reports of illegal practice and take action as appropriate</td>
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<tr>
<th>2. Enhance competence and professionalism of registrants</th>
<th>3. Identify and promote collaborative and productive relationships with key organizations and stakeholders</th>
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<tbody>
<tr>
<td>• Set expectations for practice, e.g. standards and guidelines for registrants</td>
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<td>• Support registrants to meet those expectations, using communication and educational resources</td>
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<td>• Promote continuing competence of registrants by administering requirements of quality assurance program</td>
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<td>• Practitioner wellness: assist registrants facing wellness and addiction issues to a safe return to practice</td>
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<td>• Volunteers (board, committee and working group members)</td>
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<td>• Other health colleges through BC Health Regulators (BCHR)</td>
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<td>• Ministry of Health</td>
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<td>• BC Dental Association and Certified Dental Assistants of BC</td>
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<tr>
<td>• First Nations Health Authority</td>
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<tr>
<td>• Dental educators: UBC Dentistry and CDA programs</td>
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<tr>
<td>• National players, such as Canadian Dental Regulatory Authorities Federation, National Dental Examining Board, National Dental Assisting Examining Board, etc.</td>
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<th>4. Organizational excellence</th>
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<tr>
<td>• Manage all tangible and intangible assets, including College Place</td>
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<td>• Information and document management</td>
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<td>• Provide effective IT infrastructure, services and data security</td>
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<td>• Attract, retain and develop staff resources</td>
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<td>• Volunteer recognition, e.g. awards program</td>
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<td>• Provide staff support for all committee, working groups and Board</td>
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</table>
Initiatives in support of the strategic plan (the other 20% of what we do)
Sept. 2017 – Feb. 2019*

*Timeframe has been extended to take us to the start of the new strategic and operational plan (March 1, 2019).

For reporting to the Board

Registration: Effective, Efficient, Electronic Routes of Entry

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<tr>
<th>Initiative</th>
<th>Responsible</th>
<th>Description/Highlights</th>
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| New Registrant Course                    | Led by CDSBC staff with support of online course consultant. Association-specific content being developed by BCDA.                                           | This is a working title for an online course that will provide an overview of the requirements for the practice of dentistry in B.C.                                                                                                                                         | Sept. 2017 - Course content has been transferred to consultant for comprehension and knowledge testing.  
Feb. 2018 - Course developer is working on the first draft of the course design.  
Sept. 2018 – Staff team has reviewed course content and design and have a number of adjustments to be made; however, this has been delayed due to the activities and time requirements of the leadership change over the past several months. Should be able to complete by the end of the year.  
Nov. 2018 – This has been put on hold until January due to other, more pressing, priorities. |
| First Nations Health Authority (FNHA)    | Staff                | Concern existed that the agreement with FNHA and the Ministry of Health (MoH) dealing with dental therapists provides that a tri-partite agreement transferring regulatory authority over dental therapists to CDSBC remains in effect until 1 March 2019 and | Sept. 2017 - Ongoing – 1 March 2019 deadline.  
Feb. 2018 - Working with FNHA to develop a workshop and commitment to action on cultural safety and humility for delivery to Board this month. Working through BC Health Regulators to develop registration question identifying First Nation practitioners to build capacity. |
allows for it to be extended and/or modified thereafter. Discussions between MoH, FNHA and the College over the next year will be required to determine direction of dental therapist deployment (if any) and the future of the bylaw provisions dealing with dental therapists.

Government, we understand, is looking into curriculum and possible funding for dental therapist training.

Sept. 2018 – at the June board meeting, the Board passed a motion to renew the agreement with the MoH and FNHA and remove the sunset clause that would have seen the College’s regulation of dental therapists end in March 2019. Further conversations with MoH have confirmed that the sunset clause is redundant because the regulation of dental therapists is captured in amendments to CDSBC bylaws approved by the MoH in 2013 and 2014. If the missing agreement is eventually found, the existing sunset clause can be addressed at that time.

Nov. 2018 – Ongoing liaison with the FNHA Oral Benefits Program anticipated. Initiatives for the recruitment of dentists to care for First Nations clients in communities are planned for further development once the new programs for the funding of dental care are in place. Collaborative redefinition of the schedule to the bylaws that addresses the scope of practice for dental therapists is anticipated in late 2019.

Carried over to new operational plan: “Ongoing FNHA consultation and collaboration.”

| Online application/registration | Staff | Registration process for our main categories of registrant (general dentist, temporary & practising CDAs) anticipated to be fully online in fall 2017. | Sept. 2017 - Nearing completion.  
Feb. 2018 - First phase of project (main registrant categories) is near completion on development side some minor tweaks still in the works. Implementation and roll-out with IT and systems to “go live” was deferred due to system upgrades/migration and to ensure registration renewal support phase completes.  
Sept. 2018 – First phase of project was completed in March. General Dentists, Practising and Temporary CDAs are submitting application online. Next fiscal year we will... |
Nov. 2018 – In 2019, staff will work with IT to add online applications for certified specialists and some other categories. These will be a continuation and evolution of the application processes.

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<th>Complaints Reduction and Resolution</th>
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<td>Initiative</td>
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| Proactive Bylaw 12 (Advertising & Promotional Activities) guidance on how to adhere to the new bylaw | Staff | - We have received over 50 grievances about dentist advertising since the initial revision of the bylaw went into force at the beginning of the calendar year 2017.  
- We envision publication of redacted, but real, examples of dentist advertising that is not compliant along with descriptions of how/why they offend Bylaw 12. | Sept. 2017 - Project will not start until the content of the final bylaw is in place and processes to support it are confirmed.  
Feb. 2018 - Complaints team ramping up for enforcement of bylaw as of March 2018. We can expect an increase in complaint files and resources needed to resolve these files – as was contemplated when this project was initiated.  
Updates to interpretive guidelines to be submitted for Board approval at Feb meeting. Staff will roll out communications on full implementation and on interpretive guidelines. May publish guidance on common advertising and promotional activity concerns on website.  
Sept. 2018 – The spring edition of the College Update print newsletter featured a story about the March 1 enforcement date of Bylaw 12 non-compliance submissions being handled as complaints. Examples related to three most common problems in advertising non-compliance were provided as guidance for registrants.  
Nov. 2018 - The first six months following the March 1, 2018 enforcement date is being used to evaluate the success of the new approach to Bylaw 12 infractions. A draft memo will be presented at the Dec. 11 Inquiry |
| **Online complaint submission form** | **Staff** | A new, more convenient option for complainants to submit a complaint about a registrant. | Sept. 2017 - Nearing completion.  
Feb. 2018 - Package signed off by Complaints team. Now with IT consultants in development queue and subject to budget constraints.  
Sept. 2018 – The online complaint submission form was added to the website in April 2018. Approximately 40% of complaints are now being submitted via this form. |
|---|---|---|---|
| **Practice Tips** | **Staff** | This series is authored by the complaint investigators and draws from real complaints to help registrants identify and respond to specific situations that have the potential to become complaints. | Ongoing  
Sept. 2018 – We have published 15 practice tips thus far. We have postponed publishing additional tips in recent months to allow the complaints team to evaluate this tool. Going forward, we are seeking input from the Quality Assurance Committee before publication. This is in keeping with our efforts to improve communication between the Quality Assurance Committee and complaints.  
**Nov. 2018 – carried over to new operational plan** |
| **Early detection of oral cancer** | **Requires partnership between BC Cancer, oral medicine specialists, and medical community** | Providing direction to practitioners regarding their responsibility to recognize and respond to oral mucosal diseases, particularly oral cancer. | Sept. 2017 - Preliminary assessment by a staff dentist  
Feb. 2018 - We have met with Dr. Allan Hovan from BC Cancer (formerly BC Cancer Agency). He and Dr. Poh have agreed to update CDSBC’s guidance document on Oral Cancer screening (and review it annually) which will then be referred to the Quality Assurance Committee to be updated into CDSBC’s new Standards & Guidelines document format. The new document will be promoted on BC Cancer |
as well as CDSBC and other websites. Drs. Hovan and Poh will also assist in identifying relevant publications for possible distribution, including a series of information sheets produced by BC Cancer for medical and dental practitioners who have cancer patients in their practice. CDSBC will assist in distribution of these documents by highlighting them as resources available to practitioners. *The dentist’s role in the early detection of oral cancer,* initially published as a practice tip, was the print newsletter (College Update) cover story distributed to registrants in Dec. 2017.

Sept. 2018 – We will be hosting a panel on this topic at the Vancouver & District Dental Society’s Midwinter Clinic on 30 November. Acting Director of Professional Practice Dr. Meredith Moores will moderate the panel, which includes Drs. Allan Hovan (provincial lead in oral oncology at BC Cancer); Catherine Poh (senior clinician scientist in oncology at BC Cancer and professor at UBC Dentistry), Alan Bates (provincial practice leader for psychiatry at BC Cancer) and Ash Varma (general dentist and chair, Quality Assurance Committee).

Proposed revisions to the Clinical Practice Guideline for the Early Detection of Oral Cancer are underway.

Nov. 2018 – the CDSBC and BC Cancer panel discussion on the dentist’s role in the early detection of oral cancer is taking place on Nov. 30 at the Vancouver & District Dental Society Midwinter Clinic. We are collaborating with BC Cancer on revisions to the guideline document, and this is on the agenda for the Quality Assurance Committee meeting this month.
## Professional Practice

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<td>Patient-centred care/supporting ethical decision-making</td>
<td>Ethics Committee, staff</td>
<td>At the June 2017 Board meeting, The Board accepted the recommendations of the Ethics Committee that each of seven areas be addressed, and tasked the Committee to complete the work and to bring their recommendations forward to the Board. This report was presented at the February 2018 Board meeting.</td>
<td>Sept. 2017 - Board assigned task of developing advice to Ethics Committee at its June 2017 meeting</td>
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<td>Feb. 2018 - Ethics committee met on in January to finalize its report.</td>
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<td>Sept. 2018 – All differences between the old Article 5 and the current Bylaws have been identified, considered, and presented to the Board. Additions approved by the Board in June 2018 have been made to the standards and guidelines document <em>Patient Centred Care and the Business of Dentistry</em>. It will be published in the coming weeks.</td>
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<td><strong>Nov. 2018 – File complete. Article 5 statements on corporate share structure have been reviewed. There appears to be nothing further that CDSBC can, or would wish to, regulate with regard to the corporate ownership of dental practices.</strong></td>
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<td>Statement on Third-Party Billing (dental labs)</td>
<td>Ethics Committee, staff</td>
<td>Slight alteration of the draft statement will improve the presentation and integration of the Policy content into the proposed document. The practice of charging patients/insurers fees billed by third-party business entities owned by / affiliated with a dentist will be disallowed.</td>
<td>Sept. 2017 - Public consultation period in progress (closes 20 October 2017)</td>
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<td>Feb. 2018 - The Ethics Committee has recommended that the statement be built into the document <em>Patient-Centred Care and the Business of Dentistry</em>.</td>
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<td>Sept. 2018 – The changes approved by the Board have been added to the standards &amp; guidelines document “Patient Centred Care and the Business of Dentistry.” It will be published in the coming weeks and will serve to protect patients from marked-up fees.</td>
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<td>Clarity on fee guide re: specific/complete exam</td>
<td>Staff, with consultation from Board and others</td>
<td>As part of its work to create the suggested fee guide, the BC Dental Association has asked for CDSBC direction regarding definition of complete exams for new patients.</td>
<td>Sept. 2017 - For discussion at September Board meeting and Feb. 2018 - Response as reviewed and accepted by the Board at its September meeting sent to BCDA. There is some indication that BCDA may request further help with this issue but at this time, no request has been received. File complete.</td>
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<td>Patient education</td>
<td>TBD</td>
<td>The objective is to provide patients with information to help them ask the right questions and make informed choices. This is inspired by Dr. Racich’s book <em>The Basic Rules of Being a Dental Patient</em>.</td>
<td>Sept. 2017 - Preliminary meeting to take place fall 2017. Feb. 2018 - Dr. Anderson, Mr. Marburg and Ms. Wilks met with Dr. Racich. His book has some relevance to the topic but not directly applicable. Dr. Racich indicated his willingness to assist on this topic. We also raised this topic at a joint CDSBC/BCDA executive meeting. We have also approached BCHR on the topic and there is some interest in looking at a form of “patient bill of rights” [my term, not theirs] or some other education piece for all. Sept. 2018 – Indications are that this topic is unlikely to be a priority at the BC Health Regulators group so CDSBC will need to pursue this separately. Staff may recommend that this project focus on packaging essential information for patients about what to expect from their visit to the dentist as well as what to do if they have concerns – and filling in any content gaps. The topic was raised at the most recent meeting of the Governance Working Group and will consider next steps at their October 2018 meeting. It was noted that the allocated funds remain untouched. Nov. 2018 – We will be reorganizing essential information for patients that is on our website to make it more accessible (see above).</td>
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| **Ethics course** | Dental ethics experts to develop curriculum in consultation with staff | This course will promote ethical decision-making by registrants with the intent of protecting the public by preventing complaints. It will be launched at the Pacific Dental Conference in March and will be developed into an online version with supporting material as required. | Sept. 2017 - Project is in the beginning stages (scope of work/contract development)  
Feb. 2018 - Staff continue to work with project consultants on design and delivery of the course, named *Preserving public trust: why your dental practice and future depend on it*. Ethics committee also in conversation loop.  
Sept. 2018 – We have engaged one of the three presenters at the Pacific Dental Conference course (Dr. Carlos Quiñonez from the University of Toronto) to present at the Thompson Okanagan Dental Society Meeting in October. No further progress on a CDSBC online course has been made.  
**Nov. 2018** – We are engaging Dr. Carlos Quiñonez to lead the development of an online ethics course. Timing on this is yet to be determined. Carried over to new operational plan. |
| **Specific wording in principal/associate agreements** | Staff, with BCDA | Staff are exploring the possibility of drafting standard form clauses that if accepted by the Board could be made into a standard or other enforceable document either requiring those clauses to be included into associate agreements and/or purchase and sale agreements, or deeming them to be included in all such agreements. The clauses would deal with things such as whistleblower provisions, production quotas, billing practices, etc. | Ongoing  
Feb. 2018 - Staff have met with BCDA practice advisors to formulate draft wording, which has now been referred to BCDA legal counsel who have agreed to review and advise.  
September 2018 – Wording has been provided to the BCDA for inclusion into their recommended draft agreement outlining the College’s expectations that, regardless of the business arrangement, care will always be provided that is in the best interests of the patient and that all professional requirements and responsibilities of the practitioner will be respected and facilitated. This wording will be brought back to the Board to determine next steps with respect to whether authority needs to be provided.  
**Nov. 2018** – Further discussion with BCDA has clarified the College’s position, that while clauses regarding a registrant’s ethical obligations to the patients they treat placed within an associate agreement are helpful, they... |
are already captured within the College’s expectations of registrants through existing documents. Staff is continuing work on a report to the Board with suggestions as to whether authority for inclusion in the agreement document is necessary.

| Quality Assurance (QA) Program improvement | QA Program Working Group, engagement consultant, and staff | Research and develop a comprehensive mandatory QA program that goes beyond reporting educational or practice hours. Have completed research and obtained feedback from registrants through listening sessions, webinars, focus groups and surveys. | Sept. 2017 - The working group is gathering and reviewing feedback. Following the initial consultation, they will begin drafting the revised program. Feb. 2018 - Working group and QA committee has continued to meet and to consult on development of proposals for the Board. QA chair is scheduled to present to Board for its February meeting. Sept. 2018 – Following the Board’s approval in February to accept the proposed program for consultation, the working group and staff have presented in-person sessions to present the proposed program and obtain feedback. These sessions will continue into October around the province. The working group will present a final program to the Board in February 2019 after reviewing feedback and incorporating any necessary changes. Nov. 2018 – carried over to new operational plan. Engagement efforts (including an online consultation forum) have continued throughout the consultation period, which closes on November 20. The working group will review all feedback received and submit the proposed program for Board approval in February. |
| Sedation | Sedation Committee and staff | • Pediatric sedation • Update of Deep and GA Standards & Guidelines • Roll out of inspections for moderate parenteral (IV) sedation | Ongoing Feb. 2018 - Pediatric Sedation Subcommittee reported to board at its November meeting that they are working on new guidelines. As their request/recommendation, the Board extended the moratorium on certification through “short course” format. |
| **Facial Aesthetics Working Group** | **Working Group and staff** | This working group was established by the Board to determine the role of dentists in the provision of cosmetic treatments, including neuromodulators and dermal fillers. | Sept. 2017 - Currently comparing the definitions of “dentistry” in place in other jurisdictions with the intent of submitting a draft definition to the Board this fall.  
Feb. 2018 - The working group is moving through their directed tasks having now defined scope of practice as it relates to the provision of cosmetic treatments by dentists, definition of the aesthetic patient, definition of the assessment required for that patient and a definition of treatment modalities that are in compliance with the Dentists Regulation. The final steps to determine a definition of competence will begin in March 2018. |
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|  |  | • Review of cost structure for inspections  
• Building code project – to establish building code and safety standard provisions applicable to dental facilities, including those certified for various forms of sedation. | Moderate parenteral sedation inspection/self-assessment continues to be refined and budget for additional staff person to support this initiative approved for 2018/19 fiscal year.  
We are in the process of combining the three sets of sedation Standards/guidelines and the various addenda into one document for easier reference.  
Committee and its various subcommittees continue to work on identified projects and will report as progress demands.  
Sept. 2018 – The addenda consolidation has been completed for the Minimal and Moderate Sedation Services (non-hospital facilities) document. The updated document was republished and will be communicated to registrants shortly. Work continues on the consolidation of the Deep Sedation and General Anaesthesia documents. The recruitment of additional staff to support the expanded inspection program is planned.  
**Nov. 2018 – A consolidation of the Deep and General Anaesthetic guidance documents is planned. Anticipated timeframe is the end of 2019. Carried over to new operational plan.** |
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<th>Practitioner wellness</th>
<th>Staff</th>
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<td>A practitioner wellness fund was established in 2017/18 to reduce financial barriers for registrants re: medical assessments and recovery. Next step is to articulate the criteria for access to this fund.</td>
<td>Feb. 2018 - Board approved general outline for criteria for access to fund at its September meeting. To date fund has not been accessed this year. Dr. Cathy McGregor presented on behalf of the College at the Canadian Dental Association-led workshop on wellness (as a follow-up to workshop by Canadian Dental Regulatory Authorities Federation [CDRAF] in 2012) held in Ottawa in April 2018. Registrar was in Ottawa at that time for National Dental Assisting Examining Board, Canadian Dental Assisting Regulatory Authorities and CDRAF-related meetings as well. September 2018 – work continues around developing structure to the access requirements to the College’s Wellness Fund – at this point it remains discretionary. Discussion will be had with the BCDA regarding changes to the support that they currently are offering their members. Nov. 2018 – BCDA is pursuing an association-supported practitioner health program that will support their members in seeking initial and ongoing assessments, treatment, and monitoring.</td>
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| Monitoring file oversight | Staff | New staff dentists have been hired to help with chart reviews and changes to the systematic handling of monitoring files are being considered. | Sept. 2017 - An increase in complaint consent disposition complexity has led to an increase in the number of monitoring files and delays in assessing the effectiveness of remediation.  
Feb. 2018 - A new staff member has been added in an administrative role within Monitoring to facilitate organization and classification of the open monitoring files. New reporting modalities have also been developed to facilitate communications amongst staff as well as with the Board. Older charts have been targeted with effect of reducing the current backlog in post-remediation chart reviews.  
Nov. 2018 – this initiative is carried over to the new operational plan as “Complete process mapping of complaints to determine alignment with existing monitoring process.” Based on our preliminary analysis, remedial programs, in some cases, have not resulted in complete resolution of the initial identified concerns. Accordingly, we are considering introducing different forms of remediation, including accredited, formal education. |
| Opioid Crisis | Staff | Response to federal and provincial declarations of a growing public health crisis regarding overdose deaths from opioids and the link to prescribing.  
Distribution of:  
• 2017 Canadian Guideline for Safe and Effective Use of Opioids in the Management of Chronic Non-Cancer Pain | Sept. 2017 - Some action has already been taken on this file in 2016/17; further steps being evaluated now.  
Feb. 2018 | Information package: All dentists received a hard copy information package with the print newsletter in December; this included CDSBC’s Standards & Guidelines document Prescribing and Dispensing Drugs, summary of recommendations from the 2017 Canadian Guideline for Safe and Effective Use of Opioids in the Management of Chronic Non-Cancer Pain, an information sheet for patients |
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<th><strong>Chronic Non-Cancer Pain</strong> to registrants</th>
<th>from the Institute for Safe Medication Practices Canada (which agreed to our request to add “dentists” to the title); and an infographic for prescribers that demonstrated the associated risks for different levels of morphine equivalence.</th>
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<tr>
<td>• Communications material developed by other public health agencies for use by prescribers and patients</td>
<td>Competencies: The Canadian Centre on Substance Use and Addiction is working to have a set of competencies included in medical and dental licensing exams and adopted by the provincial dental and medical regulators as part of the federal government’s Joint Statement of Action to Address the Opioid Crisis. The draft document is called <em>Competencies for Health Professionals in Pain Management, Drug Prescribing, Dependency, Addiction and Abuse</em> and was developed as part of First Do No Harm strategy. This will be on the agenda at the Canadian Dental Regulatory Authorities Federation. We are considering submitting a letter of support for these competencies to be integrated into CDSBC’s guidance for registrants, and for the content to be included in dental school and as part of the National Dental Examining Board examinations.</td>
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<td>• Educational resources, such as CPSBC Prescribers Course</td>
<td>Sept. 2018 – The cover story of the Summer 2018 College Update newsletter was on opioid prescribing. At the 2019 Pacific Dental Conference, CDSBC will be hosting a presentation on dentist prescribing of opioids and antibiotics.</td>
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<td><strong>Nov. 2018 –</strong> the College is presenting a session on safe and effective opioid and antibiotic prescribing at the Pacific Dental Conference in March. Ongoing participation in two multi-regulator initiatives on prescribing: Controlled Prescription Program Advisory Committee and the development of a joint standard on the sale of drugs.</td>
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There is extremely limited access to operating room time to provide general anaesthesia for patients who cannot be treated conservatively (e.g. patients with developmental or physical disabilities, dementia or psychosis; profoundly medically compromised patients; children).

Government funding for dedicated dental clinics with operating room facilities is required, including establishment of operating rooms within the dental suite in the new Acute Care St Paul’s hospital site.

The continuing consideration of dental anaesthesiology as a recognized dental speciality is related to this issue.

Sept. 2017 - Staff dentist to liaise with the BCDA, who has a committee in place.

Feb. 2018 - This is a complex issue that requires action from various parties, including two government ministries, the College of Physicians and Surgeons, Doctors of BC, and the BCDA. Staff have met with the BCDA to discuss the various challenges for increasing patient access to hospital-based care, and where it might be appropriate for the College to collaborate with the BCDA.

Sept 2018 – In March, the Ministry of Health announced funding for 15% additional dental surgeries, billed as the largest one-time increase in dental surgery ever in B.C. The surgeries will take place in all health authorities within the Provincial Health Services Authority.

Nov. 2018 – We have a representative attending the BC Medical Quality Initiatives, hosted by the health authorities, currently working on the standardization of credentialing and privileging in the health authority facilities.

### Governance and Operations: Doing it Right

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<tr>
<td>BC Health Regulators/</td>
<td>Staff</td>
<td>• Health Professions Act (HPA) updates</td>
<td>Ongoing</td>
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<tr>
<td>Government</td>
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<td>• Regulatory updates re: Restricted Activities</td>
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<td>• HPA section 39.2 (prior history): The Health Professionals Review Board (HPRB) has</td>
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<td>asked the colleges to develop a common framework re: how complaints should be resolved</td>
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Feb. 2018 - BCHR continues to meet every six weeks or so. Good progress on files can be reported. Government continues to look to BCHR to coordinate and lead joint initiatives. Government has asked for a “boot camp” for new board members (public and elected) along the lines of the many presentations made by Messrs. MacKinnon and Chisolm. Their stated desire is for every board member to get the message about government expectations of governance etc. on a continuous and repeated basis.
| Bylaws rewrite | Sept. 2018  
In June the Ministry of Health gave a presentation to the BCHR about transformation of the health care sector, and professional regulation specifically. The BCHR has been focused on preparing a response to the Ministry’s invitation to submit recommendations by 1 Dec. 2018. The Acting Registrar will provide more information at the Sept. board meeting.  
Nov. 2018 – We have participated in the BCHR sessions to develop the submission to the Ministry. Carried over to new operational plan.  

| Bylaws Working Group, external legal firm, staff | Preliminary feedback and decisions being sought on structural bylaws.  
Feb. 2018 - Working group continues to meet and report to the Board on a regular basis. The Board is currently considering models to replace the governance model in Bylaw 2.  
Sept. 2018 – Bylaw part 2 (College Board) is fundamental to the bylaws rewrite and the governance structure of the College. The Bylaw Working Group is submitting four motions on Bylaw 2 to the Board at the Sept. board meeting.  
Nov. 2018 – Bylaws Working Group preparing submission for November board meeting.  

| Board workshop in September 2017  
Bylaws working group will gather feedback at fall 2017 listening sessions  
Committees consulted |  

| registrant has already been the subject of a similar complaint. This will promote a consistent, transparent, predictable approach.  
- Notification working group established to address questions about and implementation of BCHR’s common public notification framework |
<table>
<thead>
<tr>
<th>Engagement</th>
<th>Staff, board and committee members</th>
<th>Ongoing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Online discussion forum being added to website to enhance public consultation efforts and improve transparency</td>
<td>Feb. 2018</td>
</tr>
<tr>
<td></td>
<td>• Ongoing presentations to dental component societies</td>
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<td></td>
<td>• Meeting with new UBC Dentistry Dean</td>
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<td>• Guest lectures delivered at UBC Dentistry</td>
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<td>• Staff support of President’s Blog</td>
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<td>Online discussion forum; has been added to the website and will be launched publicly when we next publish a policy item for consultation.</td>
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<td></td>
<td>Presentation skills workshop: Board Officers and staff who present on behalf of the College attended a presentation skills workshop on 18 Jan.</td>
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<td>UBC Dentistry: We are delivering three lectures as part of the Professionalism and Community Services Module between January and March. The DMD program is being revised and this is the final year for PACS in its current format.</td>
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<tr>
<td></td>
<td>Sept. 2018</td>
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<td></td>
<td>UBC Dentistry</td>
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<td></td>
<td>We hosted an information luncheon for incoming dental students and are delivering several lectures this fall on topics such as dental recordkeeping and the role of the College.</td>
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<tr>
<td></td>
<td>Presentations to dental societies</td>
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<tr>
<td></td>
<td>We currently deliver presentation and workshops to dental component societies on an ad hoc basis. To be more deliberate about engaging with them, we are formally offering to speak to their members. The Acting Registrar is the keynote speaker at the Thompson Okanagan Dental Society AGM in October.</td>
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<td></td>
<td>Nov. 2018 – these are ongoing regularly scheduled sessions; since they are expected to continue and they are in support of core and strategic activities, they are not listed as specific initiatives in the new operational plan.</td>
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</tbody>
</table>
| Supporting the policy framework | Staff, board and committee members | • 7 listening sessions held between November 2016 - November 2017 with all comments published on website | Ongoing  
Feb. 2018 - There are two listening sessions in the budget for 2018/19 year. We anticipate the first will be in April (tentatively Smithers/Terrace) with the second in Vancouver in October.  
Sept. 2018 – The multi-topic listening session format has evolved to a single topic format this year in support of the engagement efforts for the proposed changes to the Quality Assurance program (see above).  
Nov. 2018 – we will continue to support policy development through consultations and communications efforts; this is no longer a “stand-alone” initiative. |
| CDSBC at Canadian Dental Regulatory Authorities Federation (CDRAF) | Registrar | Current focus:  
• Renewal/governance  
• Specialty recognition process | Ongoing  
Feb. 2018 - New governance framework has now been accepted and approved by each of the DRAs (dental regulatory authorities). The Board now consists of each of the registrars (and in Que, the equivalent of registrar – Caroline Daoust). The next Board meeting will be 8/9 February with meetings with Commission on Dental Accreditation of Canada on the 8th and a Board meeting on the 9th. The Board will continue to be updated on meeting agendas and discussion through the monthly board updates posted to the Board portal.  
Sept. 2018 – The Acting Registrar attended a meeting of the CDRAF in early Sept. and is scheduled to provide an update as part of the board meeting agenda. The CDRAF Board continues to pursue a third-party services agreement for Specialty accreditation. A working group has been established to determine accreditation options if a workable agreement cannot be reached with the current provider. The Acting Registrar continues work with another working group determining and defining practitioner competency. |
<table>
<thead>
<tr>
<th>National Dental Examining Board (NDEB)</th>
<th>Registrar</th>
<th>Current focus:</th>
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</thead>
<tbody>
<tr>
<td>Royal College of Dentists of Canada (RCDC) and Commission on Dental Accreditation of Canada (CDAC)</td>
<td>Current focus:</td>
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<tr>
<td></td>
<td>• Blueprint</td>
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<td></td>
<td>• Defining the graduate dentist</td>
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<td></td>
<td>We are working with CDRAF colleagues to enter into more appropriate agreements with RCDC and CDAC to ensure appropriate oversight and direction from the regulators. RCDC is the national assessor that examines candidates for specialty programs. CDAC is the national assessor that accredits domestic as well as certain foreign dental schools. Both organizations are legally required to assess to specifications set by and in a manner acceptable to the regulators as well as oversight bodies having jurisdiction over the regulators (Health Professions Review Board, fairness commissioners, courts, etc.)</td>
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</table>

| Ongoing | Nov. 2018 – Carried over to new operational plan as “Completion of new specialty recognition process, national competency definition for dentists, and specialty certification processes through CDRAF working groups.” |

| Ongoing | Nov. 2018 – The registrar continues work with the Canadian Dental Regulatory Authorities Federation to engage the National Dental Examining Board, Commission on Dental Accreditation of Canada and the Royal College of Dentists of Canada in determining entry-level competencies and workable, collaborative agreements as to accreditation oversight. |
NEW:
Development of a risk assessment tool to be used at all levels of the complaints and remediation process.

This tool will promote consistency for complaint investigations by helping to identify the degree of risk to patient safety. It will be a public document and will promote transparency by providing more information about how complaints are resolved.

Sept. 2018 - First 2 drafts in circulation and will be presented at the Inquiry Committee training workshop in September.

Nov. 2018 – This was presented to the Sept. 21 in-person Inquiry Committee meeting as a component of the Inquiry Committee training.

At the Oct. 30 meeting of the Inquiry Committee, the draft risk assessment tool was adopted in principle for use by the Inquiry Committee and as a component of all aspects of the complaints process.

This appears on the new operational plan.

Other/ongoing initiatives that can impact delivery of core work and initiatives listed above

<table>
<thead>
<tr>
<th>Initiative or Situation</th>
<th>Responsible</th>
<th>Highlights/Summary</th>
<th>Status</th>
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</thead>
</table>
| Pressures on timely complaint resolution | Complaints team, Inquiry and Discipline panels, external counsel | Sept. 2018  
- Complaints are becoming more complex and require more time to resolve.  
- More complex files result in greater need for CDSBC oversight through monitoring, which requires significant staff time.  
Some of our complaint investigators are expected to retire in next 1-2 years. | 5 citations were directed by the Inquiry Committee in this time period:  
- 3 have been resolved with consent orders before the hearing date  
- 1 is tentatively scheduled for a discipline hearing in Nov. 2018  
- 1 is early in process  
Nov. 2018 – work continues on this; however, it is being addressed through the budgeting process and does not appear on new operational plan. We have appointed an additional admin assistant in the complaints department, which has proved successful in dealing with the backlog of correspondence. |
| Office expansion and renovation | Staff | The Board approved a motion for the College to expand into the entire space left vacant in suite 110 at College Place. | Nov. 2018 – Staff worked with an interior designer who finalized the design and submitted a tender package in October 2018, at which time a building permit application was submitted to City of Vancouver. The building permit was issued on October 10. Construction is expected to begin the last week of November, with the renovation completed by end of fiscal 2018. |
Draft 2019-22 Strategic Plan

(Including success measures and draft operational plan)

*Updated: 16 November 2018*
<table>
<thead>
<tr>
<th>Our Vision</th>
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<tr>
<td>Public protection • Regulatory excellence • Optimal health</td>
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<tr>
<th>Our Mission</th>
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<tbody>
<tr>
<td>The College of Dental Surgeons of BC protects the public and promotes health by regulating dentists, dental therapists and certified dental assistants. It does so by establishing, monitoring and enforcing the safe, competent and ethical practice of dentistry in B.C.</td>
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<table>
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<tr>
<th>Our Mandate</th>
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<tbody>
<tr>
<td>The College of Dental Surgeons of BC serves and protects the public, regulating dentists, dental therapists, and certified dental assistants by:</td>
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<tr>
<td>• Setting requirements for certification, registration, standards of practice and ethics</td>
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<tr>
<td>• Establishing requirements for, and monitoring, continuous competency</td>
</tr>
<tr>
<td>• Investigating and resolving complaints</td>
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</table>
## Our Values

The College of Dental Surgeons of BC demonstrates trustworthiness and promotes professional excellence by being:

- Ethical, open and transparent
- Fair and accountable
- Respectful and courteous
- Objective and evidence-informed
- Inclusive and embracing diversity
- Patient-centred and engaged with the public
## Our Goals and Initiatives

### Goal 1: Improve outcomes for the public through clearly stated standards of competence and conduct for dentists, dental therapists and certified dental assistants.

<table>
<thead>
<tr>
<th>Initiatives</th>
<th>Outcomes</th>
</tr>
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<tbody>
<tr>
<td><strong>We will do this by:</strong></td>
<td><strong>CDSBC has clear standards &amp; guidance for registrants that address new and developing areas of practice and take into account stakeholders’ views and experiences and provincial, national and international regulatory trends</strong></td>
</tr>
<tr>
<td>• Developing and maintaining <strong>patient-centred</strong> standards and guidance that are clear, consistent, enforceable and up to date</td>
<td>• <strong>Standards of competence and conduct are up-to-date, kept under review and reflect best practices</strong></td>
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<tr>
<td>• Establishing effective and timely Board review and oversight of standards and guidance</td>
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### Success Measures

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<tr>
<th>Operational Plan</th>
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<tr>
<td><strong>2019-2020</strong></td>
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<tr>
<td>• Completion of course for new registrants (carried over).</td>
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| Guidance is provided to help registrants apply standards of care and conduct.  
| Standards and guidance are published/distributed in accessible formats to allow registrants, potential registrants, educators, patients and members of the public to find them and also publishes info as to actions that can be taken if the standards and guidance are not followed.  
| CDSBC has developed an effective process for development, review and revision of standards and guidance under Board oversight.  
| Continued evaluation of ethical documents.  
| Presentation of opioid and antibiotic prescribing course at 2019 Pacific Dental Conference (carried over).  
| Development of online ethics course (carried over).  
| Development (with other regulators) of joint standard for sale of drugs and outcomes from the Controlled Prescription Program Advisory Committee.  
| Completion of the Facial Aesthetic Working Group’s “Guidelines for the Provision of Facial Aesthetic Treatments” (carried over).  
| Completion of the updated Deep and GA Guidelines (carried over).  
| Completion of updating the Oral Cancer Guideline (carried over).  
| Definition of new process for Bylaw 12 submissions not identified as complaints.  
<p>| Development of a standards and guidance development and review framework. |</p>
<table>
<thead>
<tr>
<th>2020-2021</th>
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<tbody>
<tr>
<td>Completion of online ethics course.</td>
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<tr>
<td>Development of course to support Infection Prevention and Control guidance document.</td>
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<tr>
<th>2021-2022</th>
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<tr>
<td>Development of process to use complaints data to determine need for new educational programming; new and revised standards of guidance.</td>
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Goal 2: Identify and strengthen productive relationships with stakeholders.

<table>
<thead>
<tr>
<th>Initiatives</th>
<th>Outcomes</th>
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<tbody>
<tr>
<td><strong>We will do this by:</strong></td>
<td>• CDSBC has clearly reported on its performance and on how it has addressed any identified concerns.</td>
</tr>
<tr>
<td>• Sharing information and consulting broadly with the public and other stakeholders</td>
<td>• Accurate and easily accessible information has been provided by CDSBC about its registrants, regulatory requirements, guidance, processes and decisions to the public and other stakeholders.</td>
</tr>
<tr>
<td>• Actively engaging the public and patients in decision making while being mindful of equity and diversity</td>
<td>• CDSBC understands the diversity of its stakeholders.</td>
</tr>
<tr>
<td>• Ensuring that we provide relevant and timely information that the public needs to make informed decisions about their health care</td>
<td>• CDSBC has consulted and worked with regulators, the public and other stakeholders to identify and manage risks to the public with respect to its registrants across all of its functions.</td>
</tr>
<tr>
<td>• Communicating and collaborating effectively with key organizations and stakeholders</td>
<td>• CDSBC has published and maintained an accurate register of those registrants who meet its</td>
</tr>
</tbody>
</table>
Success Measures

- Thorough and complete organizational response to government expectations and recommendations arising from the Harry Cayton review.

- Continued and increasing collaboration with BC Health Regulators (BCHR) to develop and implement a modernized regulatory framework in accordance with the Ministry of Health determinations from BCHR’s 2018 response to government.

- Continued participation in provincial and national projects in collaboration with regulatory and other stakeholder organizations.

- Expansion of Registrant Lookup to become Public Register, per the HPA.

- Increase data collection through updated registration/certification and annual renewal processes.

Operational Plan

**2019-2020**

- Initiate discussions and planning with government around the recommendations from the Harry Cayton report.

- Initiate discussions and planning in collaboration with BCHR regulators around any recommendations or instruction from the Ministry of Health once they have considered the BCHR’s 2018 response to government about modernized regulatory framework.

- Production of a common understanding and definition of terms shared by BCHR regulators and accomplished by a BCHR working group.

- Participation in development of BCHR public advisory group and new public awareness campaign.
- Completion of new specialty recognition process, national competency definition for dentists, and specialty certification processes through Canadian Dental Regulatory Authorities Federation working groups.

- Completion of standardization of the expanded modules, national occupational analysis for dental assisting through Canadian Dental Assisting Regulatory Authorities working groups, committees.

- Completion of two Commission on Dental Accreditation of Canada accreditation site visits for dental assisting programs.

- Ongoing consultation and collaboration with First Nations Health Authority.

- Ongoing CDSBC website review. Addition of a section for patient information.

- Annual renewal process – addition of questions: whether registrants have taken the San’yas cultural safety and competency course; whether registrants identify as Aboriginal.
- Increase clarity of the definition of limitations around “voluntary withdrawal” and “temporary leave of absence” to inform information provided to the public through the Registrant Lookup.

- Continued improvement on process to inform other provincial dental regulators of inquiry and disciplinary action.

### 2020-2021

- Continue with planning and implementing any of the government recommendations from the Harry Cayton report.

- Revision of gender question on application forms.

- Identification and engagement with public groups.

### 2021-2022

- Continue with planning and implementing any of the government recommendations from the Harry Cayton report.
Goal 3: Embrace leading regulatory practices to protect the public.

<table>
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<tr>
<th>Initiatives</th>
<th>Outcomes</th>
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<tbody>
<tr>
<td><strong>We will do this by:</strong></td>
<td><strong>CDSBC has ensured that anyone is able to raise a concern about a registrant.</strong></td>
</tr>
<tr>
<td>• Using data and risk assessment to enhance regulatory effectiveness</td>
<td><strong>CDSBC has ensured that its processes do not impose inappropriate barriers or otherwise disadvantage people with protected characteristics.</strong></td>
</tr>
<tr>
<td>• Using leading regulatory practices, such as the principles of right-touch regulation¹, to guide strategic decision-making and improve processes</td>
<td><strong>CDSBC is transparent in the way it conducts and reports on its business.</strong></td>
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¹ The principles of right-touch regulation are practices that ensure regulatory actions are targeted, efficient, and effective in achieving regulatory objectives.
| • Increasing organizational capacity to anticipate and respond to external forces and future challenges with agility, resilience and openness | • CDSBC privacy and security policy meets the standards set in Canadian legislation and the EU’s General Data Protection Regulation (GDPR). |
| • Updating and implementing a comprehensive mandatory quality assurance program so that the public is well-served by competent health professionals | • CDSBC has ensured that it has a comprehensive mandatory quality assurance program. |
| | • With respect to CDSBC policies, relevant learning from one area is applied to other areas. |
| | • CDSBC has confirmed its understanding of the diversity of its registrant population. |
| | • CDSBC has ensured proportionate requirements are in place to satisfy itself that registrants continue to be fit to practise. |
| | • CDSBC is using a risk-based framework to prioritize complaints and uses interim orders where appropriate to ensure the safety of patients. |
| | • CDSBC has ensured that its complaints process is proportionate and deals with individual files as quickly as is consistent with a fair resolution. |
| | • Through CDSBC, everyone can easily access information about dentists, dental therapists and |


<table>
<thead>
<tr>
<th>Success Measures</th>
<th>Operational Plan</th>
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<tbody>
<tr>
<td>Processes in place to facilitate third parties to provide information regarding concerns and complaints on behalf of patients and members of the public including disadvantaged and unique individuals.</td>
<td><strong>2019-2020</strong></td>
</tr>
<tr>
<td>Increase data collection through CDSBC annual renewal and registration/certification application processes.</td>
<td>• Determine process by which First Nations Health Authority can submit concerns and complaints on behalf of First Nations patients.</td>
</tr>
<tr>
<td>Increased attendance by public and registrants to Board meetings and AGM.</td>
<td>• Annual renewal process – addition of questions: whether registrants have taken the San’yas cultural safety and competency course; whether registrants identify as Aboriginal.</td>
</tr>
<tr>
<td>Processes in place to facilitate return to practice for dentists after extended absence that ensure public protection.</td>
<td>• Planning for implementation of revised Quality Assurance Program.</td>
</tr>
<tr>
<td>Development of a risk based decision tool to facilitate evaluation of applications for registration.</td>
<td>• Review of registrant assessment and monitoring process.</td>
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</table>
- CDSBC has updated and rolled out its privacy and security policy which is in accordance with the GDPR.

- Development and implementation of risk based framework for prioritization of complaints, determining initial limitations and conditions on registrants’ practice and determining outcomes from complaint investigation.

- CDSBC health and wellness program is aligned with the legislation to protect patients but facilitate a safe return to practice.

- CDSBC has implemented an improved comprehensive and mandatory Quality assurance program.

- 80% of complaints received will be resolved within 120 days.

- The average age of complaint files will be 6 months.

| 2020-2021 |
|  
| Develop a risk-based tool to assist the Registration Committee in evaluating applications for registration. |

- Complete process mapping of complaints to determine alignment with existing monitoring process (ongoing).

- Determination of alternate resolution pathway for Bylaw 12 non-compliance.

- Development and implementation of a more robust risk assessment framework for assessing intake and resolution of complaints.

- Include public participation in AGMs – first to occur in 2019.

- Include public participation in open/public portion of Board meetings.

- Reorganization of the Board agenda to include more items in the open/public portion of the meeting.

- IT security audit.
| **Develop processes that would enable registrants’ (dentists) return to practice after absence.** |
| **Review and update our Privacy and Security Policy to ensure it meets the GDPR standards.** |
| **Implement the Privacy and Security Policy.** |

**2021-2022**

- Complaints department will be appropriately staffed, facilitating more timely resolution of complaints.
- Improved QA program will be completely implemented by the end of 2022.
**Goal 4: Strengthen and clarify governance to support our mandate**

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<tr>
<th>Initiatives</th>
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<tr>
<td><strong>We will do this by:</strong></td>
<td><strong>CDSBC has clear governance policies that provide a framework within which decisions can be made transparently and in the interests of patients and the public. It has clear terms of reference for committees and working groups and effective reporting mechanisms.</strong></td>
</tr>
<tr>
<td>• Initiating a governance review to improve our governance model and identifying and responding to gaps and opportunities</td>
<td><strong>The Board has effective oversight of the work of the Registrar/CEO and the senior management.</strong></td>
</tr>
<tr>
<td>• Developing guidelines and procedures to sustain effective relationships within and between Board and staff</td>
<td><strong>The Board works co-operatively, with an appropriate understanding of its role as a governing body and members’ individual responsibilities.</strong></td>
</tr>
<tr>
<td>• Providing support for Board and staff to be knowledgeable and competent in all matters of professional regulation and good governance</td>
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<td>• Developing and implementing an annual board workplan</td>
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<tr>
<td><strong>Success Measures</strong></td>
<td><strong>Operational Plan</strong></td>
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</tr>
<tr>
<td>• Roles between staff and board and committee members are clarified and defined.</td>
<td>2019-2020</td>
</tr>
<tr>
<td>• CDSBC has an improved governance model.</td>
<td>• Facilitated workshop between Board and staff to clarify roles.</td>
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<tr>
<td>• Alignment of governance manual and operational processes and policies (i.e. reporting mechanisms) with our improved governance model.</td>
<td>• Revised orientation for new board and committee members.</td>
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**2020-2022**

• Governance review is undertaken and completed.
• Review and adjust processes and policies based on improved governance model.
• Review and adjust governance manual to align with improved governance model.

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Procedures for Reporting, Resolving and/or Investigating Respectful Workplace Complaints (DRAFT)
November 2018

In Support of Safe Respectful Workplace Policy

It is the desire of CDSBC to provide an effective and consistent process for responding to respectful workplace, bullying and harassment, and human rights complaints.

1.0 Rights, Roles and Responsibilities

CDSBC is tasked with creating and maintaining a safe and respectful workplace free from discrimination, harassment and bullying. Thus, CDSBC has an obligation to ensure that discrimination, harassment and/or bullying are neither condoned nor ignored. That said, everyone at CDSBC shares in the responsibility to contribute to and maintain a respectful workplace.

All CDSBC Individuals, including senior staff, have a responsibility to support this policy by:

- not engaging in the bullying discrimination and/or harassment of other persons;
- reporting if bullying, discrimination and/or harassment is observed or experienced; and
- applying and complying with CDSBC’s policies and procedures on bullying and harassment.

1.1 Employees

All employees are responsible for conducting themselves within the parameters of the Policy, and to contribute towards the creation and maintenance of a respectful workplace free from discrimination, harassment and bullying. Employees are expected to maintain constructive working relationships, and to practice open and effective communication. In addition, all employees share responsibility for bringing violations of the Policy to the attention of CDSBC, and CDSBC encourages prompt reporting of any alleged violations of the Policy.
1.2 Directors, Managers, and Supervisors

Directors, managers, and supervisors (the “Management”) have additional roles under the policy to establish and maintain a workplace free of discrimination, bullying, and harassment. They are responsible for taking reasonable steps so that harassment is not allowed, condoned or ignored. Their responsibilities include:

- acting as role models for professional and respectful conduct;
- providing training on this policy and on discrimination, harassment and bullying;
- ensuring employees have access to information regarding employer policies;
- taking action under the policy when inappropriate conduct is brought to their attention or has been observed;
- respecting the rights of all parties to a fair, equitable and confidential process for responding to complaints; and
- participating in investigative, corrective and/or disciplinary measures, where appropriate.

1.3 Director of Human Resources

The Director of Human Resources is specifically tasked with the following responsibilities:

- to participate in an informal resolution option;
- to receive formal complaints;
- to appoint a mediator or Investigator;
- to review all investigation reports;
- to issue discipline and/or take any corrective action necessary arising out of an investigation report;
- to ensure action is fully complied with by the participants; and
- to provide a summary of the investigation findings, conclusion(s) and action(s) taken, to the Registrar.

If a formal complaint is filed under the Policy that involves the Director of Human Resources as a complainant, respondent, or witness, the Registrar shall assume the above-noted roles and responsibilities.
2.0 Procedures

Complaints of discrimination, harassment or bullying may be dealt with independently, by the employee one-on-one with the person believed to be responsible for the conduct, or may be reported to Management. A complaint may be dealt with through initial action by the employee, or processed informally or formally as described below.

We expect that the initial action or informal approach be used first where appropriate, except in the instances where there are threats of harm to person or property or previous examples of retaliation.

A person who initiates a complaint (the “Complainant”) may, at any time, terminate the complaint or his or her participation in the complaint process. The Director of Human Resources will carefully consider this choice, but CDSBC specifically reserves the right to continue with any complaint process and/or to otherwise act as necessary to ensure that workplace discrimination, harassment or bullying issues are appropriately and conclusively addressed.

The Complainant and the person being complained about (the “Respondent”) can choose to be accompanied by a support person of their choice, including legal counsel, at any stage of the complaint process.

2.1 Initial Action

Any Complainant who believes that he or she has been subjected to discrimination, harassment or bullying is encouraged to bring the matter directly to the attention of the Respondent. Many problematic situations can be remedied quickly and effectively in this manner and the sooner you speak with the offender(s) the sooner the disrespectful behaviour may stop.

The Complainant may communicate with the Respondent verbally or in writing. The Complainant may wish to be accompanied by someone they trust when approaching the Respondent. The Complainant should describe to the Respondent the conduct complained of and its effect(s) on him/her, and state that the Complainant would like the conduct to stop, e.g. “I find your comments about my physical appearance very offensive and I would like you to stop making those comments.”

2.2 Informal Complaint Procedure

In the event that the Complainant brings the complaint directly to Management, the complainant will be advised of their options.
As part of the informal process, the Complainant may, with the assistance of the manager, meet with the respondent with a view to arriving at a solution to the situation. Alternatively, they may ask Management to speak with the Respondent through the informal complaint procedure. Management may request that the conduct cease.

There is an obligation upon Management to assist the Complainant in attempting to informally resolve the workplace conflict.

2.3 Formal Complaint Procedure

If an informal approach does not satisfactorily address the complaint, or if the Complainant does not wish to attempt an informal resolution, the Complainant may initiate a formal complaint. The Complainant and/or Respondent may, at any time during a formal complaint process, seek to resolve the complaint informally with the assistance of any member of Management. Alternatively, at the CDSBC’s discretion, an external conflict resolution professional may be utilized.

Steps:

1. The Complainant will prepare a written complaint (using the Complaint Form in Appendix A) containing all of the following:

   - description of the conduct;
   - time(s) and date(s) when the conduct occurred;
   - identity of the individual responsible for the conduct;
   - identity of any witnesses to the conduct;
   - description of the effect of the conduct on the Complainant; and
   - any supporting documents or physical evidence, such as emails, handwritten notes, photographs, or vandalized personal belongings.

Incidents or complaints should be reported as soon as possible after experiencing or witnessing an incident. This allows the incident to be investigated and addressed promptly.

2. The Complainant will forward a copy of the written complaint, in confidence, to the Director of Human Resources, the Registrar or the Board depending on the situation. Consideration will be given to the complaint, as to whether it warrants an investigation and will take into consideration:

   - The nature of the allegations
   - The urgency of the situation
   - The rights of both the Complainant and the Respondent
   - Privacy legislation, including confidentiality of information.
If it is not warranted, the complaint will be returned to the Complainant with the appropriate explanation, and the Complainant will have the option of resubmitting an amended complaint form. If the resubmitted complaint form is similarly found not to be a violation of the Policy, no further complaint concerning the same subject matter will be accepted.

If it is determined that the complaint does appear to be contrary to the Policy, the Director of Human Resources, the Registrar or the Board shall, within a reasonable time frame of the completed written complaint, notify the Respondent in writing that a formal complaint has been made by the Complainant, and of their option to submit a written reply (using the Response Form at Appendix B) to the complaint. At the same time, a copy of the Policy and the formal complaint will be provided to the Respondent.

3. Upon receiving the Respondent’s written response to the complaint, a copy will be forwarded to the Complainant.

4. An investigator will be appointed. The College may retain an independent third party to investigate the complaint. The decision to do this would be at the discretion of the College.

5. An investigation will be conducted and will include interviews with the Complainant, Respondent and any witnesses. Investigations will:
   - be undertaken promptly and diligently, and be as thorough as necessary, given the circumstances
   - be fair and impartial, providing both the complainant and respondent equal treatment in evaluating the allegations
   - be sensitive to the interests of all parties involved, and maintain confidentiality
   - be focused on finding facts and evidence, including interviews of the complainant, respondent, and any witness
   - incorporate, where appropriate, any need or request from the complainant or respondent for assistance during the investigation process

The investigator will also review any evidence, such as emails, handwritten notes, photographs, or physical evidence.

6. Within a timely manner, the Investigator will submit a report to the Director of Human Resources, the Registrar, or the Board. The report shall contain: a summary of the complaint and response, all relevant documentation obtained in the course of the investigation; a summary of relevant facts; an opinion as to whether the conduct (i.e. the act(s) complained of) constitutes discrimination, harassment or bullying as defined in the Policy and/or at law; and recommendations for resolution.
7. After reviewing the Investigation Report, the Registrar or the Board shall determine whether there has been a breach of the Policy and make recommendations for an appropriate remedy. Once these issues have been determined, the Director of Human Resources, the Registrar, or the Board shall meet with the Complainant and the Respondent separately to discuss the contents of the Report and the decision.

Where the investigation results in a finding that discrimination, harassment, or bullying has occurred, CDSBC will retain all records relating to the complaint.

Where the investigation results in a finding that discrimination, harassment or bullying did not occur, all records of the complaint will be removed from the respective personnel files of the Respondent and Complainant, and no further action will be taken.

If an employee or volunteer brings a complaint that is found to be frivolous, vexatious, and/or malicious, that employee or volunteer may be subject to discipline including termination or removal from CDSBC Board or committee.

3.0 Outcome

CDSBC Individuals against whom a complaint of discrimination, harassment, or bullying is substantiated may be disciplined, with consequences including dismissal. This policy will be applied without regard to status or seniority. Remedial or disciplinary actions may include but are not limited to:

- an apology;
- reprimand;
- referral to counselling;
- reassignment;
- removal from committee/board (for committee or board members);
- probation;
- with regard to public representatives of the Board, referral of the results of an investigation to the applicable government ministry;
- temporary suspension; and
- dismissal, with or without notice.

4.0 Discrimination, harassment or bullying by non-CDSBC personnel

CDSBC recognizes that CDSBC Individuals may be subject to discrimination, harassment or bullying in the workplace by persons who are not CDSBC Individuals (“non-CDSBC personnel”). Non-CDSBC personnel include, registrants, public, guests,
suppliers, and delivery people. In such circumstances, CDSBC acknowledges its responsibility to support and assist the person who has been subjected to such inappropriate conduct or comment.

An employee or CDSBC Individual who believes that they have been subject to inappropriate behaviour that is in contravention of this Policy by such an individual should immediately speak to Management or Human Resources.

CDSBC will take whatever action is necessary to ensure that it fulfills its responsibility to support and assist any person subjected to such inappropriate behaviour.

5.0 Discrimination, harassment or bullying complaints brought by the non-CDSBC Personnel

CDSBC prides itself on providing a collegial and professional working environment for all its registrants and guests, and it is expressly understood that no employee or CDSBC Individual shall discriminate against, harass or bully any non-CDSBC personnel in the provision of services. Any complaints brought forward by a non-CDSBC personnel shall be directed to the Director of Human Resources or the Registrar for review and resolution.

6.0 Retaliation

Retaliatory conduct is any conduct by the Respondent directed towards an employee or CDSBC Individual who:

a) has invoked the Policy in good faith, whether on their own behalf or on another employee’s behalf;
b) has participated in, or cooperated with, any process or procedure set out in the Policy; or
c) has associated with another employee/registrant/guest who has invoked the Policy or has participated in any of its processes or procedures.

Retaliatory conduct will be treated as harassment, and will be dealt with seriously, as a separate actionable matter under the Policy.
Appendix A

CDSBC Safe and Respectful Workplace
Complaint Form

I, ___________________________ (name of Complainant), have reasonable grounds to believe that ___________________________ (name of Respondent), who works or volunteers as a ___________________________ (job title/position) at CDSBC, has discriminated against me/harassed me/bullied me on or about the _____ day of __________, 20___, in contravention of CDSBC’s Safe and Respectful Workplace Policy.

Personal statement

Please describe, in as much detail as possible, the discrimination, harassment and/or bullying incident(s), including:

- the names of the parties involved;
- any witnesses to the incident(s);
- the location, date, and time of the incident(s);
- details about the incident(s) (behaviour and/or words used); and
- any additional details that would help with an investigation.

Please use additional pages as necessary.

_______________________________________________________________________
_______________________________________________________________________
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_______________________________________________________________________
Attach any supporting documents, such as emails, handwritten notes, or photographs. Physical evidence, such as vandalized personal belongings, can also be submitted.

I understand and accept the confidentiality requirements of CDSBC’s Respectful Workplace Policy.

________________________________________  _________________________________
Complainant’s Signature                        Date of Submission
CDSBC Safe and Respectful Workplace
Response Form

I, _________________________________ (name of Respondent), working or volunteering as a _________________________________ (job title/position) at CDSBC, have read the formal complaint dated the ________ day of __________________, 20_______ and filed by _________________________________ (name of Complainant), alleging that I have discriminated against/harassed/bullied the Complainant in contravention of CDSBC’s Safe and Respectful Workplace Policy.

Response statement

My response to the formal complaint is as follows: (please use additional pages as necessary)

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

I understand and accept the confidentiality requirements of CDSBC’s Respectful Workplace Policy.

__________________________________________________________
Respondent’s Signature

__________________________________________________________
Date of Submission
Appendix C

Examples of Discrimination, Harassment, and Bullying

The following are examples of workplace discrimination, harassment, and bullying:

- Breaching the confidentiality of another employee
- Comments or jokes based on the defined prohibited grounds
- Cruel practical jokes
- Derogatory comments
- Displaying or disseminating pornographic, sexist, racist or other offensive or derogatory material (e.g. posters, cartoon, drawings, etc.) including via email, internet or text message
- Interfering with a person’s normal movement
- Isolating an employee; distancing an employee from others
- Making rude, derogatory or offensive remarks
- Name calling
- Non-constructive/unwarranted criticism addressed in such a way as to intimidate, undermine confidence, or imply incompetence
- Creating unrealistic expectations regarding workload and/or completion deadlines.
- Personally picking on an employee in front of others, or in private
- Sending hostile or insulting messages
- Shouting at an employee
- Spreading malicious rumours, gossiping about or damaging an employee’s reputation
- Threatening job security
- Threats of violence, retribution, litigation or financial harm
- Unwelcome attention of a sexual nature, including:
  - Proposition of physical intimacy
  - Questions or remarks about sex life
  - Remarks about physical appearance
  - Requests for dates
- Unwelcome physical contact including touching and assault
- Using abusive or foul language and/or intimidating behaviour, including gestures and comments
- Verbal assaults
Commitment

The College of Dental Surgeons of British Columbia ("CDSBC"), in support of its values, is committed to providing a collegial and safe working environment. All individuals will be free from any form of disrespectful behaviour such as discrimination and harassment as per the BC Human Rights Code, personal or psychological harassment (including bullying) as per the Workers Compensation Act and are treated with respect and dignity. CDSBC believes that its employees’ and volunteers’ relationships with each other, its registrants and guests must be based on professionalism, mutual respect, honesty and trust.

Purpose

The purpose of this policy is to:

- maintain a working environment that is founded upon mutual respect, cooperation, and understanding;
- maintain a working environment free from discrimination, harassment and bullying prohibited by law;
- confirm for all managers, supervisors and staff that discrimination, harassment and bullying in the workplace will not be tolerated; and to
- establish a process under which complaints of workplace discrimination, harassment and bullying may be brought forward and dealt with.

This Policy is not intended to constrain or interfere with normal social interaction between and amongst CDSBC’s employees, nor is it intended to inhibit good faith activities or functions undertaken for legitimate workplace purposes (e.g. performance management, discipline, etc.) as long as these activities or functions are performed in a fair and reasonable way. Instead, the Policy has been put in effect to address and remedy conduct that constitutes workplace discrimination, harassment and bullying.
Scope

CDSBC encourages the prompt reporting of all incidents of discrimination, harassment or bullying, regardless of who the offender may be.

CDSBC recognizes that there is a potential for registrants, guests, or others with whom CDSBC conducts business with, to subject employees to discrimination, harassment or bullying in the workplace. In such circumstances, CDSBC acknowledges its responsibility to support and assist the person who has been subjected to such inappropriate conduct or comment.

This policy applies to all those working for CDSBC, including employees, whether permanent, temporary, casual, or contract workers, and volunteers, including committee, working group and board members (“CDSBC Individuals”).

This policy encompasses and covers discrimination, harassment, and bullying at CDSBC’s office; wherever CDSBC business and operations are carried out; at CDSBC-related functions, conferences and meetings; and during CDSBC-related travel. Specifically, the Policy applies to any location or function where CDSBC’s business is carried out, or to any location, function, or situation where the conduct may be reasonably viewed as having a negative impact on the workplace.

Other Remedies

Notwithstanding the Policy, CDSBC Individuals retain the option to pursue remedies under the British Columbia Human Rights Tribunal, WorkSafeBC or to initiate civil or criminal proceedings.

At all times, and notwithstanding the commencement of any external complaint or litigation, CDSBC reserves the right to commence or continue an investigation pursuant to the process set out in this Policy.

Prohibited Conduct

1. Discrimination

In an employment context, discrimination is illegal as it is contrary to the British Columbia Human Rights Code. Accordingly, a person must not:

- refuse to employ or refuse to continue to employ a person; or
- discriminate against a person regarding employment or any term or condition of employment based on the defined prohibited grounds.
The British Columbia [Human Rights Code](#) defines these “prohibited grounds” as follows:

1. Race
2. Colour
3. Ancestry
4. Place of Origin
5. Political Belief
6. Religion
7. Marital Status
8. Family Status
9. Physical Disability
10. Mental Disability
11. Sex
12. Sexual Orientation
13. Age
14. Conviction for an unrelated offence
15. Gender Identity or Expression

2. Harassment

It is a discriminatory practice to harass an individual based on any prohibited ground, and therefore harassment based on a prohibited ground is a form of discrimination.

Harassment can take many forms. It is generally defined as “conduct or comment which ought reasonably to be known to be objectionable or unwelcome and serves no legitimate work related purpose” and that is based on one of the prohibited grounds, and which also has one or more of the following attributes:

- it detrimentally affects an employee within their work environment; or
- it has adverse job related consequences such as reduced job security, or a negative impact on career advancement.

Harassment can be made out by one incident of serious or egregious conduct, or may be established by a series of separate incidents, i.e. some conduct may not be considered harassment unless it is repeated. It is important to stress that intention is irrelevant, i.e. whether or not an individual intends to harass another person has no bearing as to whether or not harassment occurred.

It is also important to stress that harassment does not include the exercise of authority related to safety, the provision of advice, assignment of work, work-related counselling or coaching, performance evaluation, discipline, or other similar supervisory or administrative functions undertaken for legitimate workplace purposes.

Minor verbal disagreements, personality differences, consensual workplace banter, and consensual workplace romantic relationships amongst peers do not normally constitute harassment based on a prohibited ground as defined in the Policy or at law.
3. **Bullying**

In this Policy, bullying behaviour is defined as conduct that disrupts civility and cooperation in the workplace and interferes with efficient and effective work flow.

Bullying is any inappropriate behaviour in the form of repeated and unwanted conduct or comment that a person knew or reasonably ought to have known would cause an employee to be intimidated or humiliated, and which affects an employee’s dignity or psychological or physical integrity, that has no legitimate work-related purpose, and results in a harmful work environment for the employee(s). Bullying can and often occurs where there is an imbalance of power between two people.

A single serious incident of such behaviour that has a lasting harmful effect on an employee may also constitute bullying.

Bullying can happen between:

- a member of management and an employee;
- an employee and a manager;
- one employee and another;
- a volunteer and an employee; or
- a volunteer and another.

Bullying is illegitimate behaviour which undermines the respect, safety, dignity, or self-esteem of an employee or which interferes with an employee’s work production and CDSBC’s business interests as an employer, and which results in a harmful work environment.

Examples of conduct which may constitute discrimination, harassment, and bullying can be found in Appendix C.

**Confidentiality**

CDSBC will endeavour to keep complaints filed under the Policy as confidential as is reasonably possible. However, disclosure of certain information or evidence may be required to investigate and/or process a complaint. In some instances, disclosure to other persons or agencies of the existence of a complaint, or of information or evidence pertaining to that complaint, may be permitted or even required by law.

All participants in any complaint brought forward under this Policy must maintain strict confidentiality respecting any information or evidence about that complaint. Accordingly, any deliberate and unnecessary breach of confidentiality will be
considered a violation of the Policy, and/or a separate instance of harassment and/or retaliatory conduct.
Annual Review

This policy statement will be reviewed in November each year. CDSBC individuals will be provided with an updated copy of the policy if there are any changes.

Note: This policy is implemented in accordance with WorkSafe BC requirements.

Procedures

Procedures for Reporting, Resolving and/or Investigating Respectful Workplace Complaints are outlined in a separate document and can be found here: (LINK).
Memo

TO: CDSBC Board
FROM: Bylaws Working Group
DATE: November 1, 2018
SUBJECT: Bylaw Part 2 – Proposed Board Model

On September 15, 2018 the College Board discussed at length Bylaw 2 – College Board. Four motions were approved and the BWG was directed by the Board to use the parameters of the results of those four motions to develop a proposal for a new Board model for consideration at the November 30 Board meeting. This would result in a smaller Board with fewer elected dentists and CDAs and proportionately more public members (Board of up to 16) based on the following four motions:

1. That the number of elected Board members be reduced for more efficient and effective governance;
2. That there will only be one CDA as part of a reduced Board size;
3. That the number of appointed (public) Board members be based on a policy of “more than one third and up to fifty percent of the Board”; and
4. That the Board officers be elected annually from the Board (rather than at-large from the dentist registrants) and that all Board members are eligible for election.

The BWG recognizes that Harry Cayton will be making recommendations to the Minister of Health at year-end regarding the CDSBC and health regulation in BC. However, both government and Mr. Cayton have encouraged the College to continue to make progressive governance decisions. It is the responsibility of the BWG to draft revisions to the bylaws and the BWG wants to demonstrate that the College can successfully address government expectations, best practices and right touch regulation in the process of developing new bylaws.
The new BC College of Nursing Professionals is considered a role model of best practices. We are told that even they recognize that their inaugural Board of 16 with 50% public members may be the first step in a process leading to an even smaller Board once they have adjusted to some of the new changes to nursing regulation in BC.

Similarly, our College must be careful that in its enthusiasm to change its Board size and composition, it does so in a way that does not handicap the ability of the College to work through its many current challenges until we see how well everything is working with some of the changes being proposed.

Our Board also needs to understand that in developing a Board proposal, this is not the “final say” before a formal Bylaw 2 is drafted – rather it is a new model that will be sent to stakeholders for consultation and that information will be returned to the BWG and Board for their final consideration and approval leading to a new Bylaw 2, possibly at the June 2019 Board meeting.

**Proposed Board Model**

**Motion 1 – Board Composition**
That the proposed Board composition of seven dentists, one Certified Dental Assistant and up to eight public members be approved in principle to allow for a 90-day consultation with registrants and stakeholders.

**Motion 2 – Board Terms, Board Officers and Eligibility Requirements**
That the proposed terms of office, Board Officer positions, and eligibility requirements be approved in principle for a 90-day consultation with registrants and stakeholders.

**Terms of Office**
- Board members (dentists and CDA) will be elected initially to a 2-year term (first term)
- Board members can then be re-elected for two additional 3-year terms (maximum of 3 consecutive terms or 8 years)

**Board Officers**
- There will be two Board Officers - a Board Chair and a Board Vice-Chair
• Board Officers are elected from within the Board for a 2-year term.
• Board Officers can be re-elected for an additional 2-year term.
• All Board members are eligible for election to the position of either Chair or Vice-Chair.
• Eligibility requirement - Board members must have served at least one-year on the Board to be eligible for election to the Chair and Vice-Chair positions.

Eligibility

• There will be a one-year cooling-off period for registrants who served on the Board of a provincial or national dental or dental assisting association.
• There will be a one-year cooling-off period for elected Board members who have served eight consecutive years on the CDSBC Board.

Rationale

Part 1: Board Composition

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| 1 CDA |

| 8 Public members (more than one third and up to 50% of the Board) |

Rationale:

• Maintaining the five electoral districts will allow a perspective from around the province. The BWG has considered the advantages of a competency-based election model, where the Nominations Committee will be responsible for encouraging a diversity of individuals to bring varying perspectives and competencies to the Board. Also being considered is
the requirement that to be eligible to run in a College election, a prospective dentist or CDA will first have to complete a Board orientation course and in their election biography indicate the competencies they can bring to the Board.

- The BWG debated the options of designating the two other dentist Board member positions, such as for a dental specialist, a UBC member, or another option. It was decided that by having two dentist members-at-large, the dental specialists and UBC will still have the opportunity to offer candidates for election, and bringing their expertise and competencies to the Board. It also allows districts with larger groups of dentists the opportunity to have more than one dentist in that electoral district run in an election and for all dentists in the province to elect the members-at-large.

- The perspective of CDAs has been maintained by having a CDA Board member

- The Ministry has indicated it would like to have more than one third (minimum in the HPA is one third) public membership on the Board to reduce the chances of the Board being improperly constituted, and best practices is for a Board of 50% public members (maximum permitted under the HPA). This would ensure the Board is always properly constituted.

  Mandating that the Board must be 50% public means that if one public member resigns, or the government does not appoint the full 50% public membership, the Board will be improperly constituted. For this reason, the BWG suggests the following wording - “up to 50% of the Board”. Legally, we are bound to adhere to the HPA Section 17 (3) and (4) which outlines the parameters around which we can amend (minimum of 1/3 and up to the same number as elected members or 50%).

  A Board of up to 16 members is still larger than best practices but given that the CDSBC is moving away from a Board where the dentists are in the majority and provide all of the leadership (President, Vice President and Treasurer), it may not be good governance to make so many changes that the organization is so handicapped, it is unsuccessful in its ability to function and to fulfill its duties.
Part 2: Terms, Officers and Eligibility Requirements

Terms of Office

Elected Board members will first be elected for a 2-year term. Members can be re-elected for two additional three-year terms for a maximum of 8 consecutive years.

Rationale:

- **Two and Three Year Terms**
  
  There is concern that an initial three-year term may be too long, particularly if there is a member who does not participate or contribute to the Board. There is also concern that two-year terms may not allow enough time to develop experience and understanding of how the Board and the College function, which a three-year term may afford.

  An initial two-year term will allow a new Board member time to learn about the College and become a participating Board member without an extended commitment. It also may be a safeguard in dealing with underperforming members staying on the Board. Two-year terms are also an easier “sell” when recruiting new board members, who already have busy lives and careers.

  Board members can be re-elected for two additional three-year terms. This will improve Board continuity and allow experienced Board members the opportunity to move into Board Officer positions. It is also a longer time period for members to accomplish strategic goals while serving on the Board.

  There is also concern regarding Board turnover. Varying term lengths will stagger Board vacancies reducing the chances of large annual Board turnovers.

- **Maximum of 8 consecutive years**
  
  A maximum number of eight consecutive years will ensure regular Board turnover, which can refresh the Board with new members who provide different perspectives, experience and expertise.

Board Officers

There will be two Board Officers - the Board Chair and Board Vice-Chair. Board Officers will be elected at the first meeting of the Board for a two-year term. The Chair and Vice-Chair can be re-elected to the same office for a second two-year term (maximum two terms). Board Officers are elected from within the Board. Both elected and appointed members are eligible to be elected as Board Officers, however they must first serve at least one year on the Board to be eligible for
election to the Board Officer positions. The Vice Chair does not automatically become the Chair.

Rationale:

- **Chair and Vice-Chair**
  Two Board Officers – a Chair and Vice-Chair – are consistent with all other BC health regulators. Although dental regulators across Canada use the terms “President” and “Vice-President”, it was determined that the title “Chair” and “Vice-Chair” are clearer from the public perspective where corporate boards use the term “President” to refer to the CEO of a company. We are also learning that the presidential terms may be changing in other provinces such as Ontario.

  If the Board is concerned about being “stuck” with an underperforming Chair or Vice Chair for two years, one option is to build into the bylaws the ability of the Board, by an extraordinary motion (2/3 majority), to remove that individual from the position of Board Chair or Vice Chair before the end of their term. This would not constitute removal from the Board as the provision to remove a member from the Board already exists in the HPA.

- **Terms**
  It was thought that one-year terms may be too short for Board Officers to get up to speed and accomplish their goals. For this reason, it is recommended that Board Officers should have two-year terms. If the Board Chair or Vice-Chair’s elected/appointed term to the Board ends while the individual still has another year in the Board Officer position, and that person is not re-elected/appointed, this would require a Board election for the open Officer position. Board Officers can be re-elected to a second two-year term – this would allow successful Chairs and Vice-Chairs to continue as Board leaders.

- **Election Process**
  Board Officers will be elected from within the Board at the first meeting of the Board. This election process is consistent with other health regulators. It also minimizes the current risk of inexperienced dentists being elected as Board Officers from the registrants. Only Board members, including the CDA and public members, are eligible to vote for the Board leadership.

- **Eligibility**
  All Board Members would be eligible to run for the Chair and Vice-Chair positions. This would allow the most qualified individuals to have the opportunity to be elected regardless of whether or not that person is a dentist. This is consistent with other health regulators. Recognizing that Board experience is invaluable, members would be required
Eligibility requirements
There will be a one-year cooling off period for individuals who are serving on the Board of a provincial or national dental or dental assisting association, including the Canadian Dental Association, BC Dental Association, Certified Dental Assistants of BC, and the Canadian Dental Assistants’ Association.
There will be a one-year cooling off period for individuals who have served eight consecutive years on the Board.
Rationale:
• One-year cooling-off period from advocacy organizations
  The mandate of the College is to serve and protect the public. The role of a dental or dental assisting association is to advocate for the professionals they serve. These organizations have different roles, so it is prudent for them to be separate and distinct from the College. For optics, the cooling-off period may create a perceived separation between the two roles and minimizes any potential conflicts of interest. On the other hand, most other BC Health Regulators do not have a cooling off period.

• One-year cooling-off period from the Board
  After a Board member has served on the Board for 8 consecutive years, they will be required to have a one-year cooling-off period from the Board before they are eligible to run in a College election. This will ensure regular Board turnover which will provide the Board with new members bringing different perspectives, experience and expertise.
At the November 30th Board meeting, the Bylaw Working Group will present its recommendations for an amended Bylaw 2 including changes to the Board composition, terms of office, Board Officer positions and eligibility requirements. The following two motions will be presented to the Board for consideration:

1. That the proposed Board composition model of 7 dentists, 1 CDA and up to 8 public members be approved in principle for a 90-day consultation with registrants and stakeholders; and

2. That the proposed terms of office, Board Officer positions and eligibility requirements be approved in principle for a 90-day consultation with registrants and stakeholders.

Accompanying this memo is a second memo from the BWG outlining their recommendations with rationale for the two motions.

These amendments to Bylaw 2 have been part of a long and unproductive process, having started with previous Boards in 2014. The BWG began its work on Bylaw 2 amendments almost two years ago and has tried varying approaches to get approval from the Board. When a complete Board amending proposal failed at the February 2018 Board meeting (one Board member wanted more than two CDAs; another did not want to see the UBC member lost; and another did not want to see the Dental Specialty member lost), a new approach was used in September. Four key motions were approved by the Board to use as parameters to base future decisions and to give guidance to a new Board model.
I have known from the beginning that there are two issues which would be very emotional - dentists losing their leadership positions on the Board, and the reduction in the number of CDAs. One can argue the objective reasons citing facts and best practices but that does not change the emotion. The Board voted in September and the decisions were clear on both issues. The vote was not decisive but it was a 60% majority and we need to move on. Whatever side you were on with each of these votes, the unsuccessful “side” is likely to be unhappy with the outcome. However, we are all losers if this is about “winning and losing”. Rather it is about respectful debate, making the best decision in the public interest and then moving on.

As a Board, we need to do better in communicating with one another. Discussions and debate should be respectful and not confrontational. Not advising the Board in advance that you do not understand something; are confused about a motion and need more information; or that you want to bring an entirely different perspective, should not be a “surprise conversation” on the day of a Board meeting. If we as a College have a strategic commitment as an organization to be open, transparent and respectful, it needs to start at the Board table. We all need to understand that when a Board makes a decision, we walk out of that room with only “one” voice. During the meeting, a member who strongly disagrees about a decision can ask to have their dissenting vote recorded in the minutes (decision of the Board as to whether this will be permitted) or the minutes can reflect that the decision was “not unanimous”. A member who feels so strongly they cannot support the Board decision and wishes to speak out against the decision always has the option of resigning from the Board, freeing themselves of their commitment to the Board.

The accompanying memo, “Bylaw Part 2 – Proposed Board Model” is being sent to the Board well in advance of the November 30th Board meeting. It is hoped this will allow Board members sufficient time to consider the issues and recommendations of the BWG.

Regarding the two motions proposed in this Memo, and as the Board Chair, I will discourage “friendly amendments” and not allow discussion to deviate from the motions being discussed. If a Board member wants to propose a formal amendment, then it needs to be stated and clearly articulated. If we are being open and transparent, this amendment needs to be sent in writing through the Chair to the Board at least five working days before the Board meeting to ensure there are no surprises and that supporting information can be provided to help in the Board’s deliberations. Regarding the two motions, I suggest debate for each motion be limited to 3 minutes per Board member and 1 minute to speak a second time after all other Board members have
spoken. I suggest the vote on each motion be by ballot. In accordance with “The Standard Code of Parliamentary Procedures”, any decision by the Chair is subject to challenge and ultimately the Board will make the final deliberations on how it proceeds. I trust Board members will be accepting of my intentions to help us proceed with this discussion on November 30th and I would welcome your feedback if you have concerns.

Thank you.