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Journal

OF THE MICHIGAN DENTAL ASSOCIATION December 2020

What Every Dentist Should Know About Sleep-Related Breathing Disorders

Incorporating Dental Sleep Medicine into Your Practice: S.E.T.U.P. for Success in Sleep

Holiday Celebrations in the Year of COVID-19: What to Do

THE DENTIST'S ROLE IN RECOGNIZING SLEEP-RELATED BREATHING DISORDERS

MICHIGANDENTAL.ORG

This is your chance to enroll in a health plan for 2021

2021 Health Care Open enrollment

MDA Health Plan	The window for changes/additions to existing plans closed Nov. 30, but new groups can be started at any time!
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Group Health Plans	Groups can be started by employers at any time. The window for adding participants is during the month of your anniversary.
Medicare Supplement plans, Medicare Advantage and Medigap plans	Make changes through Dec. 7 for benefits effective Jan. 1, 2021.

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The Dentist's Role in Recognizing Sleep-Related Breathing Disorders: A Two-Part Series

Presenting the first of six articles on sleep-related breathing disorders in this month's issue and next month's *Journal*.

Introduction by Christopher Smiley, DDS, editor-in-chief

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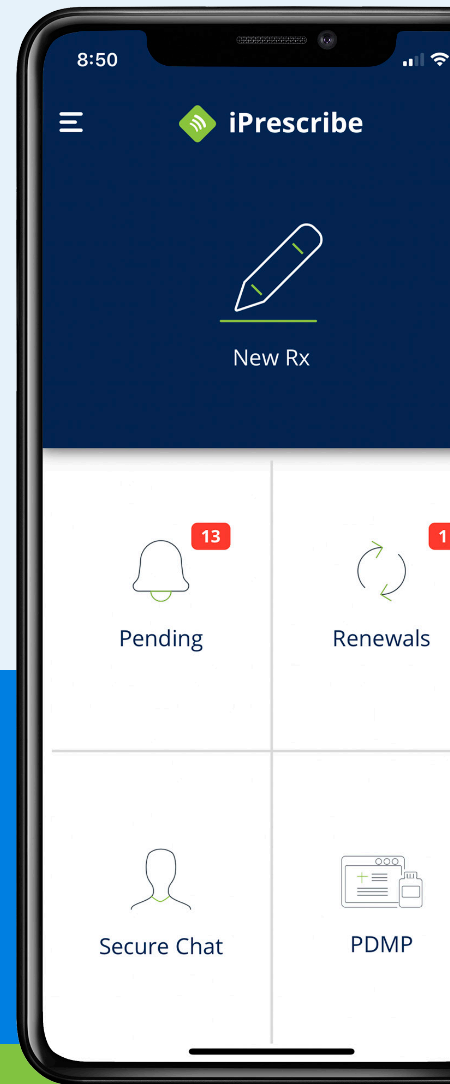
Are you ready to meet your state EPCS mandate?



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Washtenaw Community College's American Dental Association-accredited Dental Assisting program offers two pathways for dental assistants who want to become Registered Dental Assistants.

Pathway I is for the student with no previous dental experience. Students attend clinical classes in a traditional on campus setting while using Blackboard for the online component. Pathway I classes begin each Fall semester.

Pathway II/ADAEP (Alternative Dental Assisting Education Project) is for the On-The-Job-Trained (OJT) dental assistant with two or more years of dental assisting experience who has passed all three portions of the Dental Assisting National Board (DANB) CDA exam. Pathway II students receive college credit for passing the CDA exam. Students are required to attend a mandatory two-day on campus workshop at the beginning of the semester and will use Blackboard for the online component. At the end of the semester the students are required to return to campus to take a clinical final exam. Pathway II classes are very popular and begin each Fall, Winter and Spring/Summer semester.

For more information contact Tina Sprague at 734-973-3337

Or visit http://health.wccnet.edu/dentalassisting/

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MDA VALUES: We are guided by integrity and ethics; committed to the improvement of the public's overall health; we believe oral health is integral to overall health; in an inclusive environment that embraces diversity; that the profession of dentistry and the oral health team must be led by dentists to ensure the safety of the public; and that lifelong learning is critical to excellence in patient care.

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ELECTION 2020

Republicans Retain Control of Michigan Legislature

Despite millions of dollars in campaign spending and widespread predictions of a Democratic “Blue Wave,” Republicans retained a majority in the Michigan House of Representatives in this year’s election after all the votes were tallied. The House was the only state legislative body on the ballot in 2020; Gov. Gretchen Whitmer and the state Senate are not up for re-election until 2022.

The Republican majority remains at 58-52. This means both legislative chambers in the Michigan Legislature will remain under Republican control for another two years. Each party flipped two seats. The GOP picked up two seats, one near Bay City, where Republican Timothy Benson defeated incumbent state Rep. Brian Elder, and the other in Genesee County, where incumbent state Rep. Sheryl Kennedy was defeated by Republican David Martin. Democrats picked up two open seats, one in Kalamazoo County, won by Democrat Christine Morse, and the other in Oakland County, won by Democrat Kelly Breen.

What will change in the state House: State representatives are limited to serving three two-year terms, and among those term-limited in 2020 was House Speaker Lee Chatfield (R-Levering). Beginning in January, State Rep. Jason Wentworth (R-Farwell) will succeed Chatfield as speaker of the House. Wentworth, an Army veteran and former law enforcement official, will be entering his third term in January.

If you’re looking for a New Year’s resolution, **consider advocacy!** With the new legislative session beginning on Jan. 1, the new year is a perfect time to get involved with the MDA grassroots program and meet your local state officials, many of whom will be new. The MDA is constantly organizing meetings between state elected officials and member dentists across the state. They’re easy and convenient. To get involved, contact Lynn Aronoff, MDA grassroots organizer, at lynn@actionstrat.com.

Virtual legislative reception — The Washtenaw District Dental Society held a virtual legislative reception on Thursday, Oct. 22 — here’s a screenshot from the Zoom meeting. The MDA and local dentists have held a number of virtual legislative meetings during the COVID pandemic and they’ve proven quite effective, according to MDA Grassroots Legislative Coordinator Lynn Aronoff. Attending this meeting were U.S. Rep. Debbie Dingell and state Reps. Bronna Kahle, Donna Lasinski, Yousef Rabhi, and Ronnie Peterson, as well as a representative from U.S. Sen. Gary Peters’ office.

COVID-19 PANDEMIC

MDA Requests Early Vaccination for Dental Providers

The MDA has requested that Gov. Gretchen Whitmer include dental providers in the initial wave of those receiving a COVID-19 vaccine.

For protocols on employees exposed or who have tested positive, and protocols to follow if a patient you’ve treated later tests positive, plus the latest information and protocols regarding the ongoing COVID-19 pandemic, visit the MDA website at michigandental. org.

The MDA governmental affairs team monitors the COVID-19 pandemic and all MDHHS and MIOSHA recommendations.

MICHIGAN BOARD OF DENTISTRY

Rules Revisions Advancing

The Michigan Board of Dentistry has approved many of the MDA’s public comments regarding a set of revised proposed administrative rules on dentistry. The proposed rules now advance to final stages of the rule-making process.

The MDA recommendations adopted by the Board include requiring digital scanning to be done under the supervision of a dentist and requiring a health provider to be located within a reasonable distance of a referring dental therapist. Both of these recommendations will increase patient safety.

Compiled by MDA legislative staff. Questions? Contact Josh Kluzak at jkluzak@michigandental.org.

New MDA App Is Your Quick, Easy Connection to the MDA

New smartphone app — The MDA Connection App is a quick and easy way to engage with the MDA at the office, at home, or on the go.

If you're at work or on the go, the Connection app is here for you! Now the benefits of the MDA are at your fingertips with a new MDA smartphone app available for Android and IOS mobile devices.

The MDA Connection app puts you in touch with the information members most-frequently request from MDA staff or search for on the MDA website. You can catch up on the latest MDA *Journal* classifieds, browse CE courses, connect with the MDA Job Board, learn more about money-saving MDA-endorsed insurance and services programs, get practice management help, and much more!

To download to your smartphone or tablet, search "MDA Connection" on the Apple App Store and on Google Play. Don't forget to allow push notifications after installing, too. The push notifications feature allows the MDA to send special alerts and valuable information directly to your smartphone. It's another way to stay connected with the MDA — without checking your email.

The MDA Connection app itself is made up of 12 sections. They include:

Your Membership: Quickly and easily renew your membership and view frequently asked questions about membership.

ADA Member Card: With ADA membership cards now digital, this button gives you fast access to your membership card when you need it.

Continuing Education: Search the latest continuing education courses offered by the MDA, plus always have the CE requirements for license renewal at your fingertips.

Legislative Center: Sign up for the MDA's Legislative Text Alerts program, access the MDA Legislative Action Center, or schedule a time to meet your legislators through the MDA Grassroots Legislative Network.

News/MDA *Journal:* Read the latest MDA news, access past issues of the MDA *Journal eNews*, and browse the latest MDA *Journal* Digital Edition.

Practice Resources: Discover a host of practice resources available to you from the MDA, including ethics guidelines, peer review, the new Member Assistance Program, the popular MDA Practice Management book series, and other resources.

Job Board/Classifieds: Read the latest MDA *Journal* classifieds between issues or connect with the MDA Job Board, where you can place a listing or respond to a job opportunity.

MDA Insurance: Visit this one-stop shop for health, commercial, and home/auto insurance needs. You can easily request a quote, too!

MDA Services: Get exclusive access to many money-saving programs and services available through MDA Services that are essential to successfully operating a mod-

(Continued on Page 8)

MDA App (Cont'd)

ern dental practice and can save you the cost of your yearly MDA-ADA dues.

MDA Foundation: Make a gift and help the Foundation continue its mission of improving the dental health of Michigan citizens.

Annual Session: Get the details of the MDA Annual Session including courses/speakers, exhibitors, special events, and accommodations.

Contact Us: Easily reach out to the MDA for fast answers to your questions. You can connect to the MDA Facebook, Instagram, and Twitter accounts, too, or you can follow the MDA on any of its social media platforms.

Navigation within the app is a breeze, too. When you enter a section, just click the "home' icon in the upper left to return to the main page.

You asked for it

A survey conducted by the MDA showed members were interested in seeing the development of an association app. In response, former MDA President Dr. Margaret Gingrich appointed an App Workgroup in 2019 chaired by Dr. Tom Lambert. MDA staff interviewed several app developers and presented proposals to the workgroup. The workgroup elected to create an MDA app similar to one developed by the Arizona Dental Association. Funding for the MDA app was provided by MDA Insurance & Financial Group.

The MDA had investigated more advanced app options, but was not able to add the additional functionality because the ADA does not allow integration with the ADA database. An ADA app is in the works and it is expected to launch in early 2021.

The MDA anticipates the new MDA Connection app will be a useful resource and allow members to access information easily and quickly. Download it today!

Have a question?
Think MDA first!
Email membership@michigandental.org

Plans Announced for 2021 Annual Session in Lansing; Meeting May Go 'Live' Virtual; Dates and Times of Courses Will Remain the Same

2021 ANNUAL SESSION

Speakers and courses will be announced soon for the upcoming 2021 MDA Annual Session, "Destination Dental Education," scheduled to take place in person April 22-24, 2021, at the Lansing Center in downtown Lansing, with online registration scheduled to open in January.

If the COVID-19 pandemic remains an issue by next spring, the MDA will hold the meeting virtually. The speakers, courses, rates, dates, and times will remain the same.

"Whether it's held in-person in downtown Lansing, or live online, there will be an Annual Session next spring — you can count on that," said Dr. Dan Edwards, 2021 MDA Annual Session chair. Dr. Kevin Sloan, Continuing Education Committee chair, said that all Annual Session CE credits would count toward the "in-person" category for license renewal purposes regardless if the meeting is held in person or virtually.

Edwards

The MDA Annual Session is Michigan's largest CE and dental exposition event, with courses and activities for every member of the dental team. This year's CE lineup will include 30 speakers and more than 50 courses. A Leadership Forum Track has been added, which offers courses in communication skills, ethical considerations for leaders, plus diversity, equity, and inclusion topics.

Among the speakers scheduled at press time were Dr. Theresa Gonzales, Dr. Peter Auster, Dr. Seena Patel, Dr. Shakila Angadi, Dr. Francisco Ramos-Gomez, Dr. Andre Mickel, and Dr. Juan Yepes, with more to come.

Havens

The 2021 Annual Session keynote speaker will be Jeff Havens, speaking on "Us vs. Them," a program on generational leadership. This free session is open to all members of the dental team and will take place on Thursday, April 22 at 3:30 p.m., with one CE credit.

Exhibit hours have been changed for 2021. A special dentists-only Exhibit Hall hour will take place Thursday, April 22 from 7:30 until 8:30 a.m. Regular exhibit hours will be 10 a.m. until 6 p.m. Thursday and Friday, with no exhibits on Wednesday or Saturday.

Other events include "The BIG Bash at Lansing Brewing Company" Friday night, April 23, honoring MDA President Dr. Steve Meraw (open to all); the New Dentist Network Lounge at MP Social, taking place prior to the BIG Bash on Friday; tracks for leaders and new dentists; as well as courses for Certified Dental Business Professional candidates; and more.

The complete *Annual Session Preview* will be mailed in January. Full information will also be available online in January at michigandental.org/annualsession.

MDA Dues Contest Ends Dec. 31; Renew Now!

Members who renew their membership for 2021 by Dec. 31 will automatically be entered in the MDA's Dues Contest and are eligible for some great prizes. Don't miss out — the grand-prize-winner will receive his or her ADA, MDA, and local society dues for 2022 fully paid for by the MDA!

Other great MDA Dues Contest contest prizes include:

- $250 cash, courtesy of MDA Insurance.
- An e-copy of the *Staff Matters Human Resource System* (a $149 value).
- A $100 certificate good towards any MDA continuing education course.
- A copy of the MDA's book, *Most-Asked Human Resources Questions*.
- MDA Services apparel.

Contest winners will be selected by random drawing in early 2021.

Membership cards: Your American Dental Association membership card can now be accessed anytime, from anywhere — online. Traditional cards are no longer being sent. Instead, you can park it in your smartphone's virtual wallet, or print it out. To access it, log in at ada.org/myada. Then click on My Membership Card, and download or print your card.

Member benefits: Included in last month's issue of the *Journal* was the updated *MDA Member Benefits Guidebook*, a complete listing of MDA, ADA, and local society benefits. If you haven't done so already, be sure to carefully remove it from your copy, share it with your staff, and save it for future reference all through 2021.

Renew online! You can renew membership online at www.michigandental.org/dues. It's quick and easy. If you have questions about your statement, contact the MDA membership staff at 800-589-2632.

New MDA Digital Campaign Reassures Public, Features MDA Member Dentists

A new MDA digital advertising campaign set to launch this month will reinforce the message that MDA dentists are here for their patients and that they care about protecting their health. The new ads feature MDA dentists from across the state in videos shot entirely over Zoom — providing a rare, behind-the-scenes glimpse of MDA dentists in their practices, offices, and homes.

"The result is a series of videos that portray MDA dentists as caring, compassionate, and approachable oral health experts," said MDA Public Relations Committee Chair Dr. Sam Blanchard.

"With the onset of the COVID-19 crisis and during early spring shutdowns, the MDA was quick to ease public fear over returning to their dentist with our 'Dental Care Safety' Campaign," Blanchard said. "In the wake of that campaign's necessary clinical tone, the MDA is now adding more compassion and understanding to the messaging."

The new videos speak directly to the public from the heart, Blanchard said, striking a warmer tone with language like: "Care Goes Beyond Coverage"; "If You Need Dental Care, Let's Talk"; and "Together, We'll Find a Way."

"The MDA reminds Michiganders that no matter what life throws their way, their MDA dentist is here for them," Blanchard said.

State Recognizes Water Systems, Communities for Fluoridation Quality

The Michigan Department of Health and Human Services announced Nov. 5 that 71 water systems have been awarded a Water Fluoridation Quality Award from the U.S. Centers for Disease Control and Prevention.

The award recognizes those communities that maintained a consistent level of optimally fluoridated water throughout 2019. A total of 1,523 water systems in 29 states received the award, including the following Michigan systems:

Ann Arbor, Bangor, Baraga, Battle Creek-Verona System, Bay Area Water System, Belding, Benton Township, Big Rapids, Blissfield, Bridgman, Buchanan, Clare, Dowagiac, East Jordan, Eaton Rapids, Elk Rapids, Escanaba Water Department, Fenton, Fremont, Genesee County Water System, Gladstone Water Department, Grand Rapids, Gratiot Area Water Authority, Great Lakes Water Authority, harbor Springs, Hartford, Hastings, Hillsdale, Holland Baord of Public Works, Howell, Huron Shore Reg. Util. Authority, Ionia, Jackson, Jonesville, K.I. Sawyer, Kalamazoo, Lake Bella Vista, Linden, Lowell, Ludington, Manchester, Manistique, Marshall, Mason, Menominee Water Department, MHOG (Marion, Howell, Oceola and Genoa Sewer & Water Authority), Michigan State University, Midland, Milford, Monroe, Munising, Muskegon, Negaunee-Ishpeming Authority, New Buffalo, Niles, Plainfield Township, Plainwell, Saginaw, Schoolcraft, Sparta, St. Clair, St. Clair Water and Sewer Authority, St. Ignace Water Treatment, St. Johns, St. Josephb, Standish, Summit Township, Traverse City, Wakefield, Wayland, Wyoming.

Fluoridation has been recognized by the CDC as one of 10 great public health achievements of the 20th century. The CDC recommends water fluoridation as a safe, effective and inexpensive method of preventing decay. Every $1 invested in fluoridation saves at least $38 in costs for dental treatment.

MDA Office Christmas, New Year's Closings Announced

The MDA will be closed in observance of the Christmas and New Year's holidays on Thursday, Dec. 24 and Friday, Dec. 25 as well as Thursday, Dec. 31 and Friday, Jan. 1, MDA CEO/Executive Director Karen Burgess has announced.

Many MDA staff members will be taking vacation time during the last two weeks of December as well. The last two weeks of the year are typically slower than usual and staffers often take time off during that period. Some departments may not be covered every day, so if you have a special request, you may need to allow extra time.

Regular MDA office hours are 8 a.m. until 5 p.m., Monday through Friday.

Correction

A chart explaining MDA Services benefits on Page 55 of the November issue contained an error. The Eagle Associates savings highlighted should have been specified as Level 2 services, not Level 1.

Eagle Associates is the MDA-endorsed provider of OSHA, HIPAA, and OIG regulatory compliance services. The member savings on the Level 2 Eagle Associates program is $665.

It is the policy of the *Journal* to correct all errors when they occur.

Feb. 1 Is Deadline for State Board Candidates

The MDA continues to seek names of individuals interested in serving on the Michigan Board of Dentistry beginning in 2021. Each year the MDA Board of Trustees recommends names to the governor's office for consideration for appointment to the Michigan Board of Dentistry. Two positions for general dentists will be open on the Michigan Board of Dentistry in June 2021.

If you are interested in submitting your name as a candidate, forward a letter of interest and a current curricula vitae (no longer than two pages) prior to Feb. 1, 2021, to the MDA's Michelle Cruz via email at mcruz@michigandental.org. Or, you may fax a CV to 517-372-0008, attention Michelle Cruz.

The names of all nominees will be reviewed by the MDA Board of Trustees at its Feb. 19, 2021, meeting. The Board will approve two endorsements for each open position. The names and CVs of the individuals endorsed by the MDA Board will be forwarded to the governor for consideration.

Members having questions regarding the Michigan Board of Dentistry may contact MDA's Bill Sullivan at bsullivan@michigandental.org or by calling 517-346-9405.

NEWS FROM THE MDA FOUNDATION

Have You Made Your Year-end Contributions Yet?

There's still time to make your gift to the 2020 MDA Foundation Year-end Campaign — the Foundation and those it helps need your support.

Gifts from generous donors to the Foundation make it possible for deserving organizations across the state to serve more of Michigan's most vulnerable in need of dental care in 2021. Every gift, no matter the size, increases the Foundation's impact!

The MDA Foundation also supports scholarship awards given to dental, hygiene, and assisting students, as well as the MDA Member Assistance Program.

The fundraising goal this year is $60,000. To receive your potential tax benefits, please make your gift by Dec. 31. The MDA Foundation uses the proceeds from this annual campaign to help improve the quality of life in your local communities through improved dental health.

Please give today! You can make your gift online at michigandental.org/foundation.

Dental Volunteers Sought at Hope Clinic

Hope Clinic in Ypsilanti has a mission of providing medical, dental, food, care, and prayer to indigent and underserved people in Southeast Michigan. The clinic partners with those in the community who are uninsured and live in poverty to provide necessary treatment with dignity and respect.

The clinic is in the process of reorganizing and is planning to serve more patients with quality dental treatment. The clinic is equipped with eight chairs and X-ray capability at each. It uses Dentrix as its dental software system. Presently, the clinic provides basic preventive services, restorative care, and simple extractions. The clinic is eager to expand its services to include oral surgery, endodontic, and prosthetics – crowns, partials, and complete dentures.

The clinic is seeking experienced dentists for paid staff positions as well as volunteer dentists. Although Hope is a Christian organization, it welcomes dentists of any faith to join the Hope Clinic team. Those interested should contact Kay Wilson, dental director, at kwilson@thehopeclinic.org to learn more.

Holidays, Pandemic Bring Stress; Health and Well-Being Help Available

Dentists and dental team members are at high risk of stress, addiction, and emotional issues, especially during the holiday season. But there is help for those in need — both the MDA and ADA offer a variety of resources that may be of assistance. These resources include:

MDA Member Assistance Program: The new MDA Member Assistance Program helps MDA members and their families with issues such as stress, anxiety, and depression. Full details appear on the MDA website at michigandental.org/Assistance.

The Member Assistance Program is funded through the Michigan Dental Association Foundation. The program utilizes telephone triage and referral to appropriate professionals. Benefits include:

- Free support for all members, 24 hours a day, seven days a week.
- Multiple ways to access help — in-person, via telephone, video counseling, or mobile app.
- Access to face-to-face sessions, training, management tools, and work/life services including financial and legal resources and life coaching.
- Peace of mind, knowing that the MDA Member Assistance Program is there to support you and your loved ones through tough times and guide you on your journey — making your life easier and improving your total well-being.

Lewis

The Member Assistance Program's counseling services are provided on a contractual basis with AllOne Health, an outside firm with offices in Michigan. Having an outside company handle these calls may serve to ease the minds of some members who may be hesitant to call due to concerns about confidentiality.

If you or someone in your immediate family needs help, take advantage of this new service. See the advertisement on Page 63 of this issue.

MDA Health and Well-Being Program: The MDA Health and Well-Being Program matches those in need with concerned colleagues who've had similar experiences or who are familiar with addiction, recovery, or related issues. The program assists MDA members, their families, or staff in recovery, and is completely confidential. For more information, call 517-643-4171, from 8 a.m. until 4 p.m. Monday through Friday. Or, email care@michigandental.org.

MDA Website Well-Being Pages: Visit the MDA's well-being pages at michigandental.org/well-being for helpful resources, links to related websites, and other assistance.

Well-Being Resources from the ADA: Visit the ADA Center for Professional Success at success.ada.org for a variety of useful wellness resources. Included are the Dentist Well-Being Program Directory and Dental Well-Being Handbook.

Michigan Professional Recovery Program: The Health Professional Recovery Program is a confidential, non-disciplinary program designed to assist licensed or registered health professionals recover from substance abuse/chemical dependency problems or a mental health problem. The toll-free number for the HPRP is 800-453-3784. For more information, visit hprp.org.

Dr. Joan Lewis chairs the MDA Committee on Health and Well-Being. According to Lewis, alcohol abuse is the most-common substance abuse issue confronting dentistry, though stress and depression are also common problems.

RADIOGRAPHY TRAINING

ONLINE.
CONVENIENT.
SELF-PACED.
AFFORDABLE.

The Michigan Dental Association Online Radiography Training Program is the most convenient and economical way to ensure your assistants receive the radiography training required by Michigan law. No need for travel or time away from work. Your dental assistants train online, under your supervision, at their own pace.

It's affordably priced, too — just $265 per student for MDA members! To find out more or to get started, visit MyDentalRadiography.com/mda.

michigan dental
ASSOCIATION
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Michigan's Kosinski Elected Academy of General Dentistry Editor

The Academy of General Dentistry elected Timothy Kosinski, DDS, of Bingham Farms, as AGD editor during its 2020 Annual Meeting, held virtually Oct. 25. Since 2015, Kosinski has served as associate AGD editor. He replaces long-time AGD editor Roger Winland, DDS, MS, who retired after 24 years of service.

Kosinski is a two-time Michigan AGD editor and a former member of the MDA *Journal* Editorial Advisory Board, as well as a past Michigan AGD president.

"Teaching and writing are innate in me," said Kosinski. "During my two stints as editor of the Michigan AGD, I learned that I enjoyed gathering information on members and promoting the profession. I wish to continue the tradition of Dr. Winland's excellence and lead in the creation of high-quality publications," he added.

Kosinski is an affiliated adjunct clinical professor at the University of Detroit Mercy School of Dentistry and also serves on the editorial review board of *Reality*, the information source for esthetic dentistry.

Kosinski

KEEPING CURRENT

Events and Such

To publicize a local meeting or dental event in this space, contact Jackie Hammond at jhammond@michigandental.org. Continuing education courses are listed in the *Journal* Continuing Education department.

Dec. 2 — Membership Committee via Zoom, 6 p.m.

Dec. 3 — Trustee Forum Webinar, 7 p.m.

Dec. 10 — Committee on Peer Review, Health and Well-Being via Zoom, 8 a.m.

Dec. 10 — MDA Board of Trustees via Zoom, 6 p.m.

Dec. 11 — MDA Board of Trustees via Zoom, 8 a.m.

Dec. 24–25 — MDA office closed in observance of Christmas.

Dec. 31–Jan. 1 — MDA office closed in observance of New Year's.

Welcome, New Members!

The MDA is pleased to officially welcome the following individuals into membership:

Detroit: Jason Armstrong, Mayer Eckstein, Rafal Hamamh, Rouzana, Hares, Timothy Killgrove, Robert Wiesen; **Genesee:** Michelle Haskins, Michael Nguyen; **Graduate Student:** Stephanie Brown; **Kalamazoo Valley:** David Wilson; **Livingston:** Breanna Whittemore; **Macomb:** Jocelyn Friesen, Shahrzad Orenduff, Bibi Rahima, Baxinder Samrao; **Muskegon:** Scott Thielbar; **Oakland County:** Thomas Chae, Daniel Coke, Janelle McQueen, Nikeeta Patankar, Mark Wolfson; **Resort:** Nicole Thayer; **Saginaw Valley:** Karin Gifford; **Washtenaw:** Sun-Yung Bak, Bianca Boji, Debby Hwang; **West Michigan:** Carol Baldwin, Michelle Kuznia, Alexandra Maring, Suzzette Ona, Michael Ruszkowski.

In Memoriam

Dr. Reinhold W. Schmieding, Naples, Fla. Oakland County District. Died Sept. 12, 2020. Age, 95.

Dr. Richard Lewis Dulude, Midland. Saginaw Valley District. Died Oct. 19, 2020. Age, 85.

BHS Disciplinary Report

Visit www.michigan.gov/lara to access the latest disciplinary reports for dentists, registered dental hygienists, and registered dental assistants. You may also check any licensee for disciplinary actions at the same web address.

Self-Reporting of Criminal Convictions and Disciplinary Licensing Actions

Section 16222(3) of Michigan's Public Health Code requires any licensee or registrant to self-report to the Department of Community Health a criminal conviction or a disciplinary licensing or registration action taken by the state of Michigan or by another state against the licensee or registrant. The report must be made within 30 days after the date of the conviction or action. Convictions and/or disciplinary actions that have been stayed pending appeal must still be reported.

Should the licensee or registrant fail to report, and the Department becomes aware of the conviction or action, an allegation will be filed against the licensee or registrant. Sanctions for failing to report can include reprimand, probation, suspension, restitution, community service, denial or fine. For more information contact the MDA's Ginger Fernandez at 800-589-2632, ext. 430.

Call for Manuscripts

The *Journal of the Michigan Dental Association* is looking for submission of original, unpublished manuscripts of clinical interest for consideration for publication in the MDA *Journal*. Such manuscripts could consist of case studies, literature reviews, clinical techniques, research, or other topics of scientific interest.

All manuscripts submitted will be reviewed by the MDA *Journal* editorial staff, editorial review board and/or outside reviewers. The MDA *Journal* uses a peer-review process for clinical submissions. Non-clinical submissions also may be peer-reviewed, depending on the subject area.

Note that all dentist authors must be members of the MDA, ADA, or the Canadian Dental Association. All images submitted for consideration must be high-resolution digital photos. The complete MDA *Journal* "Information for Authors" may be found at michigandental.org in the Jobs/Classifieds/Journal section.

Submissions, questions about the submission process or non-clinical articles may be directed to Dave Foe, managing editor, at dfoe@michigandental.org.

Positions Open on MDA Insurance Board of Directors

Nominations from members of the MDA are being accepted now to serve on the Board of Directors of MDA Insurance & Financial Group, the MDA's insurance and services subsidiary.

The term of office is for one year, beginning on May 1, and a director may serve more than one term, but must stand for election each year.

Detailed information on the duties and responsibilities of directors and how to apply appears on the MDA website at michigandental.org/leadership-central (click on the "Get Involved" section). The deadline to apply is Feb. 1, 2020. For more information, contact Craig Start at 517-346-9441, or email cstart@mdaifg.com.

The MDA's **Committed Colleague** Recognition Program recognizes outstanding volunteer leaders in Michigan dentistry. Any member can nominate a volunteer for going "above and beyond" – it's a great way to honor those unsung heroes who do so much for dentistry.

To learn more, visit:
michigandental.org/committed-colleague

NEWS FROM THE ADA

Life-Threatening Emergencies in the Dental Office: What to Do

A safe dental office will have in place a plan of action for when a life-threatening emergency occurs. That's because an emergency, either medical or dental, can present at any time, and successfully handling it requires a plan of action that the entire staff understands and has practiced. After all, it may be the dentist having the medical emergency!

Emergency policies must be developed specific to the size and type of dental practice. What is appropriate for a small general practice is entirely different than that of a large clinic, which is yet again different from what would be expected from an oral surgery practice.

Regardless of the type of practice, an emergency plan aims to manage the patient until help arrives. This comes down to maintaining an oxygen supply to heart and brain, thus managing the airway, breathing, and circulation.

The small or solo practice may have a simple policy of two basic steps:

- Calling 911.
- Instituting Basic Life Support (BLS) procedures to support oxygenation culminating in the use of an automated external defibrillator (AED).

In this situation, the entire staff must have current CPR training. There is a staff member (and backup) appointed to call 911 stat.

An oral surgeon's office or a practice that utilizes sedation or general anesthesia should have access to more resuscitation equipment and be able to provide more advanced care. In both settings, only repeated practice can result in calm, clear communication and effective addressing of the emergency.

The takeaway: Have a basic plan and practice!

—Dr. Rich Herman, chair, ADA Culture of Safety in Dentistry Workgroup

LETTERS TO THE EDITOR

Questions State Guidance on Hypertension

The October 2020 issue of the *Journal of the Michigan Dental Association* presents new Michigan Department of Health and Human Services (MDHHS) guidelines for detection and management of hypertension for dental offices in Michigan.[1,2] On behalf of the authors of the most recent review of this subject published in *JADA*,[3] we strongly disagree with the new MDHHS guidance of when to cancel dental procedures based on elevation of blood pressure in dental offices. Our conclusions stated: "there are no prospective study investigators that have addressed whether or when to cancel dental procedures due to office-measured elevated BP. We recommend using current anesthesiology guidelines based on functional status and past BP measurements to prevent unnecessary cancellations."

We feel that the new Michigan Department of Health guidelines, if followed, will result in delayed dental care and unnecessary referrals to primary care offices, especially now during the COVID-19 epidemic with its additional restrictions. For instance, the new MDHHS guidelines algorithm recommends referring patients with a BP greater than 130/80 to their primary care physician for follow up, but do not take into account if the patient is already under the care of a physician or is on medications for hypertension. In addition, the algorithm indicates that dental treatment should be discontinued if the patient's BP is greater than 180/110, even if the patient does not have symptoms consistent with hypertensive crisis. The current ADA recommendations do not recommend deferring emergency dental care on patients whose blood pressure is above 180/110 in the absence of symptoms of a hypertensive emergency, because dental pain may be the cause of the elevated BP and will only be relieved with treatment.[2]

Finally, the new MDHHS guidelines state that the dentist should retake any BP measurements that are greater than 120/80 in one to two minutes and schedule follow-up visits or phone consultations at one week, three weeks, and six weeks. BP in this low range poses no risk for dental care, and any follow-up visits to diagnose or manage hypertension should be conducted at the primary care physician's office, not the dental office.

We strongly recommend that the MDA issue a retraction of this paper and that the Michigan Department of Health retract, then revise the new policy for hypertension screening in dental offices. We suggest using our recent *JADA* article as guidance.[3]

References

1. Deming S, Knowles L, Levy P. Michigan's new hypertension screening guidelines. What do they mean for you? J Michigan Dent Assoc https://www.michigandental.org/wpcontent/uploads/Digital%20Journals/October%202020/index.html

2. https://www.michigan.gov/documents/mdhhs/Hypertension_Screening_Guidance_690022_7.pdf

3. Steven A Yarows, Olga Vornovitsky, Robert M Eber, John D Bisognano, Jan Basile. Canceling dental procedures due to elevated blood pressure: Is it appropriate? J Am Dent Assoc 2020 Apr;151(4):239-244

Steven Yarrows, MD, Chelsea
Olga Vornovitsky, MD, Rochester, N.Y.
Robert Eber, DDS, MS, Ann Arbor
John Bisognano, MD, Rochester, N.Y.
Jan Basile, MD, Charleston, S.C.

Editor's Note: Dr. Yarows is an internal medicine and hypertension physician, IHA, and a clinical professor of internal medicine. Dr. Vornovitsky is an assistant professor, Department of Anesthesiology and Perioperative Medicine, University of Rochester Medical Center, Rochester, N.Y. Dr. Eber is a director of clinical research and a clinical professor of periodontics and oral medicine, School of Dentistry, University of Michigan, Ann Arbor. Dr. Bisognano is a professor, Division of Cardiology, Department of Internal Medicine, University of Rochester Medical Center, Rochester, N.Y. Dr. Basile is a professor of medicine, Seinsheimer Cardiovascular Health Program, Medical University of South Carolina and Ralph H. Johnson VA Medical Center, and a vice chair of clinical programs, Council on Hypertension, Charleston, S.C.

The authors respond:

Thank you for your comments on our article published in the October issue of the MDA *Journal* regarding the new Michigan Department of Health and Human Services (MDHHS) guidance for the detection and management of hypertension for dental offices. This document is the result of a multi-year collaboration between the MDHHS Hypertension and Stroke Prevention Unit and Oral Health Program staff and is intended to address gaps that dental health professionals identified on a survey about blood pressure measurement and management in dental offices. The guidance document was written by a broad-based advisory committee convened by MDHHS that included representatives from the medical and dental community. The committee met for more than a year and finalized the guidance in early 2020, synthesizing the prevailing evidence available at that time.

While it is indisputable that dental professionals have an important role to play in the screening for and management

(Continued on Page 16)

DETROIT MERCY DENTAL

Are you interested in considering a blended career in teaching? Do you have extra time to be a part of the future of dentistry?

If so, the University of Detroit Mercy School of Dentistry would like to hear from you! Over the past decade, we have helped numerous experienced clinicians transition their careers from full-time clinical practice to a second career as a dental faculty member.

The University of Detroit Mercy provides a generous benefits plan including subsidized health care, paid vacation, and a retirement plan. We provide development programs that help make clinicians effective educators by offering tuition support for adult learning classes, instruction in education pedagogy, and opportunities to attend dental education institutes for teaching and learning.

Detroit Mercy Dental is located in the historic Corktown neighborhood, the oldest surviving neighborhood in Detroit. Our campus is located within minutes of the city's cultural center and downtown, both of which offer a myriad of sports and entertainment venues as well as a variety of unique restaurants.

Interested candidates should contact the School of Dentistry.
Letters of interest and CVs should be forwarded to
wheatemi@udmercy.edu
or
Dr. Michelle Wheater
University of Detroit Mercy School of Dentistry
2700 Martin Luther King Jr. Blvd.
Detroit, MI 48208-2576.

The University of Detroit Mercy is independent and Catholic with Jesuit and Mercy co-sponsors. The University emphasizes academic excellence, ethics, personal attention to students, and the University Mission and Core Values. The University has a culturally diverse faculty and student body, and encourages applications from women and other underrepresented groups. EO/AA Employer.

LETTERS TO THE EDITOR (CONT'D)

of hypertension, one of the more challenging areas relates to the discontinuation of procedures when markedly elevated blood pressures are encountered. As you note in your publication, prospective trials are lacking, so we have no evidence base to support or refute the safety or danger of proceeding with or canceling dental procedures in those with a blood pressure > 180/110 mm Hg. However, what we do know is that the American Dental Association has weighed in on the subject and stands firm in its latest recommendations (see: https://www.ada.org/en/member-center/oral-health-topics/hypertension) that when performing elective dental care, "...no elective dental treatment..." should be done when blood pressure is > 160/100 mm Hg. Importantly, the ADA recommendations were written with full acknowledgment of your publication.

We do appreciate the work that you all have done and agree that more evidence is needed with respect to the recommendations they have put forth. Unlike your group, we were not writing an original research publication but rather an MDHHS-sanctioned guidance document and, as such, the advisory group elected to follow the ADA recommendation on postponing dental procedures. Unlike the ADA recommendations but in keeping with what you suggest, we incorporated a higher BP threshold (180/110 mm Hg) for decision-making. We, too, do not want procedures unnecessarily canceled, which is why we also strongly emphasized that patients with hypertension be instructed to continue taking their antihypertensive medications prior to coming to the dentist, even if a procedure is planned, and that proper methods are used to measure blood pressure, including confirmation by repeat measurement that an elevated reading is indeed elevated.

We do regret not citing your publication, but due to the timing of our analysis and the April 2020 date of your article appearance in *JADA*, it was too late to incorporate it. We do appreciate the perspective provided in your letter and related manuscript, but the absence of evidence is not evidence of absence. Thus, we stand behind our summary published in the MDA *Journal* as well as the MDHHS guidance document upon which it is based. Without specific data to refute our recommendations, there are no grounds for a retraction. To better inform future guidance statements, a prospective study is sorely needed.

Christine Farrell, RDH, BSDH, MPA, and Susan Deming, RDH, Lansing
MDHHS Oral Health Program
Phillip Levy, MD, MPH, Detroit
Hypertension and Oral Health Advisory Committee member
Lisa Knowles, DDS, East Lansing
Hypertension and Oral Health Advisory Committee member

Comments on "Mask Ask" Article

I would like to take slight issue with the October article "The Mask Ask: Understanding and Addressing Mask Resistance" by Drs. Frantsve-Hawley and Richey. The article is written from the standpoint that a mask is important because it can prevent the wearer from infecting other people that they come into contact with. From a public health point of view that is undoubtedly the most important benefit of mask wear. Since the onset of the COVID crisis the public has often heard the theme that "you wear the mask, not for yourself, but rather for others."

However, a mask also offers a degree of protection to the wearer as well, and that is, I believe, a very important point to be made in any effort to get resistant people to wear a mask. The public needs to understand that they themselves benefit from the mask that they wear. I would maintain that many of those who have refused to wear a mask during the current pandemic have a less-than-altruistic attitude regarding the welfare of others. That being the case, an argument that includes the protection of their own well being may be somewhat more effective than a plea to just protect others. Some folks really just want to know "what's in it for me?"

The University of Michigan Healthcare Blog (healthblog.uofmhealth.org/wellness-prevention) has recently featured a couple of very good articles regarding proper mask wear, the last of which debunks the myth that a mask does not offer protection to the wearer. Of course in this venue I am singing to the choir, but we can all be proud that our profession has always been at the forefront of educating those that we serve.

David G. Drake DDS, MS
Dexter

The authors respond:

Thank you for the opportunity to respond to the letter from the Dr. Dake that pointed out the dual benefit of wearing a mask during the COVID-19 pandemic: 1) minimizing viral spread among infected individuals, including those who are pre-symptomatic and asymptomatic; and 2) protecting the uninfected individual from possible exposure. Our article addressed the first benefit, use of masks for source control (limiting viral spread from the source of the infected individual), because this had been the rationale for mask usage largely emphasized by public health agencies[1,2] and evidence.[3,4] For example, the CDC touts instances where infected individuals did not elicit widespread infection when wearing cloth masks because such masks provided effective source control.[5]

On Nov. 10, 2020, the CDC released a Scientific Brief updating information on use of cloth masks to control the

spread of SARS-CoV-2 that shared new information indicating masks also help reduce inhalation of droplets by the wearer ("filtration for personal protection").[6] The Brief concluded there are two benefits of wearing a mask: source control and filtration for personal protection. Thus, the author of the letter to the *Journal* correctly states that there is self-protection when uninfected individuals use masks.

Community protection occurs when an infected individual (symptomatic, pre-symptomatic, or asymptomatic) dons a mass. And, the best protection comes from everyone (infected and uninfected individuals) wearing a mask—along with other recommended public health measures such as social/physical distancing and avoiding large gatherings.

This new knowledge shared by the CDC is an example of science in the making. As we have experienced so many times during the pandemic, the evolution of knowledge on COVID-19 has — and will continue to — change recommendations. This is expected as part of the scientific process. As health care professionals we should embrace the responsibility of helping our patients understand why recommendations may change and to have confidence to adapt accordingly.

References

1. CDC. Considerations for Wearing Masks. https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover-guidance.html (2020).

2. Coronavirus disease (COVID-19): Masks. https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/q-a-on-covid-19-and-masks.

3. Howard J, et al. Face masks against COVID-19: an evidence review. Preprints 2020, 2020040203 (doi: 10.20944/preprints202004.0203.v1).

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H. Grant Ritchey Jr., DDS
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The Journal welcomes letters from readers. Address letters to "Letters to the Editor, MDA Journal, 3657 Okemos Road, Suite 200, Okemos, MI 48864-3927 or email Managing Editor Dave Foe at dfoe@michigandental.org. The Journal reserves the right to reduce, revise, or reject letters submitted for publication.

Two Student Leadership Awards Given by Michigan ACD

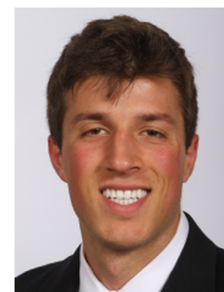
Two students, one at the University of Detroit Mercy School of Dentistry and the other at the University of Michigan School of Dentistry, received American College of Dentists 2020 Student Leadership Awards for the Michigan Section Oct. 5.

The recipients are Simon Shamoon (Detroit Mercy Dental) and Alex Bageris (University of Michigan).

At Detroit Mercy, Shamoon has served as class representative and president. He has been involved in DOCS (Dental Outreach and Community Services), where he volunteers every Saturday to provide free dental care for the underserved of Detroit. He also serves in a leadership role in DOCS as social media chair and treasurer. Shamoon is part of the Chaldean American Association of Health Professionals, which hosts health fairs at local churches providing dental screenings, dental education, and resource referral. He is an active member of Alpha Omega and has participated in a dental mission trip to the Dominican Republic.

Shamoon

Bageris is financial director for Bridge of Disciplines, a non-profit with the goal of diversifying the learning process and helping Michigan ACD members to develop an experience through self-driven, entrepreneurial initiatives involving interdisciplinary collaborations. As a part of BD, he created a project that allows students to shadow forensic dentistry when cases arise. He is spearheading an effort to have students to begin providing care at Gary Burnstein Community Health Clinic in Pontiac on Saturday mornings, and also is actively involved in his class student council as treasurer and as ASDA liason, treasurer, and vice president.



Bageris

The Top 3 Financial Moves for Year-End

With many retirement accounts taking hard hits due to COVID-19, it's vital to make sound investment moves to turn your accounts in the right direction. The MDA endorses DBS Investment Advisers, LLC, to provide wealth management and retirement planning services for MDA members because it specializes in working with dentists. DBSIA has provided the following top three financial moves you should make before the end of 2020:

1. Fully fund your retirement plan. Retirement plans have annual maximums for deferrals. Deferrals are the contributions made from your paycheck into an employer's plan.

• The 2020 deferral limit for SIMPLE IRAs is $13,500 if under age 50, and $16,500 if over age 50.

• The 2020 deferral limit for 401(k)s is $19,500 if under age 50, and $26,000 if over age 50.

Consult your Sept. 30, 2020, SIMPLE IRA or 401(k) account statements to calculate how much you have contributed to your plan this year. If you're on track to hit the maximum, you're in good shape! If not, consider increasing your contribution amount to come as close as you can to hitting the maximum for the year. This will result in maximum tax efficiency.

2. Rebalance your portfolio. Most investors will have a target asset allocation — the percentage of their portfolio invested in a given type of investment. Movements in capital markets often shift the percentage of the portfolio that is invested in each area. Think of it this way: The type of investment that is performing the best will increase in value and become a larger percentage of the overall portfolio. When this happens, it is important that an investor considers rebalancing the portfolio; selling some of the overperforming investments at a profit and using the proceeds to buy some of the underperforming investments. Investors should rebalance at *least* annually.

3. Consider adding a cash balance or profit sharing plan. Adding a cash balance or profit sharing plan allows for higher levels of tax-deductible funding for key employees than a 401(k) alone. In addition, you have up until the corporate tax return is due to establish and retroactively fund a cash balance or profit sharing plan for the 2020 tax year.

To maximize your portfolio, contact Ted Schumann II of DBSIA at ted.schumann@dbsia.net or 800-327-2377 to learn more.

Concerned About Keeping Current with an Ever-changing Regulatory Landscape?

MDA-endorsed Eagle Associates continually reviews all HIPAA, OSHA, and OIG rules, interpretations, guidelines, and enforcement strategies, and publishes updates to its policy manuals. Subscribe today and let Eagle Associates shoulder the burden of monitoring regulatory changes, freeing you up to focus on patient care. For more information on compliance service offerings, call 800-777-2337 or email info@eagleassociates.net.

Minimize Patient Physical Contact in Payment Process

As dental offices adjust to COVID-19 realities, one relatively easy area to minimize physical contact with patients is in the payment process. Did you know that most credit card terminals that accept EMV chip cards also probably accept contactless payments? Contactless cards and cards saved via smartphone digital wallets (i.e., ApplePay®) are options most practices don't even know that they can accept; look for a contactless symbol on your equipment. Contactless card payments start like normal transactions but will allow patients to hover their card or smartphone near the card reader rather than physically touching the device. Money will change hands without actually touching hands!

Another touchless payment solution is accepting payments securely through your website, which can be easy and inexpensive. Endorsed by the MDA for credit card processing, Best Card's online system gives every office a secure way to accept payments without any buildout cost or secure website hosting fees. Best of all, using those secure payment pages can also extend to emailed invoices. Those same systems also will allow for recurring payments if you offer patients payment plans.

Best Card saves the average practice $3,256 per year (24%) on processing fees. For a detailed no-obligation analysis, fax or email a recent credit card processing statement to 866-717-7247 or Compare@BestCardTeam.com.

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Open enrollment windows for getting health insurance

Individual Health Insurance*	**Ends Dec. 15**
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Small group plans: Start NEW group	**Start any time!**
Small group plans: Changes	**During the month of enrollment anniversary**
Medicare/Supplement/Advantage/Medigap: Changes*	**Ends Dec. 7**

**For effective date of Jan. 1.*

6 Reasons Why In-Office Plans Help You Treat More Patients

Wish you could treat more patients without increasing your reliance on insurance? In-Office Plans (IOPs) from MDA-endorsed Quality Dental Plan are the answer. IOPs have been implemented by thousands of practices across the country and they can help you, too. Here's how:

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4. Patients with IOPs are excited to tell others, netting more referrals.
5. Eliminate insurance paperwork.
6. Predictable revenue stream.

Ready to get started? Call 855-796-9765, or visit QDPdentist.com/mda to access exclusive MDA-member savings!

At a Glance

Ideas to Make a Practice More Virtual. Virtual tools can help practices increase efficiency while improving care. Here are ideas to make your practice more virtual:

- Update the practice website to give patients an overview of safety procedures and let them know when appointments are available.
- Use virtual forms to maximize time with patients, keep staff safer, and recover as much in-chair time as possible.
- Take advantage of virtual consult technology to provide patient care and assist in triaging urgent cases.

Learn more by visiting ProSites at prosites.com/michigandental/ to learn how virtual tools built into a website can help. The MDA endorses ProSites, and discounts are available for MDA members.

Dailey Solutions Solves Toner Cartridge Needs for 30%–40% Less

Saving money on products that you use every day, like printer toner or ink jet cartridges, can make a significant impact on your bottom line. That's why the MDA endorses Dailey Solutions to help you save on white-labeled toner and ink jet cartridges that are made to the original equipment manufacturers' specifications. Get free shipping for purchases over $50. Create an account at dsofficeusa.com, then email ordersdaileysolutionsusa.com to let them know you're an MDA member.

We Get Letters

By Christopher J. Smiley DDS
Editor-in-Chief

As editor, I often wonder if anyone notices what we've published in the *Journal* — therefore, it's reaffirming when we receive letters from our readers! This month, we share a letter that took issue with an October article that discussed the Michigan Department of Health and Human Services Hypertension Screening Guidance for Michigan Oral Health Professionals. Both the letter and the authors' response stand on their merits. However, I weigh in because the letter "strongly recommended that the *Journal* retract the MDHHS paper." The letter-writers also suggested using as guidance a recent article they published in *JADA* entitled "Canceling Dental Procedures Due to Elevated Blood Pressure: Is It Appropriate?"

For the *Journal* to retract content, substantial concerns for patient safety must be shown, or potential adverse outcomes that would result from following the article's recommendations must be identified. Consideration must also be given to the resultant impact of a retraction. Might readers become confused or lose motivation for implementing other appropriate recommendations called for in the article? If so, retraction could cause more harm than good.

The letter notes a lack of prospective studies on when to cancel dental procedures due to elevated blood pressure. Their *JADA* article points to a need to better assess a patient's risk factors before postponing dental care and referring the patient for medical evaluation. They recommend dentists use anesthesiology guidelines to prevent "unnecessary cancellations." The article extrapolates from these guidelines that "a patient arriving with high blood pressure on the day of a low-risk procedure, such as tooth extraction, can proceed, provided that he or she lacks symptoms such as a headache, chest pain, or vision changes."

The MDHHS authors stand behind their recommendations, which they note are consistent with current ADA guidelines but have a more lenient threshold for postponing care. I find it significant that both the ADA and the MDHHS expert panel recommend a threshold for canceling dental procedures due to elevated blood pressure. Both the ADA and MDHHS guidance are specific to the profession of dentistry. By contrast, the authors of the letter recommend using current anesthesiology guidelines, but it is not clear if these are relevant to guide oral health care. Anesthesiology is provided in an environment better suited for managing a hypertensive crisis during care. Assuming their guidance takes this into account, is it appropriate to apply those recommendations to the dental setting?

The *JADA* authors have contributed significantly to the body of knowledge on managing hypertension in the dental setting, particularly to incorporate functional status and risk in clinical decision-making. They pose valid concerns for the unnecessary postponement of dental treatment, yet the harm they identify is "added financial and social costs." The authors of each article agree there is a lack of evidence to indicate if or when to cancel dental procedures due to hypertension. This must not be viewed as support for either position; it is merely acknowledging there is a lack of evidence, so each paper relies on expert opinion. On one side, we are concerned that overly cautious providers are unnecessarily canceling dental care due to high blood pressure readings. On the other, practitioners are concerned with patient safety and seek medical consultation when a patient's blood pressure exceeds a threshold. Patient safety vs. unnecessarily increased costs of care? If that is the argument, then the balance of the scale tips towards assuring patient safety until evidence shows such a concern is unwarranted. It's a fair debate, but it doesn't rise to a level to retract an article.

Oral health providers want clear and unambiguous guidance to know they are in compliance and feel confident they are *doing no harm*. MDHHS guidance addresses this need. Such an approach may result in the letter's concerns, but it will also help identify patients with hypertension.

There can be no confusion about the value of dental office blood pressure screenings. Enlisting the dental community to detect undiagnosed and uncontrolled hypertension will support our patients' needs and build awareness for the medical treatment of hypertension. Most importantly, it will improve health outcomes for the citizens of Michigan. ●

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Jamie Klap, Dental Auxiliary Program Director
jamieklap1@grcc.edu | (616) 234-4240

Where Can I Find Guidance for Treating Pregnant Women?

Compiled by MDA staff with Basam Shamo, DDS
Chair, MDA Committee on Membership

Question: Where can I find the most current guidance on the safety of treating pregnant women in the third trimester?

Answer: Evidence-based guidance allows for treatment throughout pregnancy. You may wish to refer to your August 2020 MDA *Journal* and the "10-Minute EBD" column titled "Is Dental Treatment Safe for Pregnant Women," written by Dr. Melanie Mayberry. Also, the state of Michigan released the most current guidance for oral health care professionals and data from Michigan in 2015. You can find this guidance on the MDA website. Click "Practice Management," then "Practice Guidelines and Procedures" and "Perinatal Oral Health Guidance."

Question: My staff member's child was exposed to COVID-19 but does not have any symptoms. Is there a resource I can consult to find out what to do?

Answer: Your September MDA *Journal* contained information on this topic in the article "Coronavirus in the Workplace: Frequently Asked Questions and Answers," by Jodi Schafer. The issue also included the appropriate ADA protocols to follow. MIOSHA has also developed protocols detailing what to do in this and other situations, and the MDA included links to all these protocols in a recent *Journal eNews*. Be sure to read your MDA communications — they're meant to keep you informed! The ADA Flow Chart and MIOSHA Protocols can both be found on the COVID-19 section of the MDA website. In the case of exposures, you should also contact your local health department for guidance. Local rules may be in effect, and local health departments can assist with contact tracing.

Question: I received my 2021 membership renewal statement but something seems different than last year, and I can't seem to find my last year's renewal. Who is the best staff person to contact to verify if I am receiving the same discount I did last year?

Answer: If you aren't sure your membership renewal statement is correct, if something has changed in your circumstances last year that may update your membership status, or you simply want to verify if there is a better rate for your renewal, the MDA is here to help! Contact the MDA membership department at 800-589-2632 to speak about your statement, discounts, or any other concerns you may have.

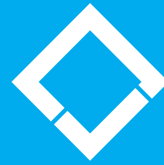
Question: I'm preparing for my future dental career, and my plans include the purchase of a dental practice. To better analyze the practice's finances I was hoping to find national and state averages for overhead percentage, collection percentage when compared to production percentage, dental supplies percentage of overhead, staff percentage of overhead, and so forth. Would you be able to direct me to someone who could send me this data?

Answer: The MDA has a wealth of practice start-up resources, including a biennial fee survey, biennial dental staff compensation and benefit surveys, an online *Establishing Your Professional Career* guide, and more. Also, the ADA offers a variety of online and in-print resources such as its Guidelines for Practice Success module and the ADA Health Policy Institute data center. Plus, your future local dental society can be a great, confidential resource for details and suggestions on settling into the area. Your tripartite membership helps on all levels for you. For more detailed assistance, email the MDA member concierge at membership@michigandental.org.

Question: We have an employee who I believe may be stealing from the practice. Before I confront her, I wonder if there are any resources from the MDA that could help me with this conversation?

Answer: Yes. As an MDA member you receive unlimited consultation with MDA HR Director Brandy Ryan. Contact her at 517-346-9416 for help. ●

Have a question? Think MDA first! Contact the MDA staff using the directory on Page 5 of this issue, or email membership@michigandental.org.



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Are the Revised DOL Regulations Retroactive?

By Dan Schulte, JD
MDA Legal Counsel

Question: One of my employees who is not directly involved in patient care (she does billing, and other office work for my practice) is very upset with me. She claims that she had a situation months ago that would have qualified her for paid leave, and now that the definition of "health care provider" has changed under the Families First Coronavirus Response Act ("FFCRA") she says I owe her back pay. Is this true? She also claims that I should have brought this to her attention and to others who now are eligible for this paid leave. Did I have to amend the notice I have in my office when the definition of "health care provider" changed?

Answer: Due to the Department of Labor revising regulations previously issued in connection with the FFCRA, employers of health care providers are now required to provide paid sick leave and family leave to a broader category of employees. No longer can a dental practice, for example, take the position that none of its employees are entitled to paid leave pursuant to FFCRA. These regulations were revised in response to a ruling by a federal court invalidating parts of the regulations. The revised regulations went into effect on Sept. 16, 2020.

The revision that you are focusing on is the new definition of "health care provider" used for determining which employees may be excluded from the FFCRA's requirement to provide paid leave. The revised regulations narrow this definition to include only those employees who are defined as health care providers under the Family Medical Leave Act, or FMLA. This generally includes health care providers who are licensed, registered, certified, etc., by a governmental authority, and those without a license, registration, or certification who actually provide diagnostic services, preventive services, treatment services, or other services that are integrated with and necessary to the provision of patient care as part of their job duties. Billers, receptionists, and other employees who do not perform these services are not covered by the exception and must be provided with paid leave pursuant to the FFCRA.

It appears that this employee of yours (whose job duties involve only billing and other office work) is now entitled to paid leave pursuant to the FFCRA. This is due to a currently existing qualifying reason (i.e., generally, becoming exposed/infected, caring for a family member who is infected, the unavailability of day care, etc.). However, if this employee had a qualifying reason at some point in the past that no longer exists, the revised regulations do not obligate you to provide back pay or any other compensation. As mentioned above, the revised regulations became effective Sept. 16, 2020, and do not include a provision that they are to be applied retroactively.

The revised regulations also lack a provision requiring that any originally required FFCRA notice to employees be modified or that employees who are now eligible for paid FFCRA leave be directly notified by you that benefits are available. Whether and to what extent you make this known to your affected employees is something to be determined on a case-by-case basis.

Send questions for publication via email to Journal Managing Editor Dave Foe at dfoe@michigandental.org.

Dan Schulte's Most-Asked Legal Questions and Dentist's Guide to Michigan Law are both available at the MDA Web Store as free downloads. Or, you can order a hard copy of each at just $19. Visit store.michigandental.org for these and other practice resources.

Dental ROI Associates PC – Greig Davis Dental CPA

Presents

Moving the Needle

Benchmarking

Dental Practice Key Performance Indicators

- What are the Key Performance Indicators (KPI) you should be using
- What are the root causes of your KPI outcomes
- How to impact your KPI's
- How do you build your unique KPI's
- How KPI's impact the budgeting process
- KPI's and valuations, how they are related
- Why good numbers can be bad and bad numbers can be good
- How accounting methods impact your KPI's
- Why accrual accounting is important
- How to build quality financial reporting

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Holiday Celebrations in the Year of COVID-19

By Jodi Schafer, SPHR, SHRM-SCP

Question: With the holiday season here, I'm at a loss for how to celebrate the holidays with my staff in a socially distant, safe manner. Typically, I invite the team over to my house for dinner, drinks, and some holiday cheer. It's something we all look forward to, and yet I don't think it is a good idea to host a gathering like this given the current situation with COVID-19. Do you have any suggestions for how I could modify our work party plans to maintain the fun without jeopardizing our health? Any tips for keeping employees safe during personal holiday gatherings as well?

Answer: I think we can all agree that 2020 has left a lot to be desired. If there was ever a year that we needed a party to take our mind off things, this would be the year! However, you are right to be concerned about COVID-19 implications, especially if you are used to having people over to your house for the holidays.

Enclosed spaces, limited distancing, eating and drinking without a mask on — the hazards begin to add up. So, it's time to get creative. Start by listing out the aspects of your celebration that you don't want to lose. If it is important to ensure that your team feels appreciated, then perhaps you could forgo the gift exchange and instead write them each a personalized thank-you note and give them an unexpected day (or partial day) off work to do something fun. Send them for a massage or a skin or nail treatment. If you love to buy presents, you can still do a Secret Santa in the office, or you could create a new twist where each of the gifts have to be homemade.

If the holidays are a chance for your staff to satisfy

Risk Factors to Consider When Planning a Gathering

Community levels of COVID-19 — Higher levels of COVID-19 cases and community spread in the gathering location, as well as where attendees are coming from, increase the risk of infection and spread among attendees.

The location of the gathering — Indoor gatherings generally pose more risk than outdoor gatherings.

The duration of the gathering — Gatherings that last longer pose more risk than shorter gatherings.

The number of people at the gathering — Gatherings with more people pose more risk than gatherings with fewer people.

The locations attendees are traveling from — Gatherings with attendees who are traveling from different places pose a higher risk than gatherings with attendees who live in the same area.

The behaviors of attendees prior to the gathering — Gatherings with attendees who are not adhering to social distancing (staying at least 6 feet apart), mask wearing, hand washing, and other prevention behaviors pose more risk than gatherings with attendees who are engaging in these preventive behaviors.

Source: Centers for Disease Control and Prevention

their sweet tooth, consider swapping out the break room smorgasbord for a recipe exchange, where every team member bakes their favorite dessert and then brings individually packaged samples for each employee to take home, with the recipe card attached. To make it more personal, team members can include a memory they have related to the item they chose to bake. If camaraderie is the goal, consider group activities that can accommodate social distancing. Perhaps you could rent out a space big enough for your team to safely gather and do your own showing of a movie favorite. If your team likes the great outdoors, perhaps you could host a bonfire with a hot chocolate bar, or go sledding as a group (assuming there is snow and your staff is adventurous)!

If this season is a chance for your office to give back, you can still do so despite the pandemic. Organize a collection for families in need or have lunch catered in for your office while you all write holiday cards for soldiers serving overseas.

As evidenced by the ideas shared above, it's much easier to plan safe celebrations for your work family than it is to ensure that your staff safely celebrate with their own families. While you can encourage your team to be cognizant of the gatherings they attend this time of year, it is practically impossible to exercise any real authority over their personal choices. Some practices do have post-travel quarantine policies in place that could impact staff who are traveling over the holidays, but aside from that, practices are limited in what they can mandate.

The best advice I can offer is to share the updated guidance from the CDC. Encourage your staff to consider the CDC risk factors in the box on the facing page prior to making their holiday plans.

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The MDA Service Promise: Helping You Succeed

The MDA works hard to provide the very highest level of service to members. The MDA stands ready to help you access member benefits such as insurance products, endorsed services, continuing education, dental supplies, and more. Plus, the MDA is your resource to answer questions about human resources, licensure, dental benefits, HIPAA/OSHA, legal questions – everything about dentistry in Michigan.

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Answering Your Needs: What You Told MDA Services

By Cindy Hoogasian
Director, MDA Services and Marketing

In early 2020, MDA Services surveyed members about the types of programs and services they would like the MDA to endorse. We've used that guide to help us develop programs that will help you succeed in your practice, and lay the groundwork for new endorsements in 2021.

New! In-Office Dental Plans: During 2020, we've added four endorsed programs to our offerings — a remarkable expansion to our catalog of services! One service our members have been asking for help with is establishing an in-office dental plan, one that patients who lack insurance, or who are underinsured, can access. We know that using the do-it-yourself method of starting an IOP can be difficult. So, after a thorough review of companies filling that need, the MDA selected *Quality Dental Plan* for endorsement. QDP offers members all the services of much higher priced in-office plan platforms, but at the best price in the industry of only 75 cents per person enrolled, per month. This is a great program for MDA members who want to develop patient loyalty and reclaim some autonomy from Preferred Provider Organization plans. Contact Luis De Hoyos at 855-796-9765 for a demo or to learn more. Also, watch for our short-form IOP webinars on demand. They're coming to you via email.

E-prescriptions: In an effort to stay ahead of legislatively mandated changes relating to how providers prescribe drugs, MDA Services researched independent providers of electronic prescription drug transmittal services. Many practice management systems have this capability built in, but the cost can be quite high. Other low-cost service providers lose their competitive edge with many add-on expenses. MDA-endorsed *iCoreRx* offers the best balance of product features and cost. iCoreRx works with most practice management systems, eliminates the need for a Lexicomp subscription as it provides this service in the module, connects with the MAPS system and documents that it was checked, and securely transmits all prescription drugs to more than 60,000 pharmacies. The cost is reasonable too, at $45 per doctor per month, with a $9 additional fee to permit prescribing controlled substances. By October 2021 all prescriptions must be transmitted electronically. Get ahead of this requirement now by calling 888-810-7706.

Discounts on toner, ink: Members asked us to find a way to save money on expensive printer/copier toner and inkjet cartridges. We allied with *Dailey Solutions USA*, a private-label manufacturer of these types of cartridges, to deliver savings of up to 40% for MDA members. All products are made to original manufacturer specifications and are guaranteed not to damage your printers. Incidentally, Dailey Solutions provided MDA members with the PPE that Blue Cross Blue Shield of Michigan gifted to all dentists in the state. You can thank Dailey Solutions by creating an account at dsofficeusa.com and purchasing your toner and ink jet cartridges from the site.

State-of-the-art websites: Finally, in recognition of the importance for practices to have a state-of-the-art website, we unveiled the endorsement of *ProSites* to meet your internet presence and marketing needs. ProSites offers a complete package of services, from website development and hosting, to search engine optimization, pay-per-click advertising, patient communication solutions, and much more. As an MDA member you'll receive very advantageous pricing when using ProSites and its menu of services. Contact Shane Bennett at 951-395-8335 or email shane.bennett@prosites.com.

Looking ahead: Atop your collective wish lists is a firm to assist in PPO network fee negotiations. This is a service we are attempting to provide, but we've had challenges finding the right fit. We will continue seeking a strong alliance to assist our members with this difficult process. Stay tuned!

We've also heard your call for help managing your information technology challenges, along with help with that essential lifeline to your patients — office telephone systems. Two other areas that members want help with is finding independent equipment repair services and independent upholstery services. MDA Services will seek the solutions you've requested. If you have a suggestion for other endorsed programs, reach out to me at choogasian@mdaifg.com. ●

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Our advisors understand the unique financial needs of dentists. Ted Schumann, II has worked almost exclusively with dental clients for the past 10 years! In addition, Dr. Jeff Brink merged his advisory firm, Anterior Guidance, with DBS earlier this year. As a practicing dentist, Dr. Brink has a thorough understanding of the ins and outs of balancing personal finances and practice ownership.

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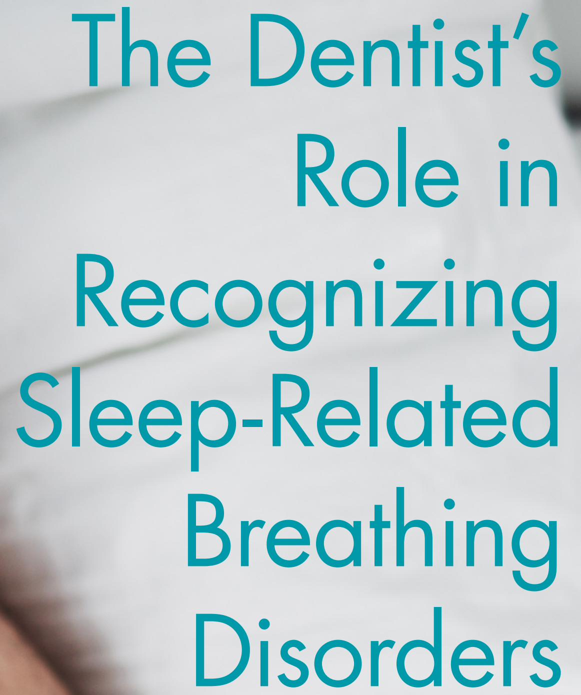

The Dentist's Role in Recognizing Sleep-Related Breathing Disorders

A Two-Part Series

This month and next, the *Journal* will present a two-part discussion on sleep-related breathing disorders and airway development. Dental sleep medicine provides an opportunity for communication and partnering with medical providers and supports dentistry's integration with overall health care. It provides another example of the essential nature of oral health care in detecting and treating a patient's medical condition and the dental clinician's role in addressing overall patient health.

ADA policy on the role of dentistry in the

treatment of sleep-related breathing disorders includes guidelines for the screening, referral, and treatment of adults and children with possible SRBDs.[1] This series will present information for readers to comply with this policy and consider integrating these services into their practice.

As the body of evidence evolves, restorative dentistry and orthodontics are taking on new purposes to consider the upper airway in diagnosis and treatment planning. A medical diagnosis is necessary, but dentists participate in the care of individuals with SRBDs and may be the initial provider to screen for these conditions. Obstructive sleep apnea is a recognized medical disorder, and Medicare and many health plans provide benefit for the treatment of mild to moderate OSA with oral appliances provided by a dentist. Dental appliances are chosen by individuals who cannot or choose not to use continuous positive airway pressure. Dentists are making a real difference with children and adults to avoid the development of SRBDs or reduce the likelihood of mild problems becoming more severe.

At a minimum, the dentist not wanting to treat SRBDs should acquire the necessary skills to identify these conditions' signs and refer those patients to a medical provider for a diagnosis. He or she then can work with colleagues in the community trained to provide dental and medical treatment options.

In this series, we offer four articles that were first presented in the *Journal of the California Dental Association* in its April 2020 issue. This month, we feature three articles: "What Every Dentist Should Know About Sleep-Related Breathing Disorders," "Incorporating Dental Sleep Medicine into your Practice: S.E.T.U.P. for Success in Sleep," and "Informed Consent for Dental Sleep Medicine." These were written by esteemed colleagues directly involved in the screening, evaluation, and treatment of SRBDs. We thank the CDA's editor, Dr. Kerry Carney, for her kind permission to reprint these excellent articles in the MDA *Journal*.

In January, we will present an additional California article, "Bruxism, Obstructive Sleep Apnea and Dentistry." Then, in keeping with our desire to offer original content, we will feature articles addressing "The Dentist's Role in Recognizing Sleep-Related Breathing Disorders in Children," and "Seeking Appropriate Training in Sleep Medicine for Clinical Dental Practice."

We intend to provide our readers with an overview of the role dentists have in the screening, evaluation, referral, or treatment of patients with or with potential SRBDs. We have not provided a step-by-step guide to provide oral appliance therapy. However, readers should be able to start screening patients for potential SRBDs immediately. Those including these services in their practice are encouraged to review the ADA policy statement with their team and discuss how they will take the next steps toward acquiring additional knowledge and skill in this area.

Dentistry's role in diagnosing, treating, and preventing SRBDs will become more significant and widespread in years to come. The opportunity to collaborate with our medical colleagues can positively impact our patients' overall health outcomes. This integration of dentistry with medical care will further position dentistry as essential health care. The reward will be healthier and more satisfied patients.

—Christopher J. Smiley, DDS
Editor-in-Chief

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What Every Dentist Should Know About Sleep-Related Breathing Disorders

By Steve Carstensen, DDS

Reprinted from the *Journal of the California Dental Association*

Abstract

Dentists have the opportunity to attend to more of their patients' health than what is found in the oral cavity. The American Dental Association has prompted members to embrace a larger scope of practice, obligating every dentist to become aware of sleep-related breathing disorders and seek additional training for all team members. Collaboration with other medical providers will become a part of everyday dental practice and airway health will become a component of every treatment plan.

No one can survive without breathing. Everyone can survive while breathing badly — but there's a price to pay for compromising respiration. When the body is denied essential nutrients, such as oxygen, normal physiologic responses like inflammation are enhanced and there are always consequences. The dentist is the best medical provider to identify those problems early in life and to help people redirect their choices toward health. Indeed, of all the medical providers in most people's lives, they spend more time with the dental hygienist than any other. Including awareness of sleep-related breathing disorders in everyday dental practice is straightforward, rewarding, and mandatory. This essay helps the dental team understand the details about what they should be doing today to make the biggest difference for their practice's and community's health.

In 2017, the American Dental Association adopted the Policy Statement on the Role of Dentistry in the Treatment of Sleep-Related Breathing Disorders.[1] That document encourages dentists to screen for SRBDs and outlines appropriate actions for them to take when they participate in the treatment and management of airway problems. The first step in understanding the dentist's role, then, is to obtain and study this landmark document, available at ada.org.

Early in the establishment of sleep medicine as a subspecialty of medical practice, positive air pressure machines came to dominate physicians' treatment choices.[2] This was supported by the rapid development of sophisticated PAP machines, improved masks, and widespread enthusiasm among physicians for having an alternative to surgery. As early as 1982, papers were published about dentists fitting patients with oral appliances to support the airway against collapse.[3] This was only a year after Colin Sullivan, PhD, BSc, MB, published his first paper on the development of continuous positive airway pressure.[4] Dentists have been collaborating with sleep physicians for nearly four decades to treat SRBDs, including obstructive sleep apnea syndrome, but oral appliances have never had the research and corporate support that PAP therapy has had. The American Academy of Sleep Medicine produces policy statements for the specialty; in 2015, the AASM and the American Academy of Dental Sleep Medicine jointly published a guideline that lists oral appliances alongside PAP devices as key therapy choices for all levels of OSAS diagnosis.[5]

Every licensed dentist is legally supported in placing oral appliances for treating SRBDs, although the lack of training in most dental education programs requires dentists to acquire additional education to include oral appliance therapy within their scope of practice. Training choices vary from lectures at dental meetings to online training to multiple-session events hosted by dental colleges. Like other areas of practice, dentists are free to decide for themselves whether they are sufficiently trained. The trade organization AADSM has a "qualified dentist" category that is earned with certain C.E. programs, but that and other self-designated accreditations have not been adopted into any regulation of dentistry. There are professional peer-reviewed journals, textbooks, blogs, and trade magazines for expanding the dentist's scope.

During the course of ordinary dental practice, patients present with a variety of clinical conditions for the dentist to assess and to apply medical decision-making skills, diagnose, and create a treatment plan to address. Professional training focuses dentists and dental hygienists on typical dental diseases such as caries, periodontal disease, occlusion, and temporomandibular disorders. While other pathologies, such as oral can-

cer, are also part of the curriculum, the typical dental practice is occupied with surgical and preventive procedures. This pattern is supported by a coding system for recordkeeping and insurance benefits that is procedure-based without the explicit requirement to document the diagnosis or medical decision-making procedures routinely found in medical encounter notes.

There are many dental conditions commonly seen that have connections to airway-related problems. One example is periodontal disease; a study published in 2016 noted that OSA correlates with increasing periodontal disease severity.[6]

The prevalence of SRBDs in the population is difficult to declare with certainty. A study in Lausanne, Switzerland, reported that 49% of men and 23% of women had moderate to severe sleep-disordered breathing.[7] The most commonly cited percentage of the at-risk population that has been diagnosed for SRBDs is 15%, and that number has not changed in the 20-plus years this author has been involved in treating airway problems. It is safe to say that every dental practice has many patients at risk for SRBDs and that the vast majority of those patients have not been tested for the disease. Of those tested, most diagnosed patients are prescribed PAP devices. Data compiled for World Sleep Day 2019 by Philips Respironics, one of the major PAP providers, shows that 65% of people with sleep apnea have never used or are no longer using therapy to treat their disease.[8] One study of VA patients showed 90-day adherence of 2.5 hours per night.[9] Considering these statistics, it is reasonable to say that dentists are treating many adults with underdiagnosed and undertreated sleep-related breathing disorders.

Dental practices emphasize regular preventive visits for their patients, and each encounter provides an opportunity to update the patient's medical history and inquire about new symptoms. The airway-aware dental team can use these visits to create meaningful conversations about SRBDs. Simple screening tools such as the Epworth Sleepiness Scale and the STOP-BANG are each comprised of eight questions that produce a score to determine risk of medically defined obstructive sleep apnea. Even simpler is the Elbow Test — if a person has been told they snore and have been prompted to change sleep position to stop snoring and/or resume breathing, there is a 90% positive predictive value for SRBDs.[10] These questionnaires are readily obtainable via any search engine. Screening tools are effectively incorporated into the dental encounter only when every member of the clinic team understands them and why they are included in the office visit. Patients will wonder why the dental office is inquiring about sleep habits and observed breathing patterns until the connection between oral and whole-body health is presented by the trained dental team member.

Technology is a tempting tool to use as a screening device. One instrument commonly found is cone beam computed tomography. These devices create accurate images of 3D structures and allow the radiologist or trained dentist the ability to assess the airway. Because the vast majority of the scans are obtained while the subject is upright and awake, however, there has been no consensus about the use of CBCT data for identifying patients at risk for SRBDs. One

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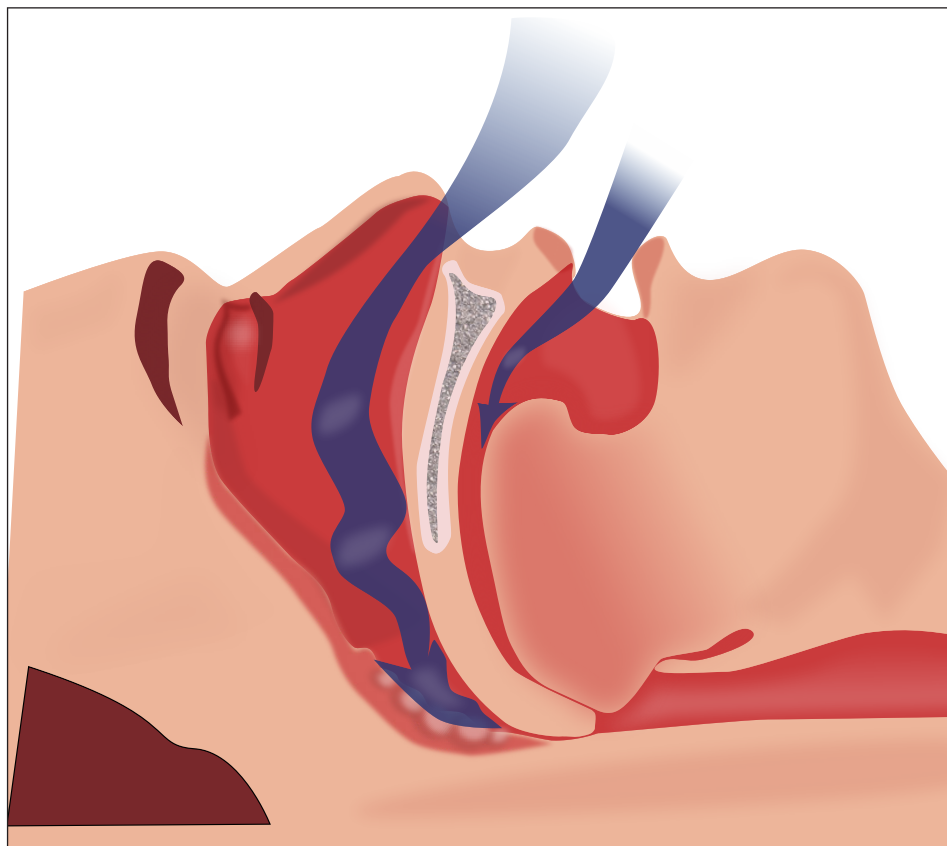

Obstructive sleep apnea — Obstructive sleep apnea occurs when the tongue and soft palate temporarily relax, the airway is narrowed or closed, and breathing is momentarily cut off. Currently, there are 29.4 million adults in the US with obstructive sleep apnea (OSA); 23.5 million of those are undiagnosed.[19]

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meta-analysis concludes that people diagnosed with OSA have a smaller minimum cross-sectional airway than that found on unaffected controls, but it does not provide a clinically useful scale to compare with the patient in the chair.[11]

Consumer-level devices and smartphone apps are also widely used to gauge various parameters of sleep, with claims by the commercial entities ranging from measuring snoring to assessment of sleep quality. These devices, while very useful for patient communication, are not validated against scientifically established testing cleared by the FDA for use in medicine. These apps and devices can be an excellent way to alert undiagnosed people to seek expert advice and for patients to gain some confidence in prescribed therapy as they watch scores improve.

Screening is used in medicine to identify who should be recommended to the next test. If a person completes an Epworth Sleepiness Scale, for example, and it results in a score of 12 (out of a possible 24), this indicates someone who has excessive daytime sleepiness. This is not specific for SRBDs, but it does mean that the person should be tested further to understand the reason behind the sleepiness. Very often this is an SRBD, so that sleepy patient should be sent for evaluation by a sleep specialist.

Dentists are not currently licensed to treat patients for SRBDs if those patients have not been diagnosed by a medical doctor. After diagnosis, they can fully manage therapy for a large segment of patients who have mild OSA without serious medical comorbidities such as cardiovascular disease. By collaborating with medical colleagues, the airway-aware dentist can be a critical part of the treatment of this large number of at-risk adults.

SRBDs in children are different in nearly every way from adults. Children (for the purposes of this essay, defined as preadolescent and before growth of the maxilla and mandible is complete) are assessed for SRBDs by observation of behavior common to a compromised airway, primarily mouth breathing and poor sleep quality. In common use are the Pediatric Sleep Questionnaire and the BEARS questionnaire; these and others are imperfect but can serve well to begin the conversation with families.[12] Those children found at risk are still recommended to be seen

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by a pediatric sleep specialist for testing in a child-friendly sleep lab.[13] There are, unfortunately, very few of these facilities or trained sleep doctors available compared to the number of children at risk, so, again, it falls to the dentist to identify those patients in their everyday dental practice.

Dentists are trained to assess and manage growth and development of the jaws to achieve dental goals like a fine occlusion and pleasing arrangement of teeth. If the scope is limited to those laudable benchmarks, a major potential health contribution is left out: establishment of maximum health for the airway associated with those growing structures. After all, the American Dental Association House of Delegates adopted a definition of dentistry in 1997 that says, in part, that "dentistry is the evaluation, diagnosis and treatment of the oral cavity, maxillofacial area and adjacent and associated structures and their impact on the human body." That means that dentists must assess the nasal cavity, airway, and oropharynx to determine if there are compromises that affect the health of the rest of the body. A child with poor breathing, whether through bad daytime habits such as mouth breathing or nighttime restrictions in respiration from SRBDs, will not be providing the rest of their body the ability to grow and develop to maximum potential.

The maxilla is the common structure defining the oral and nasal cavities and the position of the palate relative to the posterior wall of the oropharynx. As such, the three-dimensional position of the maxilla is key to whether the airway is optimized during growth. Patients with a hypoplastic maxilla or one that has been misshapen by muscle forces and air pressure compromises will suffer from an underdeveloped airway.[14] Dentists, to be able to assess their child patients for a properly developing craniofacial-respiratory complex, must learn to evaluate the three-dimensional position of the maxilla during each exam while the child is growing. If the child shows signs of airway-related problems, intervention during this period can often establish a more open airway while simultaneously encouraging alveolar growth, creating room for all the permanent teeth.

It's not just structure that draws the attention of the airway-aware dentist, however, because early problems such as tongue- and/or lip-tie, allergies, and simple bad habits can result in the mouth being the primary respiratory portal. Christian Guilleminault, MD, DSc, who defined the term "obstructive sleep apnea" and is among the world's leading clinicians and researchers, declared that "nasal breathing, 24/7, is the only possible finish line for children's airway."[15]

Dentists and their team members are ideally positioned to recognize and offer help to families to get their children on the right path for daytime as well as nighttime breathing. By encouraging healthy habits of keeping their lips together, breathing through the nose, and posturing the tongue in the roof of the mouth during a properly coordinated swallow, the trained dental team member can help children grow their craniofacial-respiratory complex to maximum advantage while there is time to shape that maxilla.

SRBDs affect more than blood oxygen levels and mechanical problems in the upper airway. For two examples, let's consider heart rhythm regulation and the balance between the sympathetic and parasympathetic divisions of the autonomic nervous system. Dentists are often surprised to learn that snoring might have effects on the heart and brain; if this essay prompts professional curiosity and the reader seeks deeper understanding, one of the writer's goals is accomplished.

The thorax expands when the diaphragm is activated, creating low pressure in the chest cavity, normally resolved with air flowing through respiratory channels. If the airway is blocked, the pressure gradient pulls more blood into the heart, overfilling the right atrium. The walls of the atrium expand, stretching beyond normal shape. Embedded in the atrial wall is the sinoatrial node, the pacemaker for heart rhythm. People with OSA have conduction abnormalities, longer electrical recovery time of the sinoatrial node, and atrial enlargement compared to people without SRBDs; this disruption to the homeostasis of the heart leads to atrial fibrillation.[16] Cardiomyopathy, atherosclerosis, hypertension, and a host of other heart diseases accompany chronic SRBDs as well.

The limbic system, a complex group of brain structures, can be simplistically considered as the connection between purely autonomic brain stem functions and the highly evolved

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About the Author

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cortical regions. Signals from sensory input are filtered in the thalamus to reduce cortical activity during sleep. The autonomic nervous system cycles between parasympathetic (rest and restore) and sympathetic (fight or flight) predominance based on the body's needs second by second, while maintaining enteric nervous system functions such as respiration.[17] Because the limbic system is the center of the body's regulatory processes, it is highly sensitive to outside input. An often overlooked part of the limbic system is embedded in cranial nerve 1, the olfactory bulb. Mechanoreceptors there send airflow signals to the limbic system to aid homeostatic regulation. Disruption to the normal pattern of pressure change during respiration yields imbalances to the hypothalamic-pituitary-adrenal or HPA axis. The HPA axis regulates cortisol production; when that system is out of sync with the circadian rhythm, all body systems are affected.[18]

Conclusion

Dentists have long had the obligation to consider whole-person health in their practices. General medicine is relatively unconcerned with the necessity to treat readily observable oral disease. Most dentists, therefore, lack the need to regularly interact with other medical professionals to provide this care, resulting in the separation of dentistry from medical practice. The growing awareness of SRBDs as a factor affecting every cell in the human body requires every medical provider to consider SRBDs when assessing and diagnosing each patient. Thus, dentists must learn how airway disruptions possibly explain clinical findings, consider the airway during evaluation and treatment planning, and interact with other medical providers in managing chronic disease. Bridging the divide between dentistry and medicine will result in higher levels of patient care and a reduction in health care burden for entire populations. Little of this expanded connection requires medical providers to learn much about oral homeostasis, but it does demand dental professionals expand their scope to embrace many aspects of primary care. What does the dentist need to know about SRBDs today? That every service provided in a dental office must consider airway health as a necessary part of the care. ●

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Incorporating Dental Sleep Medicine Into Your Practice: S.E.T.U.P. for Success in Sleep

By Marty R. Lipsey, DDS, MS
Reprinted from the *Journal of the California Dental Association*

Abstract

This article provides insight into systems for incorporating or improving a dental sleep medicine program into the dental practice.

Why should I get started? How do I get started? How do I screen my patients? What about sleep testing and diagnosis? What documents do I need in my records? How do I deal with medical insurance?

As a practitioner, lecturer, consultant, and medical billing expert, I will provide insight into these and more commonly asked questions. Clinical procedures and appliances will not be discussed in this article. It is my goal to present easily duplicated, tried-and-true systems that have been developed and fine-tuned for more than 16 years. This is a system that my team and I have successfully implemented in practice and that we have used to help hundreds of dentists implement or improve the dental sleep medicine area of their dental practices.

This is a step-by-step process for successful implementation of a dental sleep medicine program, which I will outline below as a "S.E.T.U.P. for Success in Sleep" protocol. The steps in that protocol are independent of and apply regardless of the dentist's choice of bite registration technique or appliance. These protocols are comprehensive and will benefit the entire dental team. The good news, right from the start, is that the protocols do not require the purchase of any new software or expensive instrumentation to incorporate dental sleep medicine into your practice.

A significant number of patients who walk through our doors every day present with life-threatening and life-shortening risk factors for sleep-related breathing disorders. Furthermore, the entryways to the nasal and oropharyngeal airways are constantly in our field of view during every clinical procedure throughout our day. Dentists can play a major role in the recognition of the signs and symptoms and the overall management of obstructive sleep apnea.[1] Levendowski et al.[2] found that the high prevalence of undiagnosed sleep apnea in dental patients suggests that dentists could provide a valuable service to their patients by incorporating sleep apnea screening and treatment into their practice. In their study of two dental practices, 28% of female patients and 67% of male patients were shown to have a high pretest probability of having at least mild sleep apnea. Al-Jewair et al.[3] found in a total of 200 consecutive female and male dental patients that 21.75% of the females and 78.3% of the males were at high risk of OSA.

In 2017, the ADA's House of Delegates adopted the "Policy Statement for the Role of Dentistry in the Treatment of Sleep-Related Breathing Disorders." This should be deemed as setting the current standard of practice. In that policy, dentists are encouraged to screen patients for sleep-related breathing disorders and refer as needed to the appropriate physicians for proper diagnosis. The policy also clearly states that oral appliance therapy is an appropriate treatment for mild and moderate sleep apnea and for severe sleep apnea when continuous positive airway pressure is not tolerated by the patient.

The steps for "S.E.T.U.P. for Success in Sleep" are *screen, educate, test, understand,* and *present*.

Screen

While screen is the first step in the acronym and also in actual implementation, keep in mind that we are actually educating our patients during screening. Screen and educate are truly combined cornerstones of the process.

For practitioners desiring to act in accordance with the ADA policy statement and to have a successful dental sleep medicine program in their practice, step one is to screen 100% of your patients for sleep-related breathing disorders. There are a number of recognized screening forms that are commonly used in medical practice to screen for OSA. Singh et al[4] found that four screening tools are widely recognized as being easy to administer: STOP, STOP-BANG, Epworth Sleepiness Scale, and four-variable screening tool. The bottom line is that each practice should find an organized way to screen and discuss sleep health

S.E.T.U.P. for Success

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with every patient. A point person or sleep coordinator should be tasked to assure that these forms are reviewed and that conversations take place so at-risk patients clearly understand the life-threatening and life-shortening nature of this disease.

In most dental practices, the flow for new patients is different as compared to the flow for patients of record. Likewise, the flow of these screening processes may differ as well. Including a sleep health screening form with new patient paperwork will help gather information for an initial sleep health conversation with each new patient. For patients of record, each practice should decide whether it is easier and more efficient to have patients complete a sleep health questionnaire at their recare appointment or if the hygienist or sleep coordinator should accomplish this task in a conversation with the patient.

During screening, all patients in the practice will fall into one of the categories shown in Table One. A suggested action for each category is proposed. Beyond any suggested action (and even when no action is necessary for a particular patient), keep in mind that the underlying principle of this program is that we are always striving to increase the sleep health awareness of our patients. As was mentioned previously, screening and education go hand in hand. This is a value-added service for the practice, and the educational and health lessons extend to other family members.

It is important to understand that the sole purpose of screening is to identify patients who are at risk for sleep-related breathing disorders. It is the first step in an overall process. Comparing to our usual dental world, it would be inappropriate to discuss possible root canals and crowns with a patient before a complete dental examination. During that dental examination, we would utilize all appropriate diagnostic tools and imaging. Only after a complete analysis would we then discuss treatment options. Likewise, sleep health screening is not the appropriate time to discuss treatment.

There is usually no medical diagnosis at this step in the process. With that said, this is a very common mistake made by many dental teams. During the screening process, if you are asked, "What might be wrong?" or "What treatment might I need?" the only answer is, "I don't know and that's why we are going through this screening process." The screening process is the first step in an effort to identify patients at risk and increase our patients' sleep health awareness. We then move on to educate about the risks of the disease and the benefits for those at risk to complete a diagnostic sleep study that will be reviewed and interpreted by a board-certified sleep physician. Only then might we be able to talk about what's wrong and what might be needed to fix it.

If we find that a patient has had a prior sleep study, we should obtain a copy before we begin to speculate on what to recommend or not recommend. During the overall screening process, we will also undoubtedly identify patients who were previously told by a physician that they should undergo a diagnostic sleep study and did not. Screening is also where we

Table One: Screening Protocol

Patient category	Suggested education action
Not at risk and never tested	No action for this patient. Explain why the practice has implemented a sleep health awareness program.
At risk and never tested	Review risk factors and educate as to benefits of diagnostic sleep testing
Diagnosed and compliant with CPAP	Encourage patient to continue CPAP usage
Diagnosed and noncompliant with CPAP	Review prior findings with patient in an effort to find a medically recommended treatment option with which the patient can be compliant
Diagnosed and OA compliant	Review history of treatment and continued care
Diagnosed and noncompliant with OA	Review prior findings with patient in an effort to find a medically recommended treatment option with which the patient can be compliant

will identify untreated patients previously diagnosed with OSA as well as noncompliant CPAP patients. Any and all of these situations require our further assessment of the diagnostic and treatment history before we jump in with recommendations. These situations would only then warrant further patient education and direction to the next appropriate step. Even when patients have had prior sleep tests, it is not appropriate to discuss treatment until we have reviewed medical history and prior diagnostic sleep study reports. The S.E.T.U.P. process is the most patient-, practice- and physician-friendly when you don't jump ahead. Lastly, but equally as important to mention, is that screening is not the appropriate time to discuss cost or medical insurance or appliances. We'll get there, but we have to first educate ourselves and then the patient on the specifics of their individual risk factors and the appropriate next step to take.

Educate

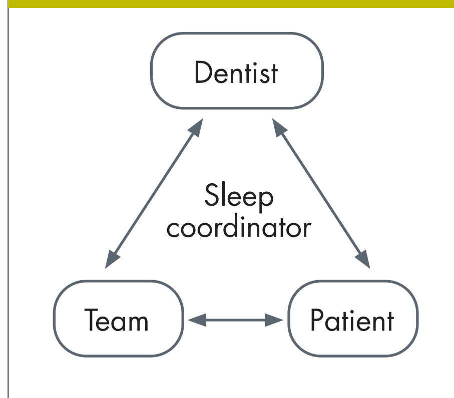
Education is the most critical part of the process and probably the "make it or break it" for the success of implementing a dental sleep program. As you read through the articles in this publication, you are increasing your own sleep health awareness, which is certainly a key component of what we will introduce as the educational triangle (Figure I). Sleep health education begins with educating ourselves and our entire team so we are then able to educate our patients to help them understand what may previously have been out of the scope of usual conversation at the dental office.

The sleep coordinator and the dental team should not assume that the patient has a thorough understanding of this disease and all appropriate treatment options even if they have previously gone through diagnostic sleep testing. The reality of the medical practice world often may not have allowed sufficient time for patients to fully understand the diagnosis and the ramifications of their diagnosis.

Education encompasses a tripartite effort for dentist, team, and patient. In most cases, sleep health is not an area of practice where the dentist received any or very little clinical education in the dental school curriculum.

For the dentist and the dental team, educating themselves in sleep health must be coupled with educating themselves in a process that informs and educates patients. The entire team must be on board. The team must understand the process that they will all carry out for implementation and follow-through of a step-by-step dental sleep medicine program for the practice.

Figure I — The educational triangle



The sleep coordinator is responsible for maintaining the integrity of the educational triangle. Without a point person other than the dentist, the program is more often miss than hit. Let's review the initial steps in education. It is through these steps that each office can identify the responsibilities and delineate the duties of the sleep coordinator. Those responsibilities and duties will also become easier to enumerate and define as we go through the remainder of the steps in the S.E.T.U.P. process. Dentists should become the captain of their teams to assure that they and the entire team have had an appropriate level of sleep health education.

The sleep health education and awareness level of the dentist should help to determine if team education is best accomplished in-house or if the team should seek outside education in areas that may include learning sleep health terms and terminology, sleep pathophysiology, diagnostic sleep testing, and oral appliance therapy. Most of what we are dealing with in incorporating dental sleep into the practice is new and different, but it certainly does not need to be difficult if the dentist assures that the educational targets are appropriate and have been achieved by the different members of the team. The sleep coordinator can be tasked with assuring that front- and back-office members understand their responsibilities and have the knowledge necessary to accomplish these tasks.

The dentist must establish a flow for the sleep program and assure that the sleep coordinator is familiar with and able to guide staff and patients through the program. Safeguards must be put in place so that the dental sleep program is not derailed before it ever gets started.

It might be one of the oldest clichés in life, but in the dental office, new habits are hard to make and easy to break. The sleep coordinator's prime responsibility is to keep the integrity of a routine sleep health screening process and to assure that patients are receiving the direction and education that is necessary to predictably and successfully move on to the next step.

Test

Up to this point, the documentation that should be in your clinical records is detailed notes of the sleep health review with the patient as well as detailed notes regarding any relevant comorbidities. A copy of any screener/questionnaire should be in the record. A copy of the patient's medical insurance card should be obtained, as it

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will be necessary for upcoming verification of medical insurance benefits.

Diagnostic sleep testing can be accomplished with polysomnography during an overnight stay in a lab or at home with a home sleep testing device. In all cases, the results must be read and interpreted by a medical doctor who will also provide a medical diagnosis and treatment recommendations. It is within the scope of dental practice to provide oral appliance therapy. Only a physician can review the sleep study data, provide the diagnosis and recommend the appropriate treatment options.

If the patient has previously undergone a diagnostic sleep study, a copy should be easy to obtain by having the patient sign a medical records release form. This can be faxed to the facility or to the physician's office where the study was completed.

If the patient is at risk and has not undergone a diagnostic sleep study, testing is the next step in the process. The results of the sleep study will dictate how to proceed and will frame the conversation and case presentation with the patient. The availability of sleep physicians and testing facilities will vary depending on the geographic location. In most metropolitan areas, patients and practices will have many options.

This article deals with incorporating dental sleep medicine into the dental practice, and we therefore will assume that most readers are near the beginning of this process. As might be practical in building any referral relationship, a face-to-face meeting with the sleep physician should be helpful and informational. It is important to discuss the sleep physician's feelings about treatment options for patients you might refer to their practice. We are looking for a physician partner who will make treatment recommendations in the best interest of the patient. We are looking for a physician partner who will recommend oral appliance therapy as a treatment option when it is appropriate according to the guidelines of the American Academy of Sleep Medicine. We are also looking for someone we can respect and learn from as we enter the medical sleep world of our dental practice. Understanding when a particular sleep physician will and will not recommend oral appliance therapy can help the dentist make the best referral choices. It is equally important to determine what the sleep physician expects of the dentist as a referrer to the sleep practice.

When the patient has completed the diagnostic sleep study, the sleep study report becomes the key document in the clinical record and is critical for medical insurance purposes. When oral appliance therapy is listed as one of the recommended treatment options, that report provides the physician's directive for the dentist to proceed.

When oral appliance therapy is a recommended treatment option and the patient chooses to proceed in that direction, their medical insurance company will usually require a patient-signed CPAP Intolerance or Refusal form in order to provide coverage for oral appliance therapy. Getting this document should become normal practice and a responsibility of the sleep coordinator.

Understand

There are, at minimum, three people involved in the understand portion of the process. The first two are the dentist and the sleep coordinator. The third is the patient and perhaps additionally the bed partner or a family member of the patient. The dentist and sleep coordinator must review and understand all findings, including but not limited to the sleep study report. Understanding the patient's per-

sonal and family medical history as well as a thorough evaluation of the patient's intraoral health is critical to this stage of the process.

The dentist and sleep coordinator should review the sleep study so they can prepare themselves to present the findings to the patient and help the patient to understand the most important and relevant findings during case presentation. The dentist and sleep coordinator should understand the technical data in the sleep study report. They should also understand how to communicate these findings in a simple and illustrative way to the patient. Items that may be critical to the patient's understanding may include: how many times does the patient choke and suffocate per hour/per night; how long is the longest choking and suffocating event; how much oxygen desaturation is the patient going through as a result of their choking and suffocating during sleep? How might the sleep health findings be related to medications that the patient is taking, to impending life-shortening or life-threatening medical issues, to excessive daytime sleepiness/drowsiness? What is the board-certified sleep doctor recommending for treatment? The list of considerations goes on and on, but there is a personalized story to tell from the data collected in each case. We must understand how to be good educators and communicators during this part of the process, so we are prepared for the case presentation.

This is the appropriate time to gather medical insurance benefit information. The patient is almost certainly going to ask the "how much" question at the case presentation. Reach out for competent help in this process. An expert third-party medical billing team can assist in not only obtaining all the necessary details of benefit verification but in completing medical insurance authorization, which is often necessary for third-party reimbursement. This part of the process is not dental business as usual. It is different, but not difficult if you outsource the process through a competent partner. The dental team should understand that assisting with medical insurance is a win-win process and more cases will be accepted when we implement a patient-friendly medical insurance protocol.

Present

The case presentation is a combined effort by the dentist and sleep coordinator. Each practice will develop its own approach and personality for successfully accomplishing this part of the process. The previous section outlined what the dentist and sleep coordinator should review and understand so that they, in turn, can help the patient to understand the details of the findings and the recommendations for treatment. Here are a few additional pearls that are positive for both patient and practice and will help your case presentations be most successful:

■ Use visual words in your case presentation. Don't assume that your patient understands the life-shortening and life-threatening nature of this disease. Paint an easy-to-understand picture. If you shortcut patient education, you shortcut the formula to success.

■ Review all treatment options from the sleep study report. Don't be negative about CPAP. It is the gold standard medical treatment and is the most appropriate treatment for severe cases. If a patient is CPAP intolerant or refuses CPAP and you have a physician's recommendation for oral appliance therapy, you should point out the benefits of this treatment option.

■ Lean on the board-certified sleep physician's written report in your case presentation. Their expertise, findings and treatment recommendations carry a lot of weight for the patient.

■ Don't guarantee success of treatment. That's not the standard in the medical world. Guarantee and provide your best effort to control this life-shortening and life-threatening disease.

■ Present an all-inclusive fee for an all-inclusive initial course of therapy. This is easier for the patient to understand and accept.

■ Be patient-, practice- and physician- friendly when it comes to working with medical insurance. Working with a partner to outsource verification of medical benefits, medical authorizations, and medical billing will help you to help more patients by getting more yeses to treatment that you present. ●

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Informed Consent for Dental Sleep Medicine

By Ken Berley, DDS, JD
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Informed consent for dental sleep medicine is a process of obtaining permission before conducting health care intervention or for disclosing personal information. An informed consent is given based on a clear appreciation and understanding of the facts, implications, and consequences of an action. Adequate informed consent is rooted in respecting a person's dignity.[1] Informed consent is collected according to guidelines from the fields of medical ethics and research ethics. Informed consent is a legal obligation due from a physician (dentist) to their patient, an obligation that may not be met by the physician's (dentist's) skillful treatment of their patient. It may only be met by the treating physician (dentist) obtaining from their patient knowing authorization for carrying out the intended medical procedure. The physician (dentist) is required to disclose whatever would be material to their patient's decision, including the nature and purpose of the procedure and the risks and alternatives. The disclosures should be made by the physician (dentist) to their patient and not through use of consent forms that are not particular to individual patients. To minimize any subsequent claim by the patient that there was a lack of adequate disclosures, the physician (dentist) should record in the patient's chart the circumstances of the patient's consent and should not rely on the patient's unreliable ability to recall those circumstances.[2,3]

Abstract

Informed consent for dental sleep medicine is a process of obtaining permission before conducting health care intervention or for disclosing personal information. An informed consent is given based upon a clear appreciation and understanding of the facts, implications, and consequences of an action. Adequate informed consent is rooted in respecting a person's dignity.

To legally provide any service or medical procedure for a patient, the patient must give permission for the treatment. The permission is only valid if it is given with full knowledge of the possible risks and benefits of the treatment. Therefore, appropriate informed consent is mandatory for oral appliance therapy. While significant complications have been rare, tooth and jaw movement secondary to mandibular advancement device usage is a common long-term result. To practice dental sleep medicine and minimize risk, patients must be adequately informed before treatment is initiated.[4]

Elements of informed consent

Appropriate informed consent is composed of three elements:[5,6] disclosure of information, capacity to consent, and voluntary consent. Each element must be satisfied to achieve adequate permission to perform any medical procedure.

The patient must be presented with adequate information to make the decision to proceed or decline the treatment. The information that must be disclosed is unique to each patient. The information must be presented in a way that the patient can understand and, ideally, be presented in the native language of the patient. Likewise, the method of disclosing pertinent information must be unique to the patient, such as for a patient with hearing problems.

The patient must have the mental capacity and be of legal age to consent. Mental capacity is a real concern for DSM practitioners. OSA has been closely linked to dementia. Frequently, our patients present with obvious neurological deficiency. It is certainly advisable to have a family member present during the consent process. Having the family member co-sign (witness) the consent document will minimize the risk associated with providing treatment on a patient who presents for treatment with obvious neurocognitive deficits. Additionally, severe sleep deprivation can make the consent process problematic.

The patient must be free to voluntarily consent. While this may not seem to be a problem, male patients are frequently under pressure from their partners to receive treatment for their snoring or obstructive sleep apnea. If in doubt, ask the partner to leave the room and have a frank conversation with the patient in private.[4]

The United States currently has no

federal statute that comprehensively addresses informed consent to health care procedures. Rather, each of the 50 states has one or more informed-consent statutes (California Informed Consent Statute 22 CCR § 72528), each of which is subject to amendment during each session of the states' legislatures. Furthermore, a state's statutes addressing informed consent may be supplemented by common-law (judicially enacted) concepts. This manuscript summarizes "best practices" as they can be gleaned from a review of the California informed-consent laws, ethical standards, and accreditation standards in the health care industry.[7]

General components of consent

In the absence of special circumstances, a physician (dentist) may not treat a patient without first obtaining their consent. Courts in many jurisdictions, however, have questioned whether consent should be binding where the patient does not, at least in some measure, consciously weigh the risks of undergoing treatment against the risks of foregoing treatment. A decision to undergo treatment despite such risks is the product of "informed consent." But the average patient's ignorance of medical science very likely makes him or her unaware of particular risks inherent in a proposed treatment, and hence prevents him or her from giving the informed consent that the law requires. Informed consent, therefore, concerns the extent to which a doctor must disclose risks inherent in a contemplated method of treatment.[8]

Common elements that should be included in all consent forms are:

- The diagnosis.
- The nature and purpose of the procedure(s) for which consent is sought.
- All material risks and consequences of the procedures.
- An assessment of the likelihood

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that the procedures will accomplish the desired objectives.

- Any reasonably feasible alternatives for treatment, with the same supporting information as is required regarding the proposed procedures.
- The prognosis if no treatment is provided.[9,10]

Disclosure

Disclosure requires the physician (dentist) to supply each prospective patient with the information necessary to make an autonomous decision and also to ensure that the patient adequately understands the information provided. This latter requirement implies that a written consent form be written in lay language suited for the comprehension skills of subject population as well as assessing the level of understanding through conversation. In order to ensure that informed consent is properly obtained, the physician (dentist) should actually discuss with the patient each of the procedures to be performed, detailing their nature, risks, and alternatives. This conversation should take place before the patient is under the influence of preoperative medications. Thus, the consent form should provide blanks for the date and precise time of signature by both the patient or their responsible party and the physician (dentist). The patient should also be given an opportunity to ask questions concerning the proposed treatment, and the written consent should confirm that the opportunity has been given. The consent should be signed by the patient or responsible party in the presence of an attesting witness.[11]

There is always concern regarding the amount of information that must be disclosed for a patient to make an informed decision about any therapy. The court in Cobbs[7] employed several postulates. The first is that patients are generally persons unlearned in the medical sciences, and therefore, except in rare cases, courts may safely assume that the knowledge of patient and physician (dentist) are not in parity. The second is that a person of adult years and in sound mind has the right, in the exercise of control over their own body, to determine whether or not to submit to lawful medical treatment. The third is that the patient's consent to treatment must be an informed consent to be effective. And the fourth is that the patient, being unlearned in medical sciences, has an abject dependence upon and trust in their physician (dentist) for the information upon which he relies during the decisional process, thus raising an obligation in the physician (dentist) that transcends arms-length transactions.

From the foregoing axiomatic ingredients emerges a necessity, and a resultant requirement, for divulgence by the physician (dentist) to their patient of all information relevant to a meaningful decisional process. In many instances, to the physician (dentist) whose training and experience enable a self-satisfying evaluation, the particular treatment that should be undertaken may seem evident, but it is the prerogative of the patient, not the physician (dentist), to determine for himself the direction in which he believes their interests lie. To enable the patient to chart their course knowledgeably, reasonable familiarity with the therapeutic alternatives and their hazards becomes essential.

The court in Cobbs held that "as an integral part of the physician's overall obligation to the patient there is a duty of reasonable disclosure of the available choices with respect to proposed therapy and of the dangers inherently and potentially involved in each."[12] A medical doctor, being the expert, appreciates the risks inherent in the procedure he is prescribing, the risks of a decision not to undergo the treatment, and the probability of a successful outcome of the treatment. But once this information has been disclosed, that aspect of the doctor's expert function has been performed. The weighing of these risks against the individual subjective fears and hopes of the patient is not an expert skill.[13] Such evaluation and decision is a nonmedical judgment reserved to the patient alone. A patient should be denied the opportunity to weigh the risks only where it is evident; the patient cannot evaluate the data, as, for example, where there is an emergency or the patient is a child or incompetent. For this reason, the law provides that in an emergency, consent is implied.[14] If the patient is a minor or incompetent, the authority to consent is transferred to the patient's legal guardian or closest available relative.[15] In all cases, the decision whether or not to undertake treatment is vested in the party most directly affected: the patient.[16]

The scope of the disclosure required of physicians defies simple definition. Some courts have spoken of "full disclosure"[17] and others refer to "full and complete" disclosure,[18] but such facile expressions obscure common practicalities. Two qualifications to a requirement of "full disclosure" need little explication. First, the patient's interest in information does not extend to a lengthy polysyllabic discourse on all possible complications. A minicourse in medical science is not required; the patient is concerned with the risk of death or bodily harm and problems of recuperation. Second, it is not a physician's duty to discuss the relatively minor risks inherent in common procedures when it is common knowledge that such risks inherent in the procedure are of very low incidence. In a medical malpractice action based on the doctrine of informed consent, an objective standard applies and the

question is whether a reasonably prudent patient, fully advised of material known risks would have consented to the suggested treatment.[19]

When there is a common procedure, a doctor must, of course, make such inquiries as are required to determine if for the particular patient the treatment under consideration is contraindicated — for example, to determine if the patient has had adverse reactions to medication; but no warning beyond such inquiries is required as to the remote possibility of death or serious bodily harm. When there is a more complicated procedure, the jury should be instructed that when a given procedure inherently involves a known risk of death or serious bodily harm, a medical doctor has a duty to disclose to his/her patient the potential of death or serious harm and to explain in lay terms the complications that might possibly occur. Beyond the foregoing minimal disclosure, a doctor must also reveal to their patient such additional information as a skilled practitioner of good standing would provide under similar circumstances. The patient's right of self-decision is the measure of the physician's duty to reveal. That right can be effectively exercised only if the patient possesses adequate information to enable an intelligent choice. The scope of the physician's communications to the patient, then, must be measured by the patient's need, and that need is whatever information is material to the decision. Thus, the test for determining whether a potential peril must be divulged is its materiality to the patient's decision.[20]

There must be a causal relationship between the physician's failure to inform and the injury to the plaintiff. Such causal connection arises only if it is established that had revelation been made consent to treatment would not have been given. At trial, the record must disclose testimony that had the plaintiff been informed of the risks of surgery they would not have consented to the operation.[21] The patient-plaintiff may testify on this subject, but the issue extends beyond their credibility. Because at the time of trial when the uncommunicated hazard has materialized, it would be surprising if the patient-plaintiff did not claim that had they been informed of the dangers they would have declined treatment. Subjectively, they may believe so, with the 20/20 vision of hindsight,

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Sleep study — A sleep study is necessary for a physician to diagnose the level of obstructive sleep apnea (OSA) and determine suitable interventions, including a dental appliance. This diagnosis must be documented for seeking benefits from most medical plans.

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but justice cannot be served by placing the physician in jeopardy of the patient's bitterness and disillusionment. Thus, an objective test is preferable, i.e., what would a prudent person in the patient's position have decided if adequately informed of all significant perils.[16]

The burden of going forward with evidence of nondisclosure rests on the plaintiff. Once such evidence has been produced, then the burden of going forward with evidence pertaining to justification for failure to disclose shifts to the physician.[22] Defenses are available when a doctor who has failed to make a disclosure required by law; for example, a medical doctor need not make disclosure of risks when the patient requests that they not be so informed.[23] Such a disclosure need not be made if the procedure is simple and the danger remote and commonly appreciated to be remote. A disclosure need not be made beyond that required within the medical community when a doctor can prove by a preponderance of the evidence that he relied on facts that would demonstrate to a reasonable man that the disclosure would have so seriously upset the patient that the patient would not have been able to dispassionately weigh the risks of refusing to undergo the recommended treatment.[24] Any defense, of course, must be consistent with what has been termed the "fiducial qualities" of the physician-patient relationship.[25]

Disclosure in dental sleep medicine

The effective management of a sleep-related breathing disorder requires the qualified dentist to provide the patient with an overview of the disease process as well as an understanding of how oral appliances treat SRBDs. OSA is the result of neuroanatomical factors and pathophysiological processes that either singularly or collectively fail to maintain the patency or opening of the upper airway. Patient education should include the role of these processes as well as highlighting demographic, ethnic, and gender risk factors. Additionally, patients should be informed about disease processes including comorbid conditions arising from or associated with OSA. The patient undergoing OAT should be informed of their SRBD severity, including an understanding of the resulting apnea-hypopnea index, respiratory disturbance index or respiratory event index from objective sleep-apnea testing.[26]

Initiating OAT includes obtaining informed consent and a letter of medical necessity and should allow for modification of the treatment plan as needed to obtain the desired therapeutic result. Informed consent is the process by which the treating dentist discloses appropriate information to a competent patient so that the patient may make a voluntary choice to accept or refuse treatment. The qualified dentist should provide the patient an opportunity to ask questions about the risks of treatment as well as educate the patient as to the risks associated with no treatment. Informed consent also requires that the qualified dentist informs the patient as to alternate therapies to OAT, such as positive airway pressure therapy, positional therapy, maxillofacial surgery, or otolaryngologic surgery. Upon agreement to a plan of treatment, the patient should sign the informed consent in front of the qualified dentist or other dental staff. The qualified dentist should then countersign and date the document, which should be kept as part of the patient's record of care.[26]

The patient should also be informed that OAT success may be impacted by fragmented sleep, oxygen desaturation, and other coexisting sleep disorders. Additionally, the qualified dentist should explain risk modifiers that may mitigate disease severity. The patient should be advised that the risk of disease severity or treatment success may be negatively influenced by using tobacco, alcohol, caffeine, or recreational substances.[27] The impact of both weight loss and weight gain should be discussed with the patient. The educated and informed patient may choose to reduce disease impact by modifying behaviors that increase SRBD risk or severity. Additionally, patients should be educated about the importance of sleep hygiene. The patient should understand the impact of ambient room lighting, temperature, the use of electronics in bed, animals on the bed, as well as the importance of

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regular sleep schedules. While these considerations may not directly affect OA efficacy, they can collectively fragment sleep and aggravate daytime sleepiness concerns. Improper sleep hygiene can also indirectly reduce patient perception of oral appliance benefit in terms of sleep quality and daytime function.[26]

The complications that could occur over a lifetime of MAD wear are numerous. It would be difficult to include a complete list of all possible issues that could arise. However, some of the possible issues include tooth movement, jaw movement, TMD, injury secondary to appliance breakage, dry mouth, excessive saliva, sore teeth, dental decay, periodontal disease, mobile teeth, fractured teeth and dental restorations, popping and noise in the jaw, acrylic or other (material) allergies, posterior open bite, difficulty chewing, residual sleepiness and symptoms after treatment, and increased AHI/RDI during a follow-up sleep study.[4]

Additionally, OSA is an unusual disease because it has been associated with many comorbid medical conditions. The law of informed refusal requires that a patient be informed of the risk associated with refusing treatment. As a result of OSA or as a complication of OSA treatment, patients may develop any or all of the following temporary or permanent comorbid diseases: coronary artery disease, high blood pressure, diabetes, cerebrovascular disease, stroke, heart problems, heart attack, atrial fibrillation, depression, mood disorders, vivid dreams, anxiety, feeling suffocated, sexual dysfunction, weight gain, obesity, dementia, Alzheimer's disease, gastroesophageal reflux, chronic obstructive pulmonary disease, congestive heart failure, cancer, excessive daytime sleepiness, increased work-related and traffic-related accidents and death.[4]

Capacity to consent

Capacity pertains to the ability of the patient to both understand the information provided and form a reasonable judgment based on the potential consequences of their decision. In general, it is the dentist's role to provide the necessary medical facts and the patient's role to make the subjective treatment decision based on their understanding of those facts.[28] The patient must have the capacity to reason and make judgments.[29] To give informed consent, the individual concerned must have adequate reasoning faculties and be in possession of all relevant facts. Impairments to reasoning and judgment that may prevent informed consent include basic intellectual or emotional immaturity, high levels of stress such as post-traumatic stress disorder or a severe intellectual disability, severe mental disorder, intoxication, severe sleep deprivation, Alzheimer's disease, or being in a coma. When the patient lacks the requisite capacity to consent, another person is generally authorized to give consent on their behalf, e.g., parents or legal guardians of a child (though in this circumstance the child may be required to provide informed assent) and conservators for the mentally disordered or consent can be assumed through the doctrine of implied consent, e.g., when an unconscious person will die without immediate medical treatment.[26]

In dental sleep medicine, practitioners routinely treat patients with "severe sleep deprivation" who have difficulty following conversations or who may fall asleep during consent discussions. If a dentist is unsure of the patient's ability to consent, it is always advisable to have a family member witness the consent and sign the informed-consent document. As a practice tip, patients who present excessively sleepy need a driver and may need to be referred back to their sleep physician for control of the patient's excessive daytime sleepiness until the MAD is effective.[4]

Voluntariness of consent

Voluntariness refers to the patient's right to freely exercise their decision making without being subjected to external pressure such as coercion, manipulation or undue influence.

A patient's decision to proceed with any medical procedure must be voluntary and without coercion and the patient must have a clear understanding of the risks and benefits of the proposed treatment alternatives or nontreatment, along with a full understanding of the nature of the disease and the prognosis.[30]

Informed refusal

The legal principals of informed consent also apply to the doctrine of informed refusal. Any adult patient who has the requisite capacity has the legal right to refuse any medical treatment.[26] The patient's ability to control their bodily integrity through informed consent is significant only when one recognizes that their right also encompasses a right to informed refusal.[31]

In obtaining an informed refusal, the health care provider is required to fulfill the same steps as in an informed consent. The patient must be provided the diagnosis, a layman's description of the procedure, the likelihood of success (prognosis), alternatives, and the risks associated with no treatment. This discussion must include MI, hypertension, strokes, diabetes, and automobile/industrial accidents. The final step of the informed refusal is to document the discussion and the refusal. It is ideal if the dentist has an informed-refusal form that is specific to this discussion. If no such document exists, detailed notes should be made in the patient's record fully memorializing the discussion.[4]

Written consent

Most practitioners believe that a written signed consent is legally re-

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quired. This is not the case. A written consent is only for documentation. Oral consent is legally binding but proving what information was presented in order to obtain consent is difficult. Typically, practitioners are wise to have a discussion with the patient outlining the common complications inherent in OAT. Included in the discussion is a time for questions to be answered. Once the discussion is completed, the written consent is presented for signature. Remember, a well-written and executed informed-consent document is your most valuable defense tool if your records are ever reviewed by a plaintiff's attorney. With a well-written, signed informed consent most lawsuits never happen.[4]

Concerns

The practice of dental sleep medicine presents some unusual risks. The most common risk of providing a mandibular advancement device is occlusion issues that develop as a result of the persistent forces placed on the teeth and jaws. MADs can cause the maxillary teeth to tilt posteriorly and the mandibular teeth to tilt anteriorly. This action will result in a posterior open bite in a significant portion of OAT patients. It is imperative for all practitioners to inform their patients of the risk. At each appointment, occlusion should be examined and morning repositioner wear should be encouraged.

Patients with a history of TMD must be informed of the possibility of muscle pain, capsulitis, dysfunction, and difficulty chewing with MAD use. MAD appliance wear will generally improve TMD symptoms with time; however, initially this may not be the case. Appropriate consent will include a frank discussion of TMD risks.

MADs place significant amounts of pressure on the teeth and existing dental restorations. Ill-fitting crowns and bridges or other restorations can be dislodged or fractured as a result of oral appliance therapy. Failing endodontic procedures can be compromised as a result of the pressure placed on these teeth by a MAD appliance. Adult patients with recent orthodontics are at risk of tooth movement. Patients with a minimum number of teeth require a directed discussion that may include a discussion of implants to help secure the MAD. Patients with a history of periodontal disease and attachment loss must be informed of any additional risk.[4]

Patients can be allergic to the material contained in the MADs. Acrylic allergies and metal allergies are not uncommon. This possibility should be discussed. Additionally, appliances can break, or parts may become dislodged. Appropriate warnings are necessary.[4]

Each patient is unique. Informed consent discussions must be specific to the clinical presentation of the patient, the severity of OSA, the capacity of the patient to understand the risks of treatment, the existence of extenuating circumstances (arthritis making insertion and removal an issue), and the patient's ability to understand English. Each of these clinical situations and patient peculiarities necessitates a different consent discussion.[31] However, a fully informed patient is more engaged in the therapy and more committed to the process. The time spent in obtaining an informed consent reduces clinician liability and results in a more motivated patient.[4]

Editor's Note: This article has been reviewed for publication in Michigan by MDA legal counsel. Readers should consult with their legal counsel on informed consent questions. This information is not intended to constitute legal advice and should not be relied upon in lieu of consultation with appropriate legal advisers in your own jurisdiction. It may not be current as the laws in the area of informed consent change frequently.

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7. 22 CCR § 72528 Informed Consent Requirements. govt. westlaw.com/calregs/Document/I4C2C6C005F7B11DFBF84F211BF18441D?contextData=%28sc.Default%29&transition nType=Default.
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9. In Roberts v. Wood, 206 F. Supp. 579 (S.D. Ala. 1962), the doctor performed a second thyroidectomy without informing the patient of the second operation's greater risk or

suggesting the preferable radioiodine method of treatment, and the patient lost the use of her true vocal cords. In Patrick v. Sedwick, 391 P.2d 453 (Alaska 1964), a referring physician told plaintiff it was nothing more than a tonsillectomy. Plaintiff's consultation with the surgeon was limited to an exchange of greetings. After the operation, one vocal cord was paralyzed and plaintiff's soft, feminine voice became harsh and hoarse. In DiFilippo v. Preston, 53 Del. 539, 173 A.2d 333 (1961), the doctor did not warn the patient of the risk, and now the patient cannot speak above a hoarse whisper and will breathe through a tracheal tube for the rest of her life. In Watson v. Clutts, 262 N.C. 153, 136 S.E.2d 617 (1964), the doctor told the patient she would have to stay in the hospital for a week before the serious operation. She suffered paralysis of both vocal cords and had to have a tracheotomy. Plaintiff in each of these cases lost on the informed consent theory. The plaintiff in Patrick v. Sedwick, supra, recovered on a negligence theory.

10. Hook v. Rothstein. 316 S.E.2d 690 (S.C. Ct. App. 1984). Noting the under the doctrine of informed consent, a physician has a duty to disclose "(1) the diagnosis, (2) the general nature of the contemplated procedure, (3) the material risks involved in the procedure, (4) the probability of success associated with the procedure, (5) the prognosis if the procedure is not carried out, and (6) the existence of any alternatives to the procedure." The extent of disclosure is ordinarily a medical judgment. Stauffer v. Karabin, 30 Colo. App. 357, 492 P.2d 862 , 865 (1971); Starnes v. Taylor, 158 S.E.2d at 344. "[T]he doctrine of informed consent does not require the physician to risk frightening the patient away from treatment which sound medical judgment indicates is necessary. . . ." 61 Am. Jur.2d Physicians, Surgeons, and Other Healers § 190, at 321 (1981). The physician is not ordinarily required to disclose the risk to the patient "where the statistical risk is remote and the severity not great." 2 D. Louisell H. Williams, supra § 22.13, at 22–34.

11. Performing a medical procedure without consent constitutes battery. The California Case law has rejected this argument and relied on the law of negligence. See: Cobbs v. Grant. [S.F. Supreme Court of California. Oct. 27, 1972] In Bank. (Opinion be Mosk, J) [8 Cal. 3d 230] In giving its instruction the trial court relied upon Berkey v. Anderson (1969) 1 Cal. App. 3d 790, 803 [82 Cal. Rptr. 67], a case in which it was held that if the defendant failed to make a sufficient disclosure of the risks inherent in the operation, he was guilty of a "technical battery" (also see Pedesky v. Bleiberg (1967) 251 Cal. App. 2d 119, 123 [59 Cal. Rptr. 294]; Hundley v. St. Francis Hospital (1958) 161 Cal. App. 2d 800, 802 [327 P.2d 131]).While a battery instruction may have been warranted under the facts alleged in Berkey, in the case before us the instruction should have been framed in terms of negligence.

12. See Cobbs: 8 Cal. 3d 243.

13. Perna v. Pirozzi. 457 A.2d 431 (N.J. 1983) Discussing the doctrine of informed consent in medical malpractice context. Informed consent is a negligence concept predicated on the duty of a physician to disclose to a patient information that will enable him to "evaluate knowledgeably the options available and the risks attendant upon each" before subjecting that patient to a course of treatment. Canterbury v. Spence, 464 F.2d 772, 780 (D.C. Cir.), cert. den., 409 U.S. 1064, 93 S.Ct. 560, 34 L.Ed.2d 518 (1972); see Calabrese v. Trenton State College, 162 N.J. Super. 145, 156 (App.Div. 1978), aff'd, 82 N.J. 321 (1980) (summary judgment for defendant-doctors reversed because of fact question whether they disclosed dangerous side effects of drugs); Kaplan v. Haines, 96 N.J. Super. 242, 255-58 (App.Div. 1967), aff'd o.b., 51 N.J. 404 (1968) (not error, in light of complete charge, to instruct jury that it should return verdict for defendants if patient "fully appreciated the danger involved in the operation"). See generally Natanson v. Kline, 186 Kan. 393, 350 P.2d 1093 (1960); M. Victor, "Informed Consent" 1981 Med. Trial Tech. Q. 138. Under the doctrine, the patient who consents to an operation is given the opportunity to show that the surgeon withheld information concerning "the inherent and potential hazards of the proposed treatment, the alternatives to that treatment, if any, and the results likely if the patient remains untreated." Canterbury v. Spence, supra, 464 F.2d at 787-88. If the patient succeeds in proving that the surgeon did not comply with the applicable standard for disclosure, the consent is vitiated. See Canterbury v. Spence, supra, 464 F.2d at 782; 2 Louiselle and Williams, Medical Malpractice § 22.08 (1982).

14. Wheeler v. Barker (1949) 92 Cal. App. 2d 776, 785 [208 P.2d 68]; Preston v. Hubbell (1948) 87 Cal. App. 2d 53, 57-58 [196 P.2d [8 Cal. 3d 244] 113].

15. Ballard v. Anderson (1971) 4 Cal. 3d 873, 883 [95 Cal. Rptr. 1, 484 P.2d 1345, 42 A.L.R.3d 1392]; Doyle v. Giuliucci (1965) 62 Cal. 2d 606 43 Cal. Rptr. 697, 401 P.2d 1]; Bonner v. Moran (1941) 126 F.2d 121 [75 App.D.C. 156, 139 A.L.R. 1366]).

16. See Cobb. Supra.

17. See: Berkey v. Anderson, supra, 1 Cal. App. 3d 790, 804; Salgo v. Leland Stanford etc. Bd. Trustees, supra, 154 Cal. App. 2d 560, 578.

18. See: Stafford v. Shultz (1954) 42 Cal. 2d 767, 777 [270 P.2d 1]; Pashley v. Pacific Elec. Ry. Co. (1944) 25 Cal. 2d 226, 235 [153 P.2d 325].

19. Reikes v. Martin 471 So. 2d 385 (Miss. 1985).

20. Canterbury v. Spence, 464 F.2d 772, 786.

21. Shetter v. Rochelle (1965) 2 Ariz.App. 358 [409 P.2d 74]; Sharpe v. Pugh (1967) 270 N.C. 598 [155 S.E.2d 108]; cf. Aiken v. Clary (Mo. 1965) supra, 396 S.W.2d 668.

22. Cobb, Supra.

23. See discussion of waiver: Hagman, The Medical Patient's Right to Know. 17 UCLA L. Rev. 758–785.

24. See discussion of informing the dying patient: Hagman, The Medical Patient's Right to Know, supra. 17 UCLA L. Rev. 758–778.

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28. Hilfiker, supra, 308 New Eng. J. Med. at 718 (acknowledging that "our ability [as doctors] to phrase options, stress information and present our own advice gives us tremendous power").

29. Matter of Conroy. 486 A.2d 1209 (N.J. 1986).

302. Ermoian v. Desert Hospital. 152 Cal. App. 4th 475 (Cal. Ct. App. 2007).

31. Matter of Conroy, Supra.

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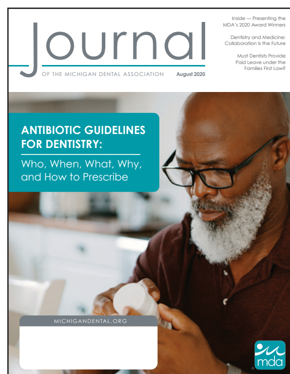

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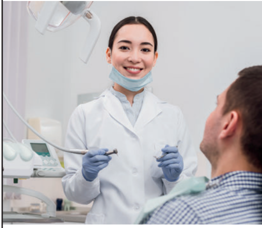

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Issue	Deadline
February 2021	January 1
March 2021	February 1
April 2021	March 1
May 2021	April 1
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Pre-recorded course: Why Does My Tooth Hurt? Diagnosing Endodontic Pain. Speaker: Susan Paurazas, DDS, MHSA, MS. Where: Online course. One CE credit.

Pre-recorded course: 60 Minute Review of Local Anesthesia for the Dental Practitioner. Speaker: Lynne Morgan, RDH, MS, MA. Where: Online course. One CE credit.

Pre-recorded course: Pain Pathways of the Head and Neck. Speaker: Maha Ahmad, PhD. Where: Online course. One CE credit.

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Journal CE Listings Policy

The *Journal* lists continuing education courses by accredited Michigan dental schools and dental societies in Michigan in this section at no charge. To place a listing, see the online CE Course Submission Form at michigandental.org/CE-Courses.

CE SPOTLIGHT

Start the New Year Right with Live CE from the MDA!

The MDA's Winter Virtual Seminar Series brings you quality *live* continuing dental education, with "in person" CE credits for you and your dental team. It's a great way for you and your team to start the new year!

Here's what's coming up:

Friday, Jan. 8, 2021: "Personalized Periodontal Medicine: A New Approach to Total Body Health," with Doug Thompson, DDS. (10 a.m. – 3 p.m.) This course is designed for general practitioners, their lead hygienist, and the entire team who are serious about advancing the periodontal health of the patients, the health of their team, and the health of the practice.

Thompson

Friday, Feb. 5, 2021: "Roll Out the Red Carpet and Let's Get Social," with Carrie Jameson-Webber (10 a.m. – 3 p.m.) This course will provide dental professionals with a better understanding of how exceptional customer service influences the entire patient experience.

Jameson-Webber

Friday, March 19, 2021: "Sleep-Related Breathing Disorders and Care for Patients with Pain" (a.m.) and "Dentists Can Care for Patients with Pain" (p.m.), both with Mayoor Patel, DDS. The morning session will address how dentists and dental hygienists play an integral role in identifying patients with a sleep breathing disorder. The afternoon session shows how dentists can successfully treat patients' pain by understanding TMDs, what to look for, and how to provide treatment.

Patel

Four CE credits are available for each course. The cost is $99 for MDA-member dentists and $59 for staff members. Non-members: Add $100. For full details or to register, visit michigandental.org/CE-courses.

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2021 ANNUAL SESSION

DESTINATION DENTAL EDUCATION

Plot your course for Michigan's largest dental meeting!

With cutting-edge continuing education courses, well-known speakers, and amazing exhibits, there's something for everyone at the 2021 MDA Annual Session.

The MDA is planning for an in-person Annual Session, but given the ever-changing circumstances surrounding the pandemic and our commitment to keeping attendees safe, this event may change to 100% virtual. *Dates and course times will remain the same.*

The MDA will keep members and those registered updated with the status of this event as more details become available.

April 22-24
Lansing Center

www.michigandental.org/annual-session

#DESTINATIONDENTALEDUCATION

Pre-recorded course: Caries Risk Assessment and Management for the Pediatric Patient. Speaker: Fouad Salama, BDS, MS. Where: Online course. One CE credit.

Pre-recorded course: No Drilling and Minimal Intervention: Paradigm Shift in Dentistry for Children. Speaker: Fouad Salama, BDS, MS. Where: Online course. One CE credit.

Pre-recorded course: Practical Tips for Health Professionals to Care for Individuals with Special Health Care Needs. Speaker: Fouad Salama, BDS, MS. Where: Online course. One CE credit.

Pre-recorded course: Restoring Abfraction Lesions with Glass Ionomers. Speaker: Camilo Machado, DDS, MS. Where: Online course. One CE credit.

Pre-recorded course: Strategies of Behavior Guidance for the Difficult Pediatric Patient: Changing How You Practice. Speaker: Fouad Salama, BDS, MS. Where: Online course. One CE credit.

Friday-Saturday, May 14-15, 2021: Treating Pediatric Tongue and Lip Ties with Lasers: A Hands-On Experience. Speakers: Martin Kaplan, DMD, Annette Skowronski, DDS, and Peter Vitruk, PhD. Where: School of Dentistry. Twelve CE credits.

Friday, May 21, 2021: A Hands-On Review of Local Anesthesia Techniques: Helping to Better Manage Your Patients' Pain. Speakers: Lynne Morgan, RDH, MS, MA, and Carl Stone, DDS, MA, MBA, MA. Where: School of Dentistry. Five CE credits.

Friday, July 16, 2021: Nitrous Oxide/ Oxygen Sedation for the Dental Hygienist. Speakers: Lynne Morgan, RDH, MS, MA, Claudine Sordyl, RN, MS, and Tamika Thompson, DDS, MS. Where: School of Dentistry. Nine CE credits.

Friday, July 16, 2021: Nitrous Oxide/ Oxygen Sedation for the Dental Assistant. Speakers: Lynne Morgan, RDH, MS, MA, Claudine Sordyl, RN, MS, and Tamika Thompson, DDS, MS. Where: School of Dentistry. Six CE credits.

UNIVERSITY OF MICHIGAN

Please contact the school at 734-763-5070 or online at https://dent.umich.edu/education/continuing-dental-education for updated listings and additional information.

Pre-recorded course: Failures and Complications in Implant Supported Prostheses: How to Manage these Situations. Speaker: Gustavo Mendonça, DDS, MSc, PhD. Where: Online course. Three CE credits.

Pre-recorded course: Human Trafficking for Dental Professionals. Speaker: Danielle Kalil, JD. Where: Online course. Two CE credits.

Pre-recorded course: Multi-Level Learning in Implant Digital Workflow and Practical Considerations (Session 1). Speakers: Gustavo Mendonça DDS, MSc, PhD; and Hsun-Liang (Albert) Chan, DDS, MS. Where: Online course. Two and one half CE credits.

Pre-recorded course: Multi-Level Learning in Implant Digital Workflow and Practical Considerations (Session 2). Speakers: Gustavo Mendonça DDS, MSc, PhD; and Junuing Li, DDS, MS, PhD. Where: Online course. Two and one half CE credits.

Pre-recorded course: Obstructive Sleep Apnea Basic Principles. Speaker: Daniela Mendonça, DDS, MSc, PhD, D.ABDSM; and Geoffrey Gerstner, DDS, MS, PhD, D.ABDSM. Where: Online course. Three CE credits.

Wednesday, Jan. 13, 2021: Live Webinar — What Would G.V. Black Do? A Historical Perspective on Modern Dental Procedures. Speaker: Stephen Sterlitz, DDS. Where: Online course. Three CE credits.

Friday, Jan. 15, 2021: Live Webinar — Interim Restoration Design, Export, and Printing and Invest in Digital Workflow: Advantages and Challenges. Speaker: Gustavo Mendonça, DDS, MSc, PhD. Two and one half CE credits.

Friday, May 28, 2021: The Jarabak Lecture. Speaker: Won Moon, DMD, MS. Where: School of Dentistry. Six CE credits.

Wednesday-Saturday, June 9-12, 2021: Ramfjord Symposium. Speakers: William Giannobile, DDS; and Hom-Lay Wang, DDS, MS, PhD. Where: The Michigan League and Lydia Mendelssohn Theatre, Ann Arbor. Thirteen CE credits.

Tuesday – Saturday, July 20-24, 2021: Advanced Periodontal Surgery: A Practical Training Course. Speaker: Hom-Lay Wang, DDS, MSD, PhD. Where: School of Dentistry. Twenty-nine CE credits.

LOCAL SOCIETIES

The MDA encourages local dental societies to publicize courses and speakers online and in the MDA *Journal* continuing education listings. These listings are published when submitted and should not be considered a definitive list or master calendar of all local CE courses offered in the state of Michigan. Local societies planning CE events are urged to check with other components when scheduling courses.

Monday, Jan. 11 Live Webinar — The Pediatric Upper Airway from Obstruction to Oral Ties — What the Dentist Should Know. Speaker: Erin Kirkham, MD, MPH. Sponsored by: Washtenaw District Dental Society. Contact: Barb Kolling at bcfkolling@washtenawdentalsociety.com. One CE credit. ●

Save the date for the

Summer Scientific Session

Friday - Saturday, Aug. 13-15, 2021 • Treetops Resort — Gaylord

Friday, Aug. 13, 2021

Golf Outing
10 a.m. shotgun start

Saturday, Aug. 14, 2021

"HPV: Elevating Our
Care in Dentistry"
8 – 11 a.m.
Speaker: Charlotte Cortis, DDS

Sunday, Aug. 15, 2021

"Medical Billing"
8 – 11 a.m.
Speaker: Jeff Burton, RN

Counts toward the Dental Business Professional Certification, insurance benefits/coding category, for three credits.

For complete information on all MDA CE courses, visit michigandental.org/CE-Courses

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