GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING
MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
SUZANNE SONNEBORN
EXECUTIVE DIRECTOR

ORLENE HAWKS
DIRECTOR

April 13, 2023

Sent Via Email

Amy Gumbrecht, Director
Bureau of Professional Licensing
611 W. Ottawa Street
Ottawa Building, 2nd Floor
Lansing, MI 48909

Director Gumbrecht:

On March 30, 2023, the Department of Licensing and Regulatory Affairs notified the Joint Committee on Administrative Rules (JCAR) of the withdrawal of the rule set entitled "Dentistry—General Rules" (2021-40 LR) to work with the Michigan Board of Dentistry and stakeholders to clarify provisions of the rule set and make revisions as necessary.

Pursuant to the Rulemaking Manual, the Michigan Office of Administrative Hearings and Rules (MOAHR) has reviewed the rules as changed and has determined that the regulatory impact or the impact on small businesses of the rules as changed would not be more burdensome than the regulatory impact or the impact on small businesses of the rule as originally proposed. Therefore, a second public hearing is not required.

The changes to the "Dentistry- General Rules" removes the requirement in R 338.11521 of a passing score on an "oral clinical examination", changes the acronym for basic cardiac life support from "BSL" to "BLS", adds "CITA" on the end of the defined term "CDCA-WREB", adds the acronym "UDA" for the defined term "unregistered dental auxiliary", deletes "advanced" from the definition of "basic cardiac life support" in R 338.11101, and removes the reference to a "licensed" UDA in R 338.11411, as UDA's are not licensed in Michigan.

MOAHR has determined that the regulatory impact and the impact on small businesses would not be more burdensome, as most of the changes are merely adding or changing an acronym or defined term. The only substantive changes to the rules, which can be found in R 338.11521 and R 338.11411, involve the elimination of the requirement of a passing score on an "oral clinical examination" and removing the word "licensed" when referring to UDAs. MOAHR has determined that the regulatory impact and the impact on small businesses would not be more burdensome, as these changes eliminate an additional testing requirement and clarify that UDAs are not licensed in Michigan.

Sincerely,

Ashlee N. Lynn

State Administrative Manager 15, Administrative Rules Division
Michigan Office of Administrative Hearings and Rules

cc: Kerry Przybylo, Manager, BPL
Liz Arasim, Regulatory Affairs Officer, BPL
Paige Fults, Director, OPLA
Suzanne Sonneborn, Executive Director, MOAHR

GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 30, 2023

Joint Committee on Administrative Rules
Boji Tower, Third Floor
124 W. Allegan St.
P.O. Box 30036
Lansing, MI 48909-7536

**Sent electronically*

RE: Rule Set 2021-040 LR (Dentistry – General Rules)

Dear Chair Haadsma, Alternate Chair Wojno, and Committee Members:

I respectfully withdraw the Dentistry – General Rules (2021-040 LR) from the Joint Committee on Administrative Rules (JCAR) pursuant to Section 45a(10)(b) of the Administrative Procedures Act (APA), MCL 24.245a(10)(b).

As provided in Section 45a(10)(b) of the Administrative Procedures Act (APA), an agency may withdraw a rule set to make revisions and then resubmit it to JCAR. Upon resubmission of the rule set, JCAR will have a new and untolled 15-session-day time period for consideration.

The Department is withdrawing this rule set to review the provisions regarding requirements for the verification of a passing score on both the American Board of Pediatric Dentistry (ABPD) qualifying examination and oral clinical examination. LARA will work with the Michigan Board of Dentistry and stakeholders to clarify provisions of the rule set and make revisions as necessary. The rules will then be resubmitted for your deliberation.

Please contact me at (517) 241-4580 with any questions or concerns regarding this matter.

Sincerely,

Paige Fults

Paige Fults
Director, Office of Policy and Legislative Affairs
Michigan Department of Licensing & Regulatory Affairs

cc: Marlon I. Brown, Chief Administrative Officer, LARA
Amy Gumbrecht, Director, Bureau of Professional Licensing, LARA
Courtney Pendleton, Deputy Director, LARA
Katie Wienczewki, Director, Administrative Rules, MOAHR

American TeleDentistry Association

Marc Bernard Ackerman
DMD, MBA
Executive Director

August 8, 2022

Department of Licensing and Regulatory Affairs Bureau of Professional Licensing
Boards and Committees Section
Attention: Departmental Specialist
P.O. Box 30670
Lansing, MI 48909-8170

RE: Proposed Administrative Rules for Dentistry - General Rules - Rule Set 2021-40 LR

To whom it may concern,

My name is Dr. Marc Ackerman and I am the Executive Director of the American Teledentistry Association (ATDA), I am also a licensed and practicing orthodontist, work and teach at a major health care facility, am a recipient of the B.F. and Helen E. Dewel Award, and have a deep passion for helping others and making sure that everyone receives the care that they deserve. That is why I founded and created the American Teledentistry Association. The Association's mission is to increase access to quality, affordable dental care and that is why I write to you today on the critical legislative matter regarding the proposed rules for dentistry as drafted by the Department of Licensing and Regulatory Affairs. To that end, please see my specific comments below.

The ATDA has concerns that certain provisions of this proposed rule would inappropriately mandate in-person examination requirements for dentists utilizing teledentistry that would, in effect, defeat many of the benefits of teledentistry. Specifically, the new definition of "patient of record" found in proposed Rule 338.11401 would require that a patient must first have an in-person examination before a dentist may utilize teledentistry technologies in the delegation of duties to aid in the treatment of that patient. The proposed language is in direct conflict with the current standard of care for dentistry and would increase costs and decrease access to affordable, quality oral health care in Michigan. It is also inconsistent with ATDA guidelines on teledentistry. There is no clinical evidence to support the assertion that patients would be safer if an in-person exam is required – particularly given the seemingly arbitrary 24-month schedule. To the contrary, there are numerous clinical studies which prove that teledentistry is just as effective as traditional dentistry at diagnosing and treating many oral conditions and that many exams can be done effectively through teledentistry technology via appropriate delegation to dental auxiliary staff.

Indeed, this rule does not appear to have any grounding in clinical science nor ordinary logic. Michigan law is clear: a provider – including a dentist – can establish a relationship remotely (including through the use of asynchronous technologies), can conduct an appropriate examination using telehealth technologies, can diagnosis and treat the patient remotely, and be

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reimbursed by both private and public insurers for doing so. Yet, with all of this provider discretion clearly articulated in public policy, this rule mandates that a patient be seen in person in order for a dentist to delegate duties to dental auxiliaries that are within their scope of practice. What purpose does restricting a dentist's discretion in making these decisions to delegate – just as they have the discretion to determine which modality of care is appropriate for a particular patient – and limiting the ability of auxiliaries to use their expertise to provide care under the guidance of a Michigan-licensed dentist? Having extensively surveyed the scientific literature on the subject of teledentistry and dentistry generally, I can say with confidence that there is no such clinical reason. Nor is it logical to restrict innovative treatment delivery models that meet the standard of care, are within the scope of practice for the providers, and increase access to care for Michiganders when the same treatment can be done remotely so long as it is done via the treating dentist and not one of their qualified staff.

Furthermore, if the Board were to restrict a provider's ability to delegate duties remotely, what basis in science or fact does the 24-month mark have? Why 24 months and not 12 months? Or 36 months? Simply put: there is no reason – it is an entirely arbitrary timeframe that does nothing to increase patient protection and instead serves to both limit the treating dentist's expert discretion as well as the patient's access to care. If the state is going to restrict access to care, then there should be a clinical basis for it – of which there is none in this instance.

To put it into concrete terms: a Bad Axe patient requests teledentistry care from a Michigan licensed dentist based in Detroit. The dentist performs a remote examination, diagnoses the issue, and creates a treatment plan. The patient then completes the treatment plan and the issue is corrected. Four months later, that same patient contacts that same provider with a new problem; however, this time the treating dentist needs an additional diagnostic test – say, a digital scan. This task can easily and simply be delegated to an auxiliary staff member who is in the Bad Axe area. Unfortunately, should this rule go through, the patient would be required to drive to the dentist's office in Detroit rather than being able to utilize the conveniently located dental auxiliary. In all likelihood, the patient will likely forgo the desired care rather than having to drive the 4+ hours round trip to Detroit.

The proposed rule would restrict access to affordable, quality oral health care by forcing Michigan residents to appear in-person at a dentist's office before being eligible to receive delegated services from dental auxiliaries irrespective of the extent to which the technology used in the examination enables the provider to meet the accepted standard of care for the condition as presented by the patient. Again, there is no evidence to suggest that examinations performed via teledentistry do not meet the established standard of care nor is there any evidence that having a patient visit a dentist in-person once every 24-months effectively does anything to further protect the patient. If not amended, the rule would inhibit access to all dental services by implementing arbitrary and clinically unjustified barriers that would make it

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much harder for patients to receive high-quality, affordable care via teledentistry in a convenient and effective manner.

Every dentist, regardless of delivery method used, is held to the same standard of care. There are dental treatments and services that are inappropriate for teledentistry and delegation; however, there are many that are teledentistry-appropriate tasks and treatments and those should not have an arbitrarily mandated standard enforced upon it. For many treatments, all of the necessary information can be collected through teledentistry technologies – including patient medical/dental history, patient presentation, collections of digital scans, and all other information deemed necessary by the treating dentist to comply with the standard of care.

Of note, we know of no prior in-person requirement for telehealth or teledentistry in any other state. Should this proposed rule go forward, it would make Michigan the most restrictive state in the nation for teledentistry.

Proposed Rule Runs Counter to Michigan Public Policy

The ATDA believes that these proposed rules not only run counter to good public policy generally, but actually also run counter to already established Michigan public policy as well as all the substantive data on oral health access in Michigan.

According to the U.S. Department of Health & Human Service's Bureau of Health Workforces, Health Resources and Services Administration (HRSA), Michigan presently has 244 Dental Health Professional Shortage Areas (DHPSA) as designated by the Department.[1] These designations are used to identify areas and population groups within the United States – and in this instance, Michigan – that are experiencing a shortage of dental health professionals. The primary factor used to determine a DHPSA designation is the number of health professionals relative to the population with consideration of high need. According to this data, over 1.49 million Michiganders live in DHPSAs. This proposed rule, in its current form, would unnecessarily restrict access to care for these Michiganders even further – leaving them with even fewer options than exist now. Surely, it cannot be the intent of the Board nor the Department to deprive the citizens of this state an avenue to receiving needed care – particularly when the teledentistry avenue may be the only one available for hundreds of thousands of Michiganders.

Unfortunately, the Michiganders who are least likely to be able to find an affordable, convenient dental health professional to serve their needs tend to be from minority

[1] Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health & Human Services, Designated Health Professional Shortage Areas Statistics: Designated HPSA Quarterly Summary, as of September 30, 2021 available at https://data.hrsa.gov/topics/health-workforce/shortage-areas

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communities and those with low socioeconomic factors. It is these same communities who would be the most adversely effected by the restrictive language in the proposed rule. According to the *2020 State of Michigan Oral Health Plan* produced by the Michigan Oral Health Coalition, oral health disparities "persist among individuals with a lower socioeconomic status, among minority racial and ethnic groups, and within special populations whose oral health needs and access to care vary from that of the general population."[2] Furthermore, "these groups experience a disproportionate burden of oral health disease due to inadequate access to care, systemic discrimination, and a lack of specialized services that address their particular health needs."[3]

This problem is only exacerbated by the lack of oral health workforce in Michigan. "Currently in Michigan the demand for dentists exceeds the supply, and this shortfall is expected to widen in the next decade" as HRSA "projects that, from 2012 to 2025, the supply of dentists will decrease 11%."[4] In the context of this grim forecast, one can expect that even more Michiganders will fall into DHPSAs and struggle to have their basic oral health care needs met.

However, Michigan policymakers are actively searching for methods to alleviate these disparities. To help combat the issue, the *Michigan State Oral Health Plan* produced by Michigan Department of Health and Human Services specifically outlines teledentistry as a solution to these barriers to care. The Department states that Michigan should "support innovative practice models that utilize cost effective practice solutions such as asynchronous teledentistry."[5] Indeed, they state that the "dental care gap also may be addressed by expanding innovative care options such as offering asynchronous teledentistry, embedding dental professionals in community-based organizations and medical centers…"[6] Should this proposed rule go into effect as presently written, these "innovative models" that the Department wants to explore will be stopped in their tracks before they can make the positive impacts they are designed to provide.

Not only has the Executive branch made their policies towards teledentistry known, but there is also strong evidence that this rule would run contrary to the public policy that the Legislature set out in MCL Section 500.3476. This statute states that any insurance policy, inclusive of dental insurance companies and nonprofit dental care corporations, "shall not require face-to-face contact between a health care professional and a patient for services appropriately

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[2] *2020 State of Michigan Oral Health Plan,* Michigan Oral Health Coalition, 2020, https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder3/Folder2/Folder2/Folder102/Folder1/Folder202/2020_MichiganStateOralHealthPlan_FINAL.pdf?rev=1eca54748529417eaa4f4709aa0eb23e

[3] *Id.*

[4] *Id.*

[5] *Michigan State Oral Health Plan*, Michigan Department of Health and Human Services, 2021.

[6] *Id.*

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provided through telemedicine." This rule would be counter to this policy by explicitly requiring an in-person examination in order for certain tasks to be delegated and, therefore, certain treatments or diagnostic tests be completed.

Lastly, this Department itself has stated that a rule requiring an in-person examination runs counter to the policy goals of the state. The Michigan Board of Dentistry's Rules Committee Work Group, at a September 29, 2020 meeting, refused to include adding the "in-person" requirement language to the definition of "patient of record."

Specifically, the Committee stated: "The Rules Committee does not agree with the comment to add 'in person' to the definition of 'patient of record' as this requirement is inconsistent with the concept of telemedicine and the dentist or dental therapist should be the professional to make the determination of whether they must examine and diagnose the patient in person." The American Teledentistry Association agrees completely with this statement and encourages the Board to renew this policy by removing the in-person requirement language from the definition of "patient of record" in the current proposed rules. There has been no change between now and when these previous rules were filed to indicate a need to add such an arbitrary requirement – indeed, throughout the COVID-19 pandemic, telehealth generally and teledentistry specifically have only become more integrated into our healthcare system and more thoroughly vetted and proven to be a viable method of treatment.

Teledentistry Technology Efficacy

The American Teledentistry Association believes that proposed Rule 338.11401(e) ignores how various forms of technology can be utilized to complete an "appropriate evaluation" by a licensed provider and arbitrarily - and with no clinical evidence – places arbitrary and potentially anticompetitive barriers on an entire suite of technologies that have been utilized for years by practitioners to serve patients in both the oral health as well as in physical and mental health settings. Notably, teledentistry has served patients without any need for a previous in-person encounter.

Telehealth technologies used in the practice of dentistry are, in many cases, just as efficacious as an in-person encounter. Creating a valid provider-patient relationship, diagnosing conditions, and treating patients using teledentistry technologies – including asynchronous technologies – does meet the standard of care for many patient presentations. Similarly, there is no clinical evidence that supports the conclusion that a patient must be seen in-person by the treating dentist before certain tasks can be delegated to dental auxiliary staff. In fact, this will only serve to limit the reach that Michigan licensed providers have which, in turn, will substantially limit access to oral health care for Michigan's most vulnerable communities.

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The scientific and clinical literature regarding teledentistry has found "a consistent trend supporting the efficacy and effectiveness of teledentistry."[7] Indeed, teledentistry is not novel. The US military has been using teledentistry to remotely treat patients since 1994, when a 15-person pilot program entitled "Total Dental Access Project" received periodontal care by digitally, asynchronously transmitting intraoral photos.[8] Technology has come a long way since the 9600-baud modem used in the TDA Project. In fact, nearly 15 years ago a 2007 study found that technology has gotten so accurate that there was "no statistically significant difference between a visual examination and an examination using an intraoral camera," concluding that "the intraoral camera and store-and-forward technology is a feasible and cost-effective alternative to a visual, in-person oral examination for oral disease screening."[9] This same confidence can be found for accepting orthodontic cases. A 2002 study – using technology from two decades ago – found that there was "[c]linician agreement for screening and accepting orthodontic referrals based on clinical photographs is comparable to other clinical decision making" such as in-person examinations.[10] That same study also found that "[c]linical factors are detectable from electronically transferred clinical photographs only."[11] Similarly, another 2002 study shows that a majority of orthodontic consultants support the concept of using teledentistry to make their professional expertise more accessible to dentists and patients.[12]

Teledentistry technologies – both synchronous and asynchronous – have been found to be effective at screening and diagnosing various oral pathogens. These are the same pathogens that would be screened for at an in-person encounter prior to orthodontic treatment. A 2013 literature review which scope included dental caries, orthodontics, endodontics, oral lesions, and screening for oral trauma determined that there is "a trend exists supporting the efficacy and effectiveness of teledentistry," that "[m]any quality studies, including studies with control groups, reported similar or better clinical outcomes when compared to conventional interventions," and that "[t]he use of teledentistry for screening of oral diseases to determine prevalence and treatment needs … is promising."[13] This literature review has been supported by other studies which determined that "[n]o statistical difference was found between

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[7] Susan J. Daniel, RDH, PhD; Lin Wu, MLIS, AHIP; Sajeesh Kumar, PhD, *Teledentistry: A Systematic Review of Clinical Outcomes, Utilization and Costs*, The Journal of Dental Hygiene, Vol. 87, No. 6. December 2013
[8] Elaine Burke, *How did we get here? A brief history of Teledentistry*, Medium, August 10, 2020.
[9] D.T. Kopycka-Kedzierawski, R.J. Billings, K.M. McConnochie, Dental screening of preschool children using teledentistry: a feasibility study, Pediatr. Dent., 29 (2007), pp. 209-213.
[10] Mandall NA. Are Photographic Records Reliable for Orthodontics Screening? J Orthod. 2002;29:125–7.
[11] Mandall NA. Are Photographic Records Reliable for Orthodontics Screening? J Orthod. 2002;29:125–7.
[12] Stephens CD, Cook J. Attitudes of UK Consultants to Teledentistry as a Means of Providing Orthodontic Advice to Dental Practitioners and their Patients. J Orthod. 2002;29:137–42.
[13] Daniel, S., Wu, L., & Kumar, S. (2013). Teledentistry: A systematic review of clinical outcomes, utilization and costs. Journal of Dental Hygiene, 87(6), 345-352.

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teledentistry and clinical screening for dental caries,"[14] that "that remote diagnosis of dental problems based on non-invasive photographs constitute a valid resource for evaluation and diagnosis,"[15] and "that intra-oral cameras are a reliable tool to identify common oral diseases, [and is] useful in assessing other conditions like pre-malignant lesions, recurrent aphthae, gingival recession and dental malocclusion."[16] In fact, another literature review found that "[r]emote diagnosis using transmitted photographic images of dentition (teledentistry) may be an alternative to visual inspection" and that three studies actually found "image analysis to be superior to visual inspection."[17]

A "growing body of evidence supporting the efficacy of teledentistry is provided by some of the studies on pediatric dentistry, oral medicine, orthodontics and periodontics. The majority of the research in these areas reported that teledentistry had similar or better outcomes than the conventional alternative."[18] "Teledentistry had excellent sensitivity (93.8%) and specificity (94.2%) for diagnosing dental pathologies [when compared to] using face-to-face examination as a 'gold standard'" and "was not associated with any serious adverse events."[19] "Teledentistry has excellent accuracy for diagnosing dental pathologies."[20]

Conversely, there have been several clinical studies that found that "the use of full records has not been shown to make large differences to clinical decision making."[21] For instance, review of several studies that examined the efficacy of radiography found that "researchers reported the limited effect radiography has on changing orthodontic diagnosis or treatment plans… [which] questions whether the present use of radiography may be excessive."[22] Additional evidence has found that the "[d]iagnostic value of orthodontic radiographs and indications for their use are

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[14] Kopycka-Kedzierawski DT, Billings RJ. Prevalence of dental caries and dental care utilization in preschool urban children enrolled in a comparative-effectiveness study. Eur Arch Paediatr Dent. 2011;12(3):133-138.
[15] Amavel R, Cruz-Correia R, Frias-Bulhosa J. Remote Diagnosis of Children Dental Problems Based on Non-Invasive Photographs: A Valid Proceeding. In: Adlassnig KP, Blobel B, Mantas J, Masic I, editors. Medical Informatics in a United and Healthy Europe 2009. Amsterdam (Netherlands): IOS Press; 2009. pp. 458–62.
[16] Kalyana Chakravarthy Pentapati, Reliability of intra-oral camera using teledentistry in screening of oral diseases – Pilot study, The Saudi Dental Journal Volume 29, Issue 2, April 2017, Pages 74-77
[17] Inês Meurer M, Caffery LJ, Bradford NK, Smith AC., Accuracy of dental images for the diagnosis of dental caries and enamel defects in children and adolescents: A systematic review, J Telemed Telecare. 2015;21(8):449-458.
[18] Mohamed Estai, A systematic review of the research evidence for the benefits of teledentistry, Journal of Telemedicine and Telecare, 24(3):147-156 · April 2018
[19] Queyroux, Alain et al., Accuracy of Teledentistry for Diagnosing Dental Pathology Using Direct Examination as a Gold Standard: Results of the Tel-e-dent Study of Older Adults Living in Nursing Homes, Journal of the American Medical Directors Association, Volume 18, Issue 6, 528 – 532.
[20] Queyroux, Alain et al., Accuracy of Teledentistry for Diagnosing Dental Pathology Using Direct Examination as a Gold Standard: Results of the Tel-e-dent Study of Older Adults Living in Nursing Homes, Journal of the American Medical Directors Association, Volume 18, Issue 6, 528 – 532.
[21] Mandall NA. Are Photographic Records Reliable for Orthodontics Screening? J Orthod. 2002;29:125–7.
[22] "Use of Ionising Radiation," Selection Criteria for Dental Radiography, Faculty of General Dental Practice, 2020.

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still debatable."[23] And, as stated above in detail, there is no agreed upon minimum record-set for orthodontics, so it seems untenable that the Board would attempt to override legislative intent based on a "standard" that simply does not exist anywhere in the literature.

All of these peer-reviewed studies and programs present conclusive evidence on the efficacy of remote technologies both in the effective diagnosis and treatment of patients who present with oral care conditions. The overly restrictive provisions included in the Board's interpretation of their rules related to teledentistry that require a prior in-office visit of a patient in order to access care through remote technology fail to consider the clinical evidence and decades of practice while unfortunately denying unserved and underserved Michigan patients increased access to affordable quality oral care.

Thank you for the opportunity to comment on the proposed rules. We encourage the Department to revise the proposed rules to eliminate the arbitrary anticompetitive provisions in the interest of expanding Michigander's access to quality oral health care. If you have any questions, feel free to call me at (617) 413-2740. I would be happy to offer any clinical insight that you or your colleagues would like.

Sincerely,

Marc Bernard Ackerman, DMD, MBA, FACD

[23] Aldin Kapetanović, Orthodontic radiology: development of a clinical practice guideline,Head, Neck and Dental Radiology, April 2020.

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August 22, 2022

Department of Licensing and Regulatory Affairs Bureau of Professional Licensing
Boards and Committees Section
Attention: Departmental Specialist
P.O. Box 30670
Lansing, MI 48909-8170

RE: Proposed Administrative Rules for Dentistry – General Rules – Rule Set 2021-40 LR

To whom it may concern,

TechNet is a national, bipartisan network of technology companies that promotes the growth of the innovation economy by advocating a targeted policy agenda at the federal and 50 state level. TechNet's diverse membership includes dynamic American businesses ranging from startups to the most iconic companies on the planet and represents more than four million employees in the fields of information technology, e-commerce, clean energy, gig and sharing economy, venture capital, and finance. TechNet is committed to advancing the public policies and private sector initiatives that make the U.S. the most innovative country in the world.

On behalf of TechNet, I am writing to you in opposition to the Department of Licensing and Regulatory Affairs' proposed rule change to the General Dentistry rules Part 4A, R338.11401 to add language requiring a patient first have an "in-person" examination before a dentist may utilize teledentistry to treat a patient.

Innovative health care technologies like teledentistry reduce costs and improve access to care. By meeting the patient where they are, teledentistry can more efficiently and conveniently deliver care to patients, particularly those in underserved areas. Increased use of teledentistry during the COVID-19 pandemic exhibited the efficacy of this approach without the need for any in-person patient visit requirement.

The proposed rule will reverse much of the positive impact made by teledentistry so far. Requiring an in-person visit prior to any teledentistry care undermines the convenience and cost benefits of remote care. The proposed rule links remote teledentistry to geography, undercutting the ability of teledentistry to reach patients in places that lack traditional, brick-and-mortar dental services. Indeed, according to a 2015 American Dental Association Health Policy Institute study, Michiganders often forgo dental care due to inconveniences related to location and scheduling, or because they simply have trouble finding a dentist.

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THE VOICE OF THE
INNOVATION ECONOMY

It is our belief that teledentistry should be supported as a tool to practice dentistry and ensure consumers have access to affordable healthcare options within the standard of care in Michigan, without an in-person visitation requirement.

We urge the Department of Licensing and Regulatory Affairs Bureau of Professional Licensing to reject this proposed rule amendment.

Sincerely,

Tyler Diers
Executive Director, Midwest
TechNet

August 15, 2022

Department of Licensing and Regulatory Affairs Bureau of Professional Licensing
Boards and Committees Section
Attention: Departmental Specialist
P.O. Box 30670
Lansing, MI 48909-8170

RE: Proposed Administrative Rule Set 2021-40 LR regarding proposed "in-person" teledentistry requirement

To whom it may concern,

SmileDirectClub is a publicly-traded oral care company, headquartered in Nashville, Tennessee, with the first med tech platform for teeth straightening. Dental practices and their affiliated dentists and orthodontists across the country contract with SmileDirectClub to use its non-clinical, administrative dental support organization services ("DSO services") as well as its med-tech platform to treat their patients who suffer from mild to moderate malocclusion with clear aligner therapy using today's remote technology. SmileDirectClub operates in all fifty states as well as in many countries outside the United States. All of the dentists and orthodontists that treat patients using the SmileDirectClub med-tech platform are licensed to practice dentistry in the state where the patient is located at the time of diagnosis and treatment and must have at least 4 years of clinical experience treating patients with clear aligner therapy in a traditional in office setting. Indeed, over 90% of these dentists and orthodontists still maintain their traditional brick and mortar offices in addition to treating patients remotely using the SmileDirectClub med-tech platform. By using SmileDirectClub's DSO services and med-tech platform, these dentists and orthodontists can offer patients clear aligner therapy at a cost of up to 60% less than traditional in office treatment while also ensuring that treatment is just as safe and efficacious as clear aligner therapy in a traditional setting. Prior to SmileDirectClub, orthodontic treatment was available to a mere 1% of the US population as a result of the cost and access barriers that had historically precluded access to this treatment while more than 85% of the population could benefit from teeth straightening. The SmileDirectClub med tech platform has changed that dramatically. In fact, dentists and orthodontists have successfully treated well over one million seven hundred thousand patients with clear aligner therapy for mild to moderate malocclusion using the SmileDirectClub med tech platform and has enabled treatment to consumers residing in 95% of the Health Professional Shortage Areas (dental deserts) since its founding in 2014.

It is also important to note that treatment using the SmileDirectClub telehealth platform is not, by any stretch of the imagination, Do It Yourself ("DIY") dentistry as some competitors and trade associations made up of market participants would have one believe. Each and every clinical decision, including whether a potential patient is a viable candidate for clear aligner therapy using a remote platform and what information is needed to make that diagnosis, is made solely by the dentists and orthodontists

who use the med tech platform and contract for SmileDirectClub's DSO services. Treatment is monitored by these doctors from start to finish, with mandatory check-ins at least every 60 days and more often if requested or required by either the patient or the treating dentist or orthodontist. In fact, statements to the contrary of this fact that were made by the American Association of Orthodontists ("AAO") were found to be unsubstantiated by the National Advertising Division of the Better Business Bureau. Although the AAO agreed to comply with the NAD's recommendation that it cease making statements that treatment through the SmileDirectClub model was not safe, efficacious or that there was not doctor involvement with treatment, it appears that they have not complied but have instead continued to perpetuate unsubstantiated statements designed to protect the pricing control over patient care that the traditional industry has been able to maintain for far too long and to the detriment of consumers.

It is because of the support that SmileDirectClub provides to Michigan-licensed dentists and orthodontists and the importance of expanding access to quality oral health care to those Michiganders that cannot afford the traditional orthodontic price tag or do not have access to an orthodontist as a result of geographic restrictions and/or limited office hours characteristic of traditional dental and orthodontic practices, that SmileDirectClub has an interest in the proposed rule amendment offered by the Department of Licensing and Regulatory Affairs on July 13, 2022 to the General Dentistry rules Part 4A, R338.11401 definition of "Patient of record" so as to add an "in-person" examination requirement to be conducted "at least once every 24 months." To that end, please see SmileDirectClub's full comments below.

The proposed "in-person" examination requirement will be an arbitrary barrier on access to treatment without any basis in evidence

In addition to cost, inadequate access to traditional in-person dental care is a leading factor preventing middle- and lower-income consumers from seeking dental and orthodontic services. In Michigan, 77 of the state's 83 counties have at least one dental shortage area, according to a 2015 Pew Research Trust study, which are largely concentrated in rural and inner-city regions where dental offices are lacking. For lower income Michiganders, the ability to find an affordable dentist and take time out of a busy schedule to attend an appointment can be a significant impediment to pursuing care. In fact, the ADA Health Policy Institute found 35% of low-income Michiganders cite inconvenient location and time for scheduling in-person treatment as a reason for not seeing a dentist in the prior 12 months.

To put it simply, having to visit a dentist in-person is a structural barrier to care for millions of Michiganders.

Inarguably, remote treatment is safe and meets the standard of care for many patient presentations. Scientific and clinical literature regarding remote teledentistry models have found consistent efficacy and effectiveness for teledentistry approaches to patient care. Patients treated over SmileDirectClub's platform experience outcomes consistent with these findings. For nearly a decade, SmileDirectClub has enabled asynchronous, remote care safely and effectively to over 1.7 million patients across the nation, including Michigan. Years of experience and hundreds of thousands of patient success stories clearly show that remote care without in-person visitation works and is critical for improving access and cost of care.

Furthermore, the proposed amendment's 24-month evaluation period is an arbitrary burden on patients that is not grounded in any evidentiary justification. All can agree that protecting patients and supporting the standard of care in Michigan should be central goals of the general rules, but how does a 24-month in-person visitation requirement do this better than a 6, 18, or 36-month visitation requirement? The obvious answer is that any generic timeline simply functions as a blanket application limiting the professional discretion of care providers. Every dentist, regardless of the method used to deliver care, is held to the same standard of care for the entire duration of the patient relationship. Decisions regarding care and when in-person visitation is needed should be made on a case-by-case basis by the treating provider. Many patients never require in-person care to address their needs and teledentistry can be appropriately utilized to meet the standard of care for these patients. Other patients may present cases that are not appropriate for teledentistry and will be directed to an in-office visit on the recommendation of the remote provider based on that provider's professional knowledge. There is no evidence that this current model fails to protect patients, nor any indication that patients would be better served by having to schedule and commute to a brick and mortar dental office for an examination when the standard of care does not otherwise require doing so. Forcing patients to make unnecessary in-person visits also reduces the central benefit of remote care: easier, more convenient access to lower cost quality care.

Finally, the amendment language creates uncertainty as to when the in-person visit is required to take place during the 24-month period in order to establish a "Patient of record" relationship. The proposed language states that a patient of record relationship is created when a patient receives an in-person evaluation resulting in a treatment plan at "least once every 24 months." But the rule does not specify *when* the in-person visit must occur during the 24-month period or if an in-person visit is required at all for patient relationships and treatment plans shorter than 24 months. Given the proposed language, an in-person visit may only be necessary at 23 months and 30 days into the patient provider relationship in order to maintain a "Patient of record" status. It is logical to conclude from the proposed language that patient relationships and treatment plans shorter than 24 months never require an in-person visitation to maintain "Patient of record" status. Certainly, not indicating when in-person visitation is required to occur will invite uncertainty among providers seeking to meet the "Patient of record" definition in order to delegate assignment of care, and whether new treatment plans for the same patients restart the clock.

SmileDirectClub respectfully submits the following recommended language to amend R338.11401(e) removing "in-person" and the arbitrary 24-month time requirement from the proposed amendment:

> *(e) "Patient of record" means a patient who has been examined**, evaluated,** and diagnosed **with a resulting treatment plan** by a dentist**, or dental therapist to the extent authorized by the supervising dentist, in-person at least once every 24 months.** ~~and whose treatment has been planned by a dentist or a patient who has been examined, evaluated, assessed, and treatment planned by a dental therapist to the extent authorized by the supervising dentist.~~ A patient of record includes a patient getting radiographic images by allied dental personnel with training pursuant to R 338.11411(a) after receiving approval from the assigning dentist or dental therapist.*

The Department of Licensing and Regulatory Affairs' proposed rule to add an in-person requirement and arbitrary time mandate for receiving teledentistry care in Michigan is a regressive step in the wrong direction. I urge your department to reject this amendment for the benefit of patients in Michigan.

Respectfully,

Peter Horkan
Vice President, Government Affairs
SmileDirectClub

Oral and maxillofacial surgeons:
The experts in face, mouth and jaw surgery®

American Association of Oral and Maxillofacial Surgeons

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Karin Wittich, CAE
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VIA EMAIL: BPL-BoardSupport@michigan.gov

August 19, 2022

Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing, Boards and Committees Section
Attention: Departmental Specialist
P.O. Box 30670
Lansing, MI 48909-8170

RE: 2021-40 LR

To Whom it May Concern:

On behalf of the 9,000 members of the American Association of Oral and Maxillofacial Surgeons (AAOMS) – and the 206 members practicing in Michigan – we offer comment on the proposed rule changes to found in 2021-40 LR.

Anesthesia is at the core of OMS training and practice. OMS residency education standards require a dedicated 32-week resident rotation on medical and anesthesia service as well as an ongoing outpatient experience in all forms of anesthesia throughout four- to six-years of residency training. OMSs are trained in medical assessment and emergency management on par with our medical colleagues. Our training and ability to deliver treatment safely and affordably to patients via our team model of practice in our offices is unparalleled.

A review of claims data provided by FAIR Health for 2018, 2019 and 2020[1] show that OMSs are the dental specialists providing the overwhelming majority of deep sedation/general anesthesia and IV sedation services in the U.S. to patients who have private dental insurance. Because OMSs provide the majority of dental office-based anesthetic care in the country, they are uniquely qualified to offer informed opinion on this regulation.

[1] Statistics calculated by AAOMS using data from the U.S. Census Bureau and information provided by FAIR Health based on its privately insured dental claims data for calendar years 2018, 2019 and 2020. Of the total 6,240,366 moderate and deep sedation/general anesthesia (DS/GA) cases performed in this period, 79 percent – or 4.911.840 – were delivered by OMSs. In the 1- to 7-year-old age group, OMSs provided 44 percent (16,707) of the total DS/GA cases (38,257). In the 8- to 12-year-old age group, OMSs provided 81 percent (85,919) or the total DS/GA cases (105,791). For moderate sedation, in the 1- to 7-year-old age group, OMSs provided 34 percent (1,439) of the total moderate IV sedation procedures (4,244) and in the 8- to 12-year-old age group, provided 76 percent (10,378) of the total moderate IV sedation services (13,698).

Given the unique training and experience of the OMS, it would be inappropriate to subject an OMS to the standard of any dentist much like it is inappropriate to stipulate an anesthesiologist must follow the standards of a CRNA. We urge the department to consider this point carefully as subjecting a profession to an inapplicable standard of care not only fosters confusion but can jeopardize patient care and access to care.

The AAOMS Parameters of Care[2] reflect the guidelines for treatment and outcome expectations for 11 designated areas of oral and maxillofacial surgery, including Anesthesia in Outpatient Facilities. It is updated regularly to reflect the latest scientific research, surgical technique and policy positions. Additionally, the AAOMS Office Anesthesia Evaluation[3] was designed to ensure that each practicing AAOMS member maintains a properly equipped office and is prepared to use appropriate techniques for managing emergencies and complications of anesthesia in the treatment of the OMS patient in the office or outpatient setting.

Further, these documents, *in addition to* CODA standards, form the basis of all OMS training, from residency through ongoing continuing education. It establishes the basis of not just the OMSs training, but the training of their staff and auxiliaries as well. Thus, the inclusion of these references enhances the standard for the practitioners and their staff.

We would ask the Board to work with the Michigan Society of Oral and Maxillofacial Surgeons to revise 2021-40 LR to not only match other state requirements in this area, but also to recognize the unique expertise of the practitioners that match their level of education and daily practice. We thank you for the opportunity to submit these thoughts and look forward to our continued collaboration on this and other issues affecting dentistry. Please contact Ms. Sandy Guenther of the AAOMS Governmental Affairs Department at 847-678-6200 or sguenther@aaoms.org for questions or additional information.

Sincerely,

J. David Johnson, Jr., DDS
AAOMS President

CC: Frank Farbod, DMD, MD President, MSOMS
Richard Small, Executive Director, MSOMS
Karin K. Wittich, CAE, Executive Director, AAOMS

[2] https://members.aaoms.org/PersonifyEbusiness/AAOMSStore/Product-Details/productId/1518255.
[3] https://members.aaoms.org/PersonifyEbusiness/AAOMSStore/Product-Details/productId/2076557.

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August 12, 2022

Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing— Boards and Committees Section, Attention: Departmental Specialist
P.O. Box 30670
Lansing, Ml 48909-8170

To Whom It May Concern:

I am writing in opposition to the proposed rule change in Part 4A, R 338.11401 (e) of the Dentistry General rules as part of the public comment process.
(e) "Patient of record" means a patient who has been examined, evaluated, and diagnosed with a resulting treatment plan by a dentist, or dental therapist to the extent authorized by the supervising dentist, in-person once every 24 months. ~~and whose treatment has been planned by a dentist or a patient who has been examined, evaluated, assessed, and treatment planned by a dentist therapist to the extent authorized by the supervising dentist.~~ A patient of record includes a patient getting radiographic images by allied dental personnel with training pursuant to R 338.11411(a) after receiving approval from the assigning dentist or dental therapist.

This proposed definition change to "patient of record" would require patients be examined "in-person" before any oral healthcare can be rendered regardless of the patient's unique presentation. I am concerned that this rule will add significant costs and will raise barriers to care for patients - particularly working-class and rural patients who already find it difficult to find a convenient and affordable dentist. If this rule is allowed to go into effect, it will - without any clinical justification - arbitrarily block access to oral healthcare that thousands of our constituents want, need, and deserve.

By unnecessarily mandating an in-person examination — regardless of the standard of care — this proposed change will make accessing oral healthcare even more difficult for the hundreds of thousands of Michiganders that struggle to access regular dental care, instead of easier.

Mandating an initial in-person encounter will only exacerbate the disparity in access to oral healthcare.

The Board of Dentistry Rules Committee considered this very same definition change in 2020. At the September 29, 2020 Board of Dentistry Rules Committee Work Group on these rules, they summarily dismissed an American Association of Orthodontists' proposal to add "in-

person" to the definition of "patient of record." In dismissing the amendment, the Rules Committee stated the following:

"The Rules Committee does not agree with the comment to add "in person" to the definition of "patient of record" as this requirement is inconsistent with the concept of telemedicine and the dentist or dental therapist should be the professional to make the determination of whether they must examine and diagnose the patient in person. "

Considering this, it is unclear as to the reversed course, especially given our COVID-19 pandemic experience and the success we experienced with tele-health. Whatever the cause, I believe that it is (1) not sound public policy, (2) will hurt my constituents by limiting their access to care, and (3) attempting to supplant the Legislature's decision on this issue. Additionally, this would make Michigan the only state in the country with this onerous anti-patient requirement.

It is my hope that the Board will make the necessary amendment to this section of the proposed rules and will remove the in-person examination mandate. Thank you for your consideration on this critical issue and do not hesitate to contact me at any time at 517-373-1706 or at BronnaKahle@house.mi.gov if you have any questions.

Respectfully Submitted,

Bronna Kahle

Bronna Kahle
State Representative
57th District

August 22, 2022

VIA EMAIL BPL-BoardSupport@michigan.gov

Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing
Boards and Committees Section
Attention: Department Specialist
P.O. Box 30670
Lansing, MI 48909-8170

RE: Public Comment on Proposed Rule 2021-40 LR (Dentistry – General Rules)

To Whom It May Concern:

On behalf of Byte, I write to express our opposition to specific changes to the Dentistry – General Rules rule set reflected in Proposed Rule 2021-04 LR ("Proposed Rule"). At Byte, we're on a mission to make the inaccessible, accessible. Byte provides customers access to clear aligner treatments through a nationwide network of experienced dentists and orthodontists. Each treatment plan is reviewed, prescribed and overseen by a dentist or orthodontist who is licensed in the customer's state of residence.

As the Michigan Board of Dentistry (the "Board") is aware, the COVID-19 pandemic exacerbated longstanding inequities especially with respect to affordability and accessibility to health care. Many of the communities that faced social, economic, and geographic barriers to accessing dental care and prior to the pandemic were the same communities that were hardest hit by the pandemic. Fortunately, technology has been a powerful tool in reducing health disparities and profoundly changing the way providers deliver health care and the way patients expect to receive care.

Acknowledging the pivotal role telehealth played in increasing access to health care throughout the pandemic, the Michigan Legislature passed and enacted a package of bills aimed at expanding telehealth in the state. *See* House Bills 5412-5416 (2020) ("Telehealth Package"). In her signing letter to the Legislature, Governor Whitmer emphasized that "the virtues of telemedicine are not unique this moment, so Michiganders will benefit from reduced costs, increased accessibility, and lower transmission rates of infectious diseases at the doctor's office for years to come."[1] Unfortunately, the Proposed Rule could undermine the legislative intent of the Telehealth Package and effectively decrease access to safe and affordable oral health care currently available across the state.

As drafted, Rule 338.11401(e) of the Proposed Rule could be interpreted to require an in-person examination before any dental care can be provided. However, any dentist who seeks to provide services—whether in person or via telehealth modality—to a Michigander would need to be licensed in the state and thus would already be subject to the Dental Board's oversight. Thus, this provision would unnecessarily inhibit access to dental and orthodontic services by implementing arbitrary and clinically unjustified

[1] The Office of the Governor, *Gov. Whitmer Signs Bills Increasing Health Care Access Into Law*, June 24, 2020, https://www.michigan.gov/whitmer/news/press-releases/2020/06/24/gov-whitmer-signs-bills-increasing-health-care-access-into-law.

administrative barriers that would make it much harder for patients to receive high-quality, affordable care via teledentistry in a safe and effective manner.

Moreover, there does not appear to be any clinical or patient safety justification for imposing this requirement. In fact, the Board of Dentistry Rules Committee Work Group expressly rejected a previous attempt to make similar changes to the definition of "patient of record" in 2020.[2] The American Association of Orthodontists proposed adding "in-person" to the definition of "patient of record" and the Rules Committee responded that it:

> does not agree with the comment to add "in person" to the definition of "patient of record" as this requirement is inconsistent with the concept of telemedicine and the dentist or dental therapist should be the professional to make the determination of whether they must examine and diagnose the patient "in person."

Thus, as currently drafted, the Proposed Rule could protect brick-and-mortar practices at the expense of most pertinently low-income, marginalized, and traditionally underserved communities who have utilized teledentistry throughout the pandemic to access the dental and orthodontic care they want and need.

Thank you for the opportunity to comment on the Proposed Rule. We respectfully urge the Board to revise the Proposed Rule to ensure Michiganders continue to have access to the oral health care they enjoyed during the pandemic and beyond.

Sincerely,

Shirley Kim
Director of Government Affairs and Community Relations

[2] *See* Michigan Board of Dentistry Rules Committee Work Group Meeting, Minutes, Sept. 29, 2020, https://www.michigan.gov/-/media/Project/Websites/lara/bpl/Folder45/9-29-20_Dentistry_Rules_Work_Group_minutes_with_attachment.pdf?rev=407b3420c4544ad2af1aff52abf351bb.

Public Comments on Proposed Changes to Dentistry Work Rules

From: Craig C. Spangler, DDS

Comment on 338.11120

Rule 1120: Does the word "maintain" mean write and enter or does it mean keep physical possession of the record. Can this be clarified?

Rule 1120 (2) (c): This should read "Diagnosis and treatment plan as determined by the dentist." No other dental professional can diagnose. Without a diagnosis, there is no treatment plan. CODA standards dictate that dental therapists are trained to identify, evaluate, and assess. The word diagnose is never used in the CODA standards for Dental Therapy Programs. Diagnosis and treatment planning is a duty that cannot be delegated, or may be delegated. I believe there is a conflict between what the law says and what dental therapists are trained to do. The alternative is to put a training requirement regarding treatment planning in the rules for dental therapists. It would be unsafe to have any dental professional licensed to do something they are not trained to do especially if they are miles from the contractually obligated dentist. It is contrary to the intent of the administrative rules.

Comment on 338.11247

Rule 338.11247 (3) Clinical Academic License

There are two comments that I would like to make regarding this category of licensure. The first is that I believe that they should also have to complete the same Dental Continuing Courses as the unrestricted license holder in each professional category. While these licenses are for one year, they should be responsible for one third of the CE requirements for the full license holder in the category. As many of the license holders in this category are dental school faculty, they become insulated from knowledge in other areas of dentistry and

dental practice. This hinders their ability to work with predoctoral students and have current information in all areas of dentistry, not just the area in which they work. This has led to a group of faculty that are not invested in helping predoctoral students successfully transition to private practice.

My second comment is that we need to restrict the number of academic license holders sponsored by any one educational institution to 50. This licensure category has been abused to the detriment of the dental students in Michigan dental schools. Predoctoral students are seeking mentors who have practiced in a clinical setting in Michigan. If we are to provide more dentists to the State of Michigan, it will be by having full time faculty as role models that have worked in private practice in Michigan. Most of the licensees in this category are not invested in understanding and developing what is good for the people of the State of Michigan. This over reliance on Academic Clinical licenses also hinders the opportunities of dentists who have actively practiced in Michigan, passed the ADEX/CDCA or its equivalent, and wish to teach predoctoral students.

Comment on 338.11617

1a. The use of "telehealth" should be limited to "patients of record" as defined elsewhere in the rules. This would define a "patient of record" as someone who has been examined in person within the past 3 years. If they are a patient of record of the dentist or dental therapist, they could be treated by telehealth.

4 c. The use of the word "diagnose" is inappropriate. No one can diagnose with an image (unless it is a microscopic image of the patient's biopsied tissue). The use of telehealth can "identify" but it cannot diagnose. If the word "diagnose" is included in the statement that starts "Verify that telemedicine is appropriate to evaluate, diagnose……." this statement will never be true.

Curtis S. VanderWall
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THE SENATE
STATE OF MICHIGAN

August 11, 2022

Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing– Boards and Committees Section,
Attention: Departmental Specialist
P.O. Box 30670
Lansing, MI 48909-8170

Greetings!

I am writing in opposition to the proposed rule change in Part 4A, R 338.11401 (e) of the Dentistry General rules as part of the public comment process.

> (e) "Patient of record" means a patient who has been examined, **evaluated,** and diagnosed **with a resulting treatment plan** by a dentist, **or dental therapist to the extent authorized by the supervising dentist, in-person at least once every 24 months.** ~~and whose treatment has been planned by a dentist or a patient who has been examined, evaluated, assessed, and treatment planned by a dental therapist to the extent authorized by the supervising dentist.~~ A patient of record includes a patient getting radiographic images by allied dental personnel with training pursuant to R 338.11411(a) after receiving approval from the assigning dentist or dental therapist.

This proposed definition change to "patient of record" would require patients be examined "in-person" before any oral healthcare can be rendered regardless of the patient's unique presentation. I am concerned that this rule will add significant costs and will raise barriers to care for patients - particularly working-class and rural patients who already find it difficult to find a convenient and affordable dentist. If this rule is allowed to go into effect, it will - without any clinical justification - arbitrarily block access to oral healthcare that thousands of our constituents want, need, and deserve.

By unnecessarily mandating an in-person examination – regardless of the standard of care – this proposed change will make accessing oral healthcare *even more* difficult for the hundreds of thousands of Michiganders that struggle to access regular dental care, instead of easier.

Mandating an initial in-person encounter will only exacerbate the disparity in access to oral healthcare.

The Board of Dentistry Rules Committee considered this very same definition change in 2020. At the September 29, 2020 Board of Dentistry Rules Committee Work Group on these rules, they summarily dismissed an American Association of Orthodontists' proposal to add "in-person" to the definition of "patient of record." In dismissing the amendment, the Rules Committee stated the following:

> *"The Rules Committee does not agree with the comment to add "in person" to the definition of "patient of record" as this requirement is inconsistent with the concept of telemedicine and the dentist or dental therapist should be the professional to make the determination of whether they must examine and diagnose the patient in person."*

Considering this, it is unclear as to the reversed course, especially given our COVID-19 pandemic experience and the success we experienced with tele-health. Whatever the cause, I believe that it is (1) not sound public policy, (2) will hurt my constituents by limiting their access to care, and (3) attempting to supplant the Legislature's decision on this issue. Additionally, this would make Michigan the only state in the country with this onerous anti-patient requirement.

It is my hope that the Board will make the necessary amendment to this section of the proposed rules and will remove the in-person examination mandate. Thank you for your consideration on this critical issue. Please feel free to contact me with any questions you may have.

Sincerely,

Senator Curtis S. VanderWall, Chair
Senate Health Policy Committee
35th District

Curtis S. VanderWall
STATE SENATOR, 35TH DISTRICT
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Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing– Boards and
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Attention: Departmental Specialist
P.O. Box 30670
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MICHIGAN HOUSE OF REPRESENTATIVES
ANGELA WITWER
STATE REPRESENTATIVE

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Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing– Boards and Committees Section,
Attention: Departmental Specialist
P.O. Box 30670
Lansing, MI 48909-8170

Dear Director Hawks:
I am writing in opposition to the proposed rule change in Part 4A, R 338.11401 (e) of the Dentistry General rules.

> (e) "Patient of record" means a patient who has been examined**, evaluated,** and diagnosed **with a resulting treatment plan** by a dentist**, or dental therapist to the extent authorized by the supervising dentist, in-person at least once every 24 months.** ~~and whose treatment has been planned by a dentist or a patient who has been examined, evaluated, assessed, and treatment planned by a dental therapist to the extent authorized by the supervising dentist.~~ A patient of record includes a patient getting radiographic images by allied dental personnel with training pursuant to R 338.11411(a) after receiving approval from the assigning dentist or dental therapist.

This proposed definition change to "patient of record" would require patients be examined "in-person" before any oral healthcare can be rendered regardless of the patient's unique presentation. I am concerned that this rule will add significant costs and will raise barriers to care for patients - particularly working-class and rural patients who already find it difficult to find a convenient and affordable dentist. If this rule is allowed to go into effect, it will - without any clinical justification - arbitrarily block access to oral healthcare that thousands of our constituents want, need, and deserve.

By unnecessarily mandating an in-person examination – regardless of the standard of care – this proposed change will make accessing oral healthcare *even more* difficult for the hundreds of thousands of Michiganders that struggle to access regular dental care. According to Pew Research, more than 1.7 million residents of the state live in areas with dentist shortages. Furthermore, the Centers for Medicare & Medicaid Services reports that 58% of Michigan children on Medicaid—more than 630,000 kids—did not see a dentist in 2019. The American Dental Association's Health Policy Institute, in a survey study of Michigan patients, found that 25% of Michiganders avoided smiling due to the condition of their mouth and teeth – with that number jumping to 41% for low-income residents. And for those Michiganders who have not seen a dentist in the past 12 months, 51% did not do so because of cost and 34% did not do so because they could not find a convenient location or time to visit the dentist. Similarly, these categories have even more drastic disparities for low-income residents.

Mandating an initial in-person encounter will only exacerbate the disparity in access to oral healthcare.

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MICHIGAN HOUSE OF REPRESENTATIVES

ANGELA WITWER

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The Board of Dentistry Rules Committee considered this very same definition change in 2020. At the September 29, 2020 Board of Dentistry Rules Committee Work Group on these rules, they summarily dismissed an American Association of Orthodontists' proposal to add "in-person" to the definition of "patient of record." In dismissing the amendment, the Rules Committee stated the following:

> *"The Rules Committee does not agree with the comment to add "in person" to the definition of "patient of record" as this requirement is inconsistent with the concept of telemedicine and the dentist or dental therapist should be the professional to make the determination of whether they must examine and diagnose the patient in person."*

It is unclear why the Board has reversed course, especially given our COVID-19 pandemic experience and success with tele-health. Whatever the cause, I believe that it is (1) not sound public policy, (2) will hurt my constituents by limiting their access to care, and (3) attempting to supplant the Legislature's decision on this issue. Additionally, this would make Michigan the only state in the country with this onerous anti-patient requirement.

It is my hope that the Board will make the necessary amendment to this section of the proposed rules and will remove the in-person examination mandate.

Thank you for your consideration on this critical issue. If you have any additional questions, please let me know.

Most Sincerely,

Representative Angela Witwer
Minority Vice Chair, House Health Policy Committee
Michigan House District 71

Catlin, Kimberly (LARA)

From: Beavers, Heather (DHHS)
Sent: Thursday, August 18, 2022 4:26 PM
To: Ditschman, Andria (LARA); BPL-BoardSupport
Cc: Farrell, Chris (DHHS); Sutton, Sandy (DHHS-Contractor); Suddeth, Erin (DHHS-Contractor)
Subject: Public Comment Dentistry - General Rules

Hello,

We appreciate all the time and efforts put forth by LARA and the Board of Dentistry to create this new document.

I am submitting comments on behalf of the Michigan Oral Health Program for the Dentistry – General Rules.

1. We suggest that all pronouns be changed to they or their to be gender neutral.

2. Regarding the new infection control requirement, we suggest adding "the current version" before the Centers for Disease Control and Prevention's infection control guidelines.

3. On page 36, Under definitions Section(e) Patient of Record – we recommend deleting "in-person". We are especially concerned with the dental workforce shortages and rural areas in Michigan that geographically limit access to care(including persons in nursing homes that have limited or no mobility). Including this requirement in the definition will negatively impact the people that need dental care the most.

4. We also recommend that anyone who is part of the dental team, has a license with LARA and works at an underserved clinic(ex. FQHC) receive a determined amount of CEUs for working with the underserved population. Although this statement is a bit vague, there are other disciplines where this already happens and the policy could be replicated.

Please reach out with any questions or clarification that you may need. Thank you for your consideration.

Kind Regards,

Heather Beavers MM, RDH
Early Childhood Oral Health Specialist
Division of Child & Adolescent Health
Michigan Oral Health Program
Michigan Department of Health and Human Services

Catlin, Kimberly (LARA)

From: Tseng, Irene (LARA-BoardMember)
Sent: Friday, August 19, 2022 11:20 AM
To: Ditschman, Andria (LARA)
Cc: Johnston, Mark (LARA-BoardMember)
Subject: Rules Comments

Hello,

The Rules committee should consider the following points:

- In R 338.11411(3)(bb), the delegation table, change the reference to absorbent points to paper points for consistency with language used in the RDA test.
- Modify references from CDCA-WREB to CDCA-WREB-CITA throughout the document.
- In R 338.11411(2), modify the last few words of the last sentence to – "under section 16611 of the code, MCL 333.16611, **and** as provided in Table 1."
- In R 338.11501(4), modify (c) and (d) or combine, as they seem repetitive. Modify as follows: "(c) Hold at least a master's degree in a specialty listed in subrule (4) of this rule, that is recognized in Canada, from a dental institution that is recognized through an accreditation process approved by the NDEB or CDAC, with all training completed in Canada."
- R 338.11701(3), address how many CE hours are required if a licensee holds two specialty licenses. I don't think it is unreasonable to require 20 hours of CE PER specialty license each licensing cycle.
- Consider adding more explanation of what is required in the jurisprudence and ethics courses or consider allowing the Board CE committee to review the contents of courses that are offered to fulfill this requirement.

Irene Tseng

Catlin, Kimberly (LARA)

From: Ditschman, Andria (LARA)
Sent: Monday, August 29, 2022 7:34 PM
To: Ditschman, Andria (LARA)
Subject: FW: Comments Necessary for Public Hearing

From: Johnston, Mark (LARA-BoardMember) <JohnstonM13@michigan.gov>
Sent: Friday, August 19, 2022 9:58 AM
To: Ditschman, Andria (LARA) <DitschmanA@michigan.gov>; Tseng, Irene (LARA-BoardMember) <TsengI@michigan.gov>
Subject: Re: Comments Necessary for Public Hearing

Here is the revised edition, credit to U of D/M for the initial wording.

Dental providers must be aware of the legal and ethical principles that guide patient care, professional interactions, and record keeping. The first portion of any presentation should review core ethical principles and their guidance to address frequently encountered ethical dilemmas. The second portion of any presentation should discuss critical legal concepts, including contracts, intentional and unintentional torts, informed consent, and informed refusal. Ethical principles often serve as the foundation of legal obligations. Thus, the intersection of law and ethics will be integrated into the presentations.

Presentation objectives:

1. Describe five key ethical principles; autonomy, beneficence, justice, veracity, and non-maleficence, and the guidance they provide to dental providers.
2. Describe fundamental legal principles important to dental providers, including contracts, intentional and unintentional torts, informed consent, and informed refusal.
3. Emphasize the importance of record keeping, include specific examples of what content should be included, including a template that can be modified to meet individual needs.
4. Present a framework to resolve frequently encountered ethical dilemmas.

Mark M Johnston DDS
Board of Dentistry
c:517/290-5578

Catlin, Kimberly (LARA)

From: Spangler, Craig (LARA-BoardMember)
Sent: Monday, August 15, 2022 4:35 PM
To: Ditschman, Andria (LARA)
Subject: Public Comment on Proposed Rules
Attachments: Public Comments on Proposed Changes to Dentistry Work Rules Spangler 7.17.22 .docx

Hello Andria,

I have attached my comments on the rules for entry into the public comments relating to the proposed rules. Thank you for making sure I did it in a timely way.

Craig Spangler

Catlin, Kimberly (LARA)

From: Misty Davis <mdavis@mpca.net>
Sent: Monday, August 22, 2022 12:26 PM
To: Ditschman, Andria (LARA)
Subject: Rules comment

Good morning,

I would like to submit the following proposed change to rule R 11209:

(b) Pass **all parts,** ~~the comprehensive, competency-based clinical examination developed and scored by~~ **written and clinical, of the ADEX examination that is conducted by** the CDCA**-WREB, a successor organization, or by another regional testing agency,** or an examination that is substantially similar as determined by the Board to the ADEX examination, with a passing converted score of not less than 75 on each component of the examination.

Justification: Language limited to a specific entity can potentially create unnecessary barriers for dental therapists graduating from regions that use other entities. For example, dental therapists graduating from the CODA-accredited dental therapy program at Ilisagvik Tribal College are not required to take CDCA-WREB exams. An accessible pathway to Michigan licensure should allow for the Board to accept substantially similar exams conducted by other entities.

Thank you,

Misty Davis, RDH, BS
Oral Health Program Manager
517.827.0879 (Office)
mdavis@mpca.net

mpca THE VOICE OF COMMUNITY HEALTH CENTERS

Catlin, Kimberly (LARA)

From: Amy Zaagman <azaagman@mcmch.org>
Sent: Monday, August 22, 2022 1:37 PM
To: BPL-BoardSupport; Ditschman, Andria (LARA)
Subject: Comment to Dentistry - General Rules (MOAHR #2021-40 LR)

Please accept the following comments to the proposed Dentistry – General Rules:

We would request that rule R 11209 be changed to read

(b) Pass **all parts,** ~~the comprehensive, competency-based clinical examination developed and scored by~~ **written and clinical, of the ADEX examination that is conducted by** the CDCA**-WREB, a successor organization, or by another regional testing agency,** or an examination that is substantially similar as determined by the Board to the ADEX examination, with a passing converted score of not less than 75 on each component of the examination.

Justification: Language limited to a specific entity can potentially create unnecessary barriers for dental therapists graduating from regions that use other entities. For example, dental therapists graduating from the CODA-accredited dental therapy program at Ilisagvik Tribal College are not required to take CDCA-WREB exams. An accessible pathway to Michigan licensure should allow for the Board to accept substantially similar exams conducted by other entities.

Thank you,
Amy Zaagman

Amy U. Zaagman
Executive Director
517-482-5807 - office
517-230-1816 - mobile
www.mcmch.org

Amy U. Zaagman
Executive Director
517-482-5807 - office
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Catlin, Kimberly (LARA)

From: Ditschman, Andria (LARA)
Sent: Tuesday, August 30, 2022 2:16 PM
To: Ditschman, Andria (LARA)
Subject: FW: Dental and Dental Hygiene Licensure in Michigan

From: Richael Cobler <richael@crdts.org>
Sent: Monday, August 22, 2022, 12:55 PM
To: Gumbrecht, Amy (LARA) <GumbrechtA@michigan.gov>
Subject: Dental and Dental Hygiene Licensure in Michigan

Dear Director Gumbrecht,

I am the Executive Director for Central Regional Dental Testing Service, Inc. (CRDTS) and recently came across this document Acceptable-Dentistry-Exams.pdf (michigan.gov) under Licensing Information on the Michigan Board of Dentistry website. CRDTS was unaware of this recent change to exclude the CRDTS examinations as a pathway toward dental and dental hygiene licensure.

As the CRDTS dental and dental hygiene exams are "substantially equivalent to the ADEX examination" pursuant to R 338.11255 and R 338.11259, we formally request that Michigan revisit this matter. I would like to send a representative of CRDTS to the next Michigan Board of Dentistry meeting to give a presentation to the board and discuss the matter with them. I note on the board website that there will be a meeting October 12, 2023. Please advise if CRDTS can be included on the agenda for that meeting.

As you know portability for candidates seeking licensure is an important matter. Restricting acceptance of licensure examinations to one agency creates an undue burden for candidates. With the merger of CDCA, WREB and CITA, we at CRDTS have a deep concern about monopolization of the testing industry. I'm sure the board will agree that a monopoly is not in the best interest of the Dental Board, the candidates, or the professions. We would appreciate the opportunity to discuss the board's decision and the criteria used in coming to this decision.

I look forward to hearing from you at your earliest convenience regarding a CRDTS presentation to the Michigan Board of Dentistry at the October meeting.

Thank you in advance.

Richael "Sheli" Cobler
Executive Director
Central Regional Dental Testing Service, Inc.
1725 SW Gage Blvd. | Topeka, KS | 66604
785.273.0380 | richael@crdts.org
www.crdts.org

Catlin, Kimberly (LARA)

From: BPL-BoardSupport
Sent: Monday, August 22, 2022 7:13 AM
To: Ditschman, Andria (LARA)
Subject: FW: Board of Dentistry Rule Changes comments
Attachments: MDAA Proposed Rules Comments Aug 22, 2022.pdf

From: Kimberly Hoppes <kaweber11@hotmail.com>
Sent: Sunday, August 21, 2022 8:34 PM
To: BPL-BoardSupport <BPL-BoardSupport@michigan.gov>
Subject: Board of Dentistry Rule Changes comments

Dear Department Analyst,

Please find attached comments regarding the proposed changes to the Administrative Rules for Dentistry.

Sincerely,

Kimberly Hoppes, CDA, RDA
President
Michigan Dental Assistants Association

Michigan Dental Assistants Association

MDAA
Kim Hoppes, CDA, RDA, President
PO Box 118
Lennon, MI 48449

August 20, 2022

Michigan Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing– Boards and Committees Section
Attention: Departmental Specialist
P.O. Box 30670
Lansing, MI 48909-8170

Dear Department Specialist,

The Michigan Dental Assistants Association appreciates the opportunity to comment on the proposed rules for dentistry and we commend the Department, the members of the Board of Dentistry and the Rules Committee for all their hard work for the profession of dentistry. Our comments are as follows.

1) **Rule 338.11411** which would require the dentist employer to verify that their unregistered dental auxiliary has obtained CPR and infection control training prior to being delegated functions. We commend the department and board for taking very seriously the need to assure that the public is being treated by knowledgeable and competent staff.
   MDAA feels that that there is a large disconnect which occurs when new on the job trained assistants are hired and feel that there is a need for them to know the duties they can perform and under what level of supervision. We therefore recommend the following:

Add a (c) The employer dentist must provide the unregistered dental auxiliary with a current copy of the delegation of duties chart and the dentist must explain the levels of supervision.

Rationale: Many on the job trained assistants never see a chart of allowable duties and this is considered a very weak link in our profession. In addition, this may assist in reducing the number of duties being performed outside their scope of practice and will in turn potentially reduce the potential for causing patient harm. The MDAA specifically wants this statement to say that the dentist must provide and explain the duties chart rather than put this off on another employee to do. Since review of duties annually is now required for all licensed dental professionals, it is important that the unlicensed also acquire this knowledge as well.

2. On the proposed changes to the delegation of duties chart (a) MDAA is not in favor of lowering the level of supervision from General to Assignment allowing the unlicensed dental auxiliary to expose radiographs when the dentist is not on the premise **unless** the proposed change to Rule 338.11411 above remains in the language.

   Rationale: MDAA feels that if any dental professional is going to see a patient potentially alone in the office that they must have CPR training to be prepared to deal with medical emergencies, have infection control training and as mentioned above also know the allowable duties.

3. R 338.11704 (1) (a) in the chart of Acceptable Continuing Education activities.
   MDAA takes providing CE to dental professionals very seriously and works hard to provide CE that increases dental knowledge. We would like to comment on the statement in the box that says "A continuing education program or activity is **approved**, regardless of the format in which it is offered, if it is approved or offered for continuing education credit by any of the following:"

   We feel that just having the word "approved" is kind of misleading when it is widely known that there are coursed provided by organizations that do

not meet the states standard for acceptable continuing education. The word “approved” makes it sound as if anything MDA/MDAA/MDHA puts on would be accepted by the department if a dental professional was audited for CE compliance. This is addressed for other entities wanting to provide CE who have to go through a review of their CE program and the department can deny a program, but we feel that the statement used in R 338.11704 (3) (c) would also be appropriate in section (1) (a) in the chart:

(c) A course or program must substantially meet the standards and criteria for an acceptable category of continuing education under this rule and must be relevant to ~~health care~~**healthcare** and advancement of the licensee’s dental education.

Rationale: Inserting this statement would help better direct organizations to only provide CE that would be acceptable .

Again, thank you for reviewing our comments and should you have any questions regarding our suggestions please reach out to me.

Sincerely,

Kim Hoppes, CDA, RDA
MDAA President
517-526-2155
kaweber11@hotmail.com

From:	Nawrocki, Gianna
To:	BPL-BoardSupport
Cc:	Mick, Nathan; Nathan Thomas; Ditschman, Andria (LARA)
Subject:	Public Comment- Dentistry General Rules
Date:	Monday, August 22, 2022 3:51:31 PM
Attachments:	image001.png AAO and MAO Public Comments- Michigan.pdf

Hello,

Please see the attached public comments submitted on behalf of the American Association of Orthodontists and the Michigan Association of Orthodontists regarding Rule Set 2021-40 LR, Dentistry-General Rules. We appreciate the opportunity to submit comments.

Thank you,
Gianna

Gianna Nawrocki
Government Affairs Associate
314-292-6527
401 N Lindbergh Blvd, St. Louis, MO 63141

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August 22, 2022

Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing– Boards and Committees Section
Attention: Departmental Specialist
P.O. Box 30670 Lansing, MI 48909-8170

VIA E-MAIL: BPL-BoardSupport@michigan.gov

Dear Michigan Department of Licensing and Regulatory Affairs:

This letter is sent on behalf of the American Association of Orthodontists ("AAO") and the 450 Michigan orthodontists, who are members of both the AAO and Michigan Association of Orthodontists ("MAO") to provide comments on the proposed rule changes to 338.11101 - 338.11821 Administrative Rules for Dentistry- General Rules, as published in the July 18th, 2022, issue of the Michigan Register. We appreciate the opportunity to provide further feedback.

I. SPECIALTY ADVERTISING

The AAO supports regulations that require those who are advertising as "specialists" to have successfully completed a post-doctoral program in a program that is accredited by an accreditation agency recognized by the U.S. Department of Education (U.S. DOE), i.e. CODA. CODA is the only nationally recognized accrediting body for educational institutions in dentistry and the related dental fields, receiving its accreditation authority from the acceptance of all stakeholders within the dental community and recognition by the United States Department of Education. The AAO is opposed to dentists with less education and training being able to advertise on the same level or in the same manner or with similar words used to describe those true specialists who have graduated from accredited programs that receive accreditation from an agency recognized by the U.S Department of Education (U.S. DOE), as the AAO believes it is not in the best interest of patients' health and safety.

An accreditation standard backed by the U.S. DOE best assures Michigan citizens that an individual who truthfully designates himself or herself as a specialist has met high standards for education and training. Allowing a dentist to advertise as a "specialist" without completing a multi-year accredited program backed by the U.S. DOE, risks diluting Michigan's "specialty" laws and allowing certain providers, who do not have years of supervised clinical and didactic training and/or who have not satisfied extensive criteria, to advertise on par with those providers who have long term, comprehensive education and training through U.S. DOE accredited programs. Such dilution threatens the health and safety of Michigan patients by obscuring important distinctions between dental professionals as well as their respective educational and training backgrounds. As such, the AAO supports the proposed rule R 338.11501 Specialties (2) that require that, "Each branch of a dental specialist that is licensed by the board is defined in the rules, and by the standards set forth by CODA under R 338.11301."

II. PATIENT OF RECORD DEFINITION

We propose adding language to Part 4, Delegation and Supervision, R 338.11401 Definitions, (e) "Patient of Record." The AAO supports language to clarify that performing an in-person examination must occur prior to dental, and especially orthodontic, treatment because it would allow the treating dentist to more fully understand what is going on beneath the gums (impacted teeth, bone loss, etc.), seek to avoid complications, and in the case of orthodontists, determine if patients are suitable candidates for orthodontic treatment. The AAO believes there are certain diagnoses and evaluations that can only be performed in-person or are best performed in-person (x-rays, etc.) during an examination, and the AAO believes that dental treatment, especially the movement of teeth via orthodontic treatment, should not be undertaken without sufficient diagnostic information obtained during such an examination. The AAO's proposed revisions are in red.

(e) "Patient of record" a patient who has been examined**, evaluated,** and diagnosed **with a resulting treatment plan** by a dentist**, or dental therapist to the extent authorized by the supervising dentist, in-person at least once every ~~24 months~~. 12 months.**

III. DELEGATED AND ASSIGNED DENTAL PROCEDURES FOR ALLIED DENTAL PERSONNEL

Similar to orthodontists in many other states, Michigan dentists are feeling the effects of a shortage of workforce, and specifically, are having a difficult time finding and hiring dental assistants, and more specifically, orthodontic assistants. As the Dental Administrative Rules currently state, and present in the current Draft rule changes, only Registered Dental Assistants (RDAs) are allowed to carry out many of the tasks orthodontists require, and yet, RDAs are not trained to accomplish these tasks. Becoming an RDA requires a two-year degree or certificate from a CODA-accredited program in advanced general dentistry techniques, a Board exam, a background check, licensure application, annual CE requirements and associated costs. Dental assistants today who frequently complete a 12-month Dental Assisting class at a Community College at their own expense–and with specialty-specific training from the orthodontist/dentist or from a specific orthodontic assistant training program can be better suited for tasks specific to an orthodontist's office.

Also, RDAs would need to complete additional specialty training to understand how to work for an orthodontist, and there are not enough RDAs available to serve as orthodontic assistants in Michigan. Becoming a dental assistant is a much easier path for the dental workforce. It requires a course in dental radiography (with equipment not used in a specialty office) but is part of the dental assisting classes before a dental assistant can begin on-the-job specialty training.
All orthodontists became general dentists prior to completing a 2–3-year residency to become orthodontists. Dentists understand RDAs are ideal for general dental practice with expanded clinical training and privileges. However, RDA's do not have training in orthodontic band size selection and fitting; the clinical difference in twin brackets; clear brackets; acrylic verses ceramic brackets; auto-ligation brackets; lingual brackets; wire ties verses elastomeric modules; arch wire placement; safety/treatment concerns of round wire vs. rectangular wire; sizing and

placement of coil spring; utilization of FORSUS and Carriere appliances; elastic placement; placement of Kobiashi hooks; placement of temporary aligner attachments; critical inspection of aligner fit; aligner hygiene instruction; retainer clasp adjustment; digital panorex; lateral and A-P cephalometric radiography; activation of temporary skeletal anchorage devices (TADs); and critical clinical photography.

The current Rules and the Draft rules changes do not address these concerns and specifically prohibit dental assistants, who might be specifically trained in orthodontics, from safely completing tasks. Yet, untrained RDAs do have the authority.

In an orthodontist's office, it is commonplace that both an RDA and dental assistant, without any specific training outside of the training and education required, would need the same amount of teaching and practice in orthodontic procedures once in an orthodontist's office. Since dental assistants have a shorter pathway to become eligible to work in a dental office, allowing dental assistants to perform certain orthodontic tasks under direct supervision is not only a practical request, but it is one solution to help the workforce issues Michigan dentists are facing.

To better meet the needs of modern orthodontic practices, the AAO and MAO advance the following delegated and assigned dental procedures changes for Unlicensed Dental Auxiliaries (UDA). We believe that with the required education and proper training, UDAs can, and are able to, perform the outlined tasks under the direct supervision of a dentist without jeopardizing patient safety or care.

Expanding the authority of UDAs to perform the orthodontic tasks outlined above and under the direct supervision of an orthodontist supports patient health and safety. through the in-office and third-party training being provided to orthodontic dental assistants. The requested changes are consistent with equivalent auxiliaries and their allowable duties in several other states, including Illinois, Wisconsin[1], and Ohio. Unfortunately, Michigan's Rules do not reflect this reality.

We ask that you consider allowing orthodontic tasks to be delegated to the proposed UDA, currently Dental Assistant, (with Direct Supervision) rather than only RDAs. Currently, Dental Assistants are not permitted to do those tasks. This will help address the acute shortage of orthodontic assistants (RDAs) in the Michigan workforce and incentivize more individuals becoming a dental assistant We ask that you consider the following changes to Table 1 - Delegated and Assigned Dental Procedures for Allied Dental Personnel to allow dental assistants—or proposed unregistered dental auxiliaries- to perform certain orthodontic tasks under direct supervision. Our proposed changes are also displayed in Table 1 - Delegated and Assigned Dental Procedures for Allied Dental Personnel

1. Changing items (h), (i), (j), (k), (l), and (~~z~~**y**) to "D", Direct Supervision, would allow orthodontically trained Dental Assistants to safely perform these tasks under the direct supervision of their orthodontist.
2. Keep (w) Temporarily cementing and removing temporary crowns and bands, and add "A", Assignment, to UDAs

3. Changing item (~~m~~n) to "A" would allow orthodontic assistants to provide counseling to patients for optimal oral health and diet with multiple orthodontic and orthopedic therapies.
4. Modifying item (v) and deleting "and bands" as that is redundant to item (e).
5. To better meet the needs of modern orthodontic practices the MAO advances the following delegated and assigned dental procedures changes for Unlicensed Dental Auxiliaries (UDA). The

Table 1 - Delegated and Assigned Dental Procedures for Allied Dental Personnel

	UDA	RDA	RDH	Procedure
(h)	D	D	A	Removing orthodontic bands, brackets, and adhesives with ~~non-tissue cutting~~ **hand** instruments **only**. **Use of high-speed rotary instruments is not in the scope of practice of a UDA, RDA, or RDH.**
(i)	D	A	A	Polishing ~~specific~~ **assigned** teeth with a slow-speed rotary hand piece immediately before ~~a procedure that requires~~ acid **procedure** ~~etching before placement of sealants, resin-bonded orthodontic appliances, and direct restorations~~. (IL allow)
(j)	D	G*~~–~~	G*	Etching and placing adhesives before placement of orthodontic brackets and attachment for aligners.
(k)	D	D	D	Cementing orthodontic bands or initial placement of orthodontic brackets and attachments for aligners.
(l)	D	A	~~–A~~	Removing excess **temporary** cement from supragingival surfaces of a tooth with ~~a non-tissue~~ ~~cutting instrument~~ **with hand instruments only**.
(~~z~~**y**)	D	G*	A	Taking impressions for intraoral appliances including bite registrations.

These changes would not impact the defined privileges for Registered Dental Assistants or Hygienists. Instead, they would allow specialist dental assistants and trained dental assistants to accomplish tasks under the appropriate level of supervision. These modifications to the current Draft Changes of LARA's Dentistry General Rules help create workforce solutions will improve access of patient care to specialty services.

Thank you again for the opportunity to provide comments on the proposed rules. If you or your staff have any questions or would like to discuss our proposed changes, please contact the MAO's representative, Mr. Kevin McKinney, at Kevin McKinney, kevin@mckinneyandassociates.net or the AAO's Government Affairs Associate, Gianna Nawrocki, at ghnawrocki@aaortho.org.

Sincerely,

Nathan Mick
Director of Advocacy, State and Federal

Nathan E. Thomas, DDS, MS
President, Michigan Association of Orthodontists
ABO Board Certified Orthodontist

9151 Red Arrow Hwy, Bridgman, MI 49106

Catlin, Kimberly (LARA)

From: BPL-BoardSupport
Sent: Monday, August 22, 2022 4:00 PM
To: Ditschman, Andria (LARA)
Subject: FW: Dentistry - General Rules revisions

From: Kathryn Swan <swankath@gmail.com>
Sent: Monday, August 22, 2022 3:55 PM
To: BPL-BoardSupport <BPL-BoardSupport@michigan.gov>
Subject: Dentistry - General Rules revisions

I am writing as an orthodontic specialist concerned about the revision of the General Rules regarding Dentistry dated July 13, 2022.

R 338.11101 Definitions

I'd like first to object to the creation of the new title "unregistered dental auxiliary." This terminology is insulting to our well trained, dedicated, and often long-term employees who do not have an RDA license. This term appears to have been created not to solve a problem in the dental workplace, but rather to stroke the egos of certain dental personnel. While Registered Dental Assistants are valuable, they do not own the descriptor of "dental assistant." This, by pure grammar and English language, is any person who assists the dentist. There is no need to introduce this confusing additional terminology.

Part 4A, R 338.11411 Delegated and assigned dental procedures for allied dental personnel. (Specifically Table 1 located in section 3)

Most important to me and my orthodontic colleagues is that the way the rules are currently written – as well as the proposed revisions – make the practice of orthodontics in Michigan virtually impossible. I am referring specifically to Rule 338.11411, which refers to MCL 333.1611 Table 1: Delegated and Assigned Dental Procedures for Allied Dental Personnel.

I've been in practice for 15 years, and over that time have seen an expansion in the duties allowed for an RDA. These changes have undoubtedly been good for dental patients, and have expanded access as general dentists are able to delegate out more portions of procedures and increase the number of patients they can service on a given day. However, as more and more skills have been added to the RDA curriculum, available class time has run out. What has been eliminated has, in most cases, been specialty care. So as an orthodontic specialist, when I hire a recently graduated RDA, I still have to train them in almost every skill in my office before I can allow them to work on my patients. There is virtually no time or education savings for me to hire an RDA versus to train an on-the-job dental assistant. In addition, most general dentists utilize one or two chairside assistants. Due to the highly delegated nature of orthodontic work, each orthodontist might require four to eight chairside assistants. At our local community college, the RDA class has not even been full the last few years. And sadly, many of the graduates in my experience consider dental assisting to be a good career while they are young, and then "retire" to have a family. There are simply not enough RDAs to service our orthodontic offices. And while the CDA to RDA programs have been great for many of my general dentist

colleagues, we are not equipped to teach packing amalgam and other general dentistry skills in our offices. Therefore, this pipeline is entirely closed to our specialty. This has been a challenge for years, and creates an unnecessary barrier to employment.

My specific concerns on Table 1 include sections (h)-(tt) as follows:

(h) – There is no reason a dental assistant cannot be trained to safely remove bands, brackets, and adhesives with a rotary instrument. This is legal in several other states, and they do not see large numbers of patients with permanent harm after orthodontic appliance removal. Especially in this age of electric handpieces, where the top speed can be programmed in for each use, this does not present a significant risk. There are burs designed to remove only adhesive and not cut enamel. This can be done safely, and individual orthodontists are more than capable of providing this training on a one-on-one basis.

(i) The above logic can also be applied to polishing of teeth. This is a necessary step in the orthodontic bonding process to remove the pellicle, and with currently available equipment the rotation of the prophy cup can be throttled at a very safe speed while still achieving the goal. Orthodontists are more than capable of providing this equiment and training to their assistants.

(j) Etching the enamel prior to the application of brackets or aligner attachments is also something that is no longer taught in the RDA programs. The current table shows an asterisk indicating 10 hours of didactic and clinical training is needed before even an RDA can perform this task. This type of training does not exist. Our local program (GRCC) provides a half-day on orthodontic procedures, and that doesn't happen every year. Again, orthodontists are more than capable of training this skill on a one-on-one basis. No orthodontist wants an etch accident, and no orthodontist would let an assistant of any training level work on their patients without proper training in this *as determined by that orthodontist*.

(k) and (l) I can think of no content in the RDA curriculum that would assist in performing either of these skills. Again, the individual orthodontist provides all relevant training.

(m) See the comments for (h) above. Also, it seems like RDA's are allowed to use hand instruments to remove cement, and then also not allowed to use hand instruments to remove cement? However, I have no objection to restricting their adhesive or cement removal to supragingival areas. (Though I'm sure some of my colleague would disagree...)

(n) Most of the nutritional counseling provided in orthodontic offices is to discuss foods that should be avoided to prevent bracket breakage, or to prevent decalcification. This is fairly straightforward, and any clinical or nonclinical employee in the office should be able to discuss this with patients. To make it any other way seems like it actually does more harm than good – I want patients hearing about these things in as many ways and from as many people as possible in my office.

(p) Looking around with a mouth mirror and recording findings which will be verified by the doctor does not harm anyone. This is a skill that can be trained in office, since what the orthodontist is looking for is often much different than what a general dentist is looking for.

(r) Again, due to the risk of decalcification, application of fluoride and fluoride varnishes is a routine part of orthodontic visits. There is no part of the RDA education (that can't be replicated with individual training by the orthodontist) that makes a licensed assistant more qualified to perform this task.

(v) Sizing of bands is a reversible procedure, and a dental assistant of any training only learns to do this well via repetition. Certainly, an on-the-job trained dental assistant can safely perform this procedure under at least direct supervision.

(y) Most orthodontic impressions – or digital scans – are used for dual purposes: first as a study model, and then for the appliance fabrication. It has long been unnecessary to require different levels of training or supervision when they are

typically used for both purposes. This clearly indicates there is no difference in the quality level between the two for orthodontic purposes.

Hopefully this has provided some enlightenment into why the current rules are unrealistic for orthodontists in Michigan. This artificial barrier to employment of capable people willing to work and be trained should not continue. There are simply not enough RDA educational seats, nor enough time in their curriculum to teach the orthodontic skills in addition to the other requirements. The CDA to RDA pathway is not an option for orthodontists. And in addition, the "extra" training courses for the RDAs to perform some of our most common procedures don't even exist.

If anything, all of the orthodontic specialty tasks should be allowed to be performed by any dental assistant under either direct or general supervision, and the orthodontist should be solely responsible for the training. We are doing the training now anyway, and the results reflect on our professional licenses regardless. If the Board feels it is necessary, an endorsement policy could be put into place requiring certain hours of didactic and clinical instruction that the orthodontist could attest to. This would fill the gap that has been left, as no existing assistant training programs provide actual training for orthodontic assistants.

Thank you for your consideration.

Kathryn Swan, DDS, MS

Catlin, Kimberly (LARA)

From: BPL-BoardSupport
Sent: Thursday, August 18, 2022 1:58 PM
To: Ditschman, Andria (LARA)
Subject: FW: Comments on Dentistry General Rules
Attachments: Michigan Dental Association Comments.pdf

From: Bill Sullivan <bsullivan@MichiganDental.org>
Sent: Thursday, August 18, 2022 1:57 PM
To: BPL-BoardSupport <BPL-BoardSupport@michigan.gov>
Cc: Neema Katibai <nkatibai@michigandental.org>
Subject: Comments on Dentistry General Rules

Good Afternoon,

Please accept the attached comments pertaining to the Dentistry – General Rules (MOAHR #2021-40 LR).

Thank you.

Bill Sullivan, J.D.
Vice President of Advocacy and Professional Affairs
Michigan Dental Association
3657 Okemos Rd., Ste. 200
Okemos, MI 48864-3927
517-346-9405
bsullivan@michigandental.org

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August 18, 2022

Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing – Board and Committees Section
P.O. Box 30670
Lansing, MI 48909-8170
ATTN: Departmental Specialist

RE: Dentistry – General Rules (MOAHR #2021-40 LR)

To Whom It May Concern,

The Michigan Dental Association (MDA) opposes the proposed changes to R338.11601(1), which covers requirements for dentists to treat patients under general anesthesia or deep sedation in a dental office, and R338.11602(1), which establish requirements for dentists to treat a patient who is under moderate sedation or minimal sedation in a dental office. The proposed language is unclear as to the requirements a dentist must satisfy to treat a patient who has been anesthetized or sedated by another qualified professional, such as a physician anesthesiologist, another dentist, or nurse anesthetist.

R338.11601 – General Anesthesia, deep sedation; requirements

The proposal for R338.11601(1) states that "[a] dentist shall not administer general anesthesia or deep sedation to a dental patient or collaboratively provide treatment with a physician anesthesiologist, another dentist or nurse anesthetist . . . in a dental office in the administration of general anesthesia or deep sedation to a patient, unless the dentist complies with the following requirements," to administer anesthesia. It is not clear whether the use of the word "treatment" in the proposal would prohibit a dentist from providing dental treatment to a patient who has been anesthetized or put in deep sedation by a qualified professional if the dentist is not qualified to anesthetize or sedate the patient themselves. To avoid this confusion, the MDA proposes the following be adopted in place of the proposal for R338.11601(1):

"A dentist shall not administer general anesthesia or deep sedation to a dental patient or collaboratively provide general anesthesia or deep sedation with a physician anesthesiologist, another dentist, or nurse anesthetist, under section 17210 of the code, MCL 333.17210, in a dental office unless the dentist complies with the following requirements:"

R338.11602 – Moderate or minimal sedation; requirements

The MDA raises the same issues with R338.11602(1) as it does with R338.11601(1). The MDA proposes the following be adopted in place of the proposal for R338.11602(1):

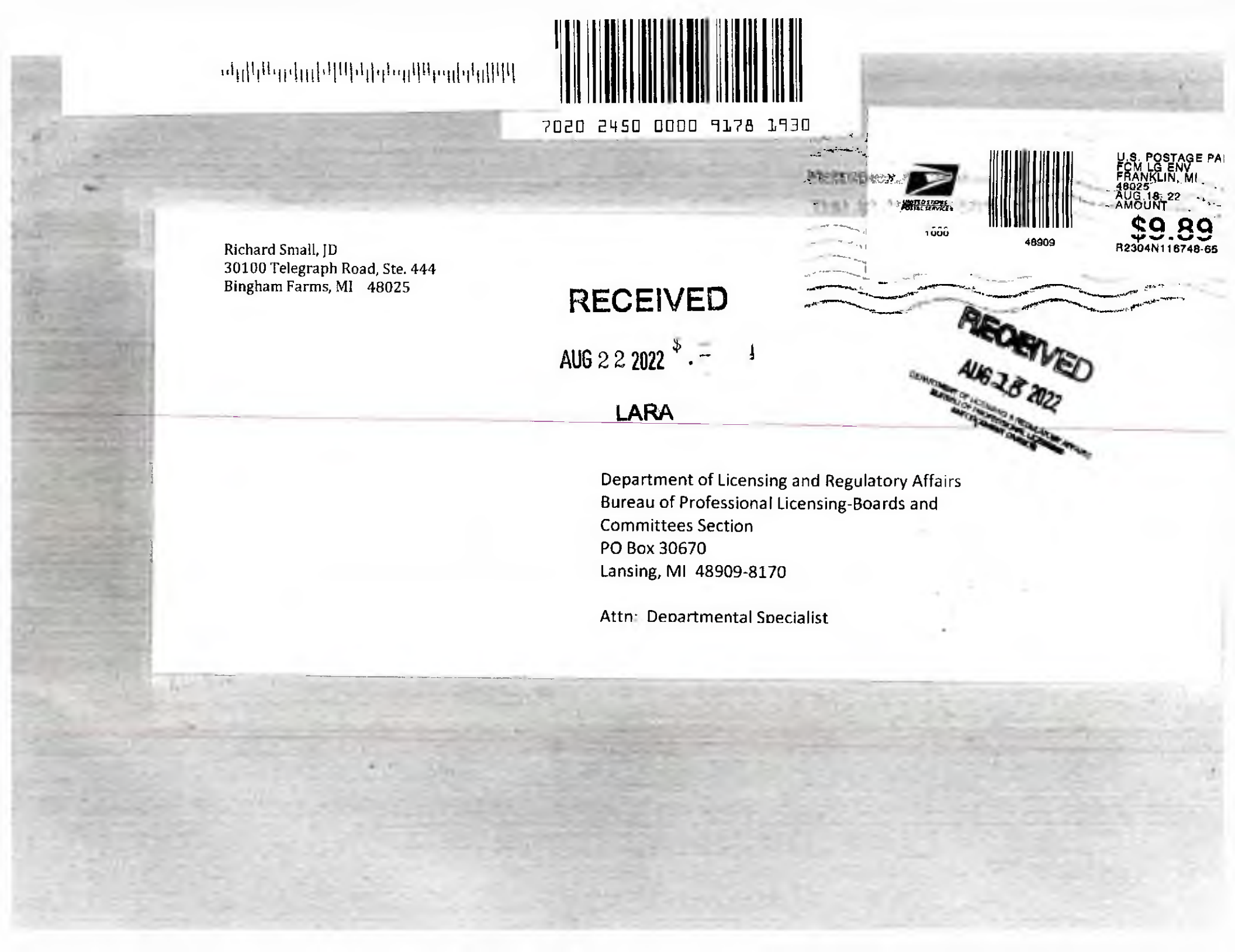
"A dentist shall not administer moderate or minimal sedation to a dental patient or collaboratively provide moderate or minimal sedation with a physician anesthesiologist, another dentist, or nurse anesthetist, under section 17210 of the code, MCL 333.17210, in a dental office unless the dentist complies with the following requirements:"

Requiring dentists to be qualified to administer anesthesia or sedation to provide dental treatment to an anesthetized or sedated patient will significantly limit access to care. Dentists frequently work with qualified professionals, such as oral surgeons and anesthesiologists, to safely administer anesthesia while the dentist delivers the necessary dental care. The current proposal by the Board of Dentistry will cause confusion among dentists as to when and how they are able to treat their patients who require sedation or anesthesia, which will hurt the delivery of dental care to patients. The MDA strongly believes clarifying this language will achieve the desired result of protecting patients, while providing clear guidelines for dentists to follow.

Thank you for considering our requests and if you have any questions please contact Bill Sullivan, Vice President of Advocacy and Professional Relations at bsullivan@michigandental.org or 517-346-9405.

Sincerely,

Vincent Benivegna, DDS
President
Michigan Dental Association



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Richard Small, JD
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SAFETY BOARDS

Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing-Boards and
Committees Section
PO Box 30670
Lansing, MI 48909-8170

Attn: Departmental Specialist

Michigan Society of Oral and Maxillofacial Surgeons
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(248) 227-7796
Fax (248) 646-7411
rich@rsmallagency.com

August 16, 2022

Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing-Boards and Committees Section
PO Box 30670
Lansing, MI 48909-8170

Attn: Departmental Specialist

RE: Public Hearing, August 22, 2022
Dentistry-General Rules: MOAHR 2021-40 LR
Proposed modification of R-338.11601 and 338.11602

PUBLIC COMMENT SUBMISSION

MSOMS REQUEST TO MODIFY Part 6, adding AAOMS as recognized national professional organization providing emergency medical management and monitoring guidelines

Dear LARA;

Below is a request to modify proposed language in R-338.11601 and R-338.11602 regulating office-based anesthesia.

The Request:
The MSOMS (Michigan Society of Oral and Maxillofacial Surgeons) requests that the State of Michigan list AAOMS (American Association of Oral and Maxillofacial Surgeons) as an authorized professional organization for courses on managing medical emergencies and current monitoring guidelines in the Administrative Rules, Sections R-338.11601 and 338.11602. **See EX 1** (requested additional language highlighted).

Proposed Anesthesia Rule:
The current proposal updating Michigan rules for general anesthesia and sedation require a course in managing medical emergencies, including current monitoring guidelines for adults from the ADA, ASA and for children from the ASA, AAP and AAPD. AAOMS should be a recognized professional provider for these and related courses. Michigan licensed oral and maxillofacial surgeons (OMSs) provide most office-based sedation and anesthesia in Michigan dental offices. Neither the ADA, ASA or AAPD provide anesthesia CE that directly addresses the needs of OMSs, while AAOMS has done this for decades.

Office-based anesthesia provided by OMSs is focused on patient safety and high standards taught in their CODA residencies. Importantly, AAOMS courses provide crucial updates in post-graduate CE courses. AAOMS is a specialty component of the ADA. AAOMS is the national organization OMSs rely on for CE, particularly for important updated safety, emergency management and treatment guidelines.

Not recognizing AAOMS to provide these courses will impede access to safe care by the dental group providing the most office-based anesthesia in Michigan. Adding AAOMS to the list of other national authorities providing emergency management courses will have no negative consequences, while providing a valuable benefit to those taking required courses offered by AAOMS.

Who are OMSs?

Oral and maxillofacial Surgeons (OMSs) are unique, licensed dental specialists who complete 12 to 14 years of post-secondary education in dentistry and medicine, providing a majority of deep sedation, general anesthesia and IV sedation in the US. They provide 79% of office-based moderate and deep sedation/general anesthesia. They provide 44% of deep sedation and general anesthesia for children ages 1 to7, and 81% for children 8 to 12. Data shows they have a low complication rate compared to the total anesthesia cases performed. **EX. 2**

OMSs are involved in lifelong learning primarily from AAOMS courses. This includes advanced protocols for medical emergencies for OMSs and staff. **EX. 3.**

Oral and maxillofacial surgeons are one of the original 7 dental specialties recognized and licensed in Michigan. They must receive advanced training beyond that required for a Michigan dental license, successfully complete a 4 to 6 year CODA residency and demonstrate competency in their field. **MCL 333.16608**. CODA (Commission on Dental Accreditation) residency education is a requirement for specialty licensure. CODA adopted "Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery", including general anesthesia and sedation guidelines for adults, geriatric and pediatric patients. **EX. 4.**

During their residencies and hospital training, OMSs must anesthetize at least **300 cases**, in addition to anesthetizing at least **50 patients under 13** and **managing children under 8. Ex. 4**. These courses include some of what is taught by the ADA, ASA and pediatric groups, and adopt ACLS, PALS and other standards. Only AAOMS, however, provides comprehensive and updated courses advancing patient safety for OMSs providing office-based anesthesia.

AAOMS requires members to successfully complete an Office Anesthesia Evaluation every 5 years, confirming members are up to date on OMS anesthesia and safety standards. The primary way OMSs and staff keep up on treatment and safety developments after residency is taking courses on emergency management and monitoring guidelines from AAOMS. **EX. 5**. (Office Anesthesia Evaluation Manual, cover sheet only: see document for details).

What is AAOMS and what does it do?

AAOMS is the nationally recognized dental specialty component for oral and maxillofacial surgeons. It represents over 9000 OMSs nationally, requiring rigorous CE assuring the public that OMS staff meets stringent national standards. **EX 6**. AAOMS is to oral and maxillofacial surgeons as the ADA is to dentists, and what the AAPD (American Academy of Pediatric Dentistry) is to pediatric dentists. AAOMS is an ADA CERP Recognized Provider. AAOMS not only works on developing and maintaining CODA residency requirements, and consults with the ASA on anesthesia issues but it also offers courses ensuring those taking them are up to date on current guidelines, protocols and safety standards. AAOMS plays an important role offering courses on anesthesia safety, treating medical emergencies and monitoring guidelines among other topics.

Why AAOMS is an important source of CE courses on anesthesia emergencies:
AAOMS offers regularly updated courses on emergency medical management of anesthesia complications and monitoring guidelines advancing patient safety and addressing complications effectively. They do much more.

AAOMS developed a program for anesthesia assistants working in OMS offices called **DAANCE** (Dental Anesthesia Assistant National Certification Examination). This is a 36 hour, 2 part CE certification program. **AAOMS is an ADA CERP Recognized Provider** offering courses for OMSs, their staff and other dental professionals with valid anesthesia credentials. This program can be completed in 6 months. The certifying exam is given at over 100 locations. AAOMS also offers anesthesia emergency simulation as part of its **OBEAM** program helping OMSs and staff practice and master critical techniques for administering and monitoring office-based anesthesia. This program helps offices assess their readiness to meet office anesthesia emergencies. **EX. 7**. These programs, along with emergency medical management courses, ensure those who take them are updated on important patient safety matters.

What is the MSOMS specifically asking the State to do?
The MSOMS and Michigan licensed oral and maxillofacial surgeons are asking the State of Michigan to modify its proposed Part 6 language in the Administrative Code, Rules R-338.11601 and R-338.11602. This request adds AAOMS to both rules as a recognized provider of courses on managing medical emergencies associated with office-based anesthesia, plus monitoring guidelines. This will not negatively affect any dentist. It will enhance access to care by making it easier for OMSs, staff and others to take high quality, updated courses on treating medical emergencies and monitoring guidelines up to their standards of care. Not adding AAOMS will deny OMSs providing office anesthesia to most Michigan patients of their primary source of important CE designed to enhance patient safety during anesthesia. There is no negative ramification or downside to this request.

If any State agency of staff needs any additional information, please contact the undersigned by phone or email.

Respectfully Submitted:

Richard L. Small, JD
MSOMS Executive Director, General Counsel
rich@rsmallagency.com
(248) 227-7796

/s/

Dr. Frank Farbod, MSOMS President

Encl.
EX 1: Administrative Code, R-338-11601 to 338.11602
EX 2: AAOMS: Dental Sedation and Anesthesia Delivery in the Office-Based Setting
EX 3: AAOMS White Paper: Office-Based Anesthesia Provided by the Oral & Maxillofacial Surgeon
EX 4: CODA Accreditation Standards for OMSs
EX 5: AAOMS Anesthesia Evaluation Manual, 8th Edition (cover sheet only)
EX 6: About AAOMS
EX 7: DAANCE and OBEAM information

PART 6A. GENERAL ANESTHESIA AND ~~INTRAVENOUS CONSCIOUS SEDATION AND ENTERAL~~ SEDATION, 5-27-22 version
Requested additions highlighted

R 338.11601 General anesthesia**, deep sedation**; **requirements** ~~conditions; violation~~.

Rule 1601. ~~(1)~~ A dentist shall not administer general anesthesia **or deep sedation** to a dental patient or **collaboratively provide treatment with a physician anesthesiologist, another dentist, or nurse anesthetist, pursuant to section 17210 of the code, MCL 333.17210, in a dental office** ~~delegate and supervise the performance of any act, task, or function involved~~ in the administration of general anesthesia **or deep sedation** to a dental patient, unless ~~all~~ **the dentist complies with both** of the following ~~conditions~~ **requirements** ~~are satisfied~~:

(a) The dentist has **demonstrated competency by having** ~~completed~~ **met all the following requirements:**

(i) Complete a minimum of 1 year of advanced training in general anesthesia and pain control in a program that meets the standards adopted in R 338.11603(l). A program that is accredited by CODA as meeting the accreditation standards for advanced dental education programs in anesthesiology, or in oral and maxillofacial surgery, meets the requirements of this subdivision.

(ii) Complete a course in managing medical emergencies that includes the following:

(A) Current monitoring guidelines for adults from the ADA or the American Society of Anesthesiologists (ASA), or the American Association of Oral and Maxillofacial Surgeons (AAOMS) for oral and maxillofacial surgeons, and for children from the ASA, or AAOMS for oral and maxillofacial surgeons, the American Academy of Pediatrics (AAP), and the American Academy of Pediatric Dentistry (AAPD).

(B) Equipment and material used in an anesthesia or sedation emergency.

(C) The personnel needed for anesthesia or sedation.

(D) The drugs needed for resuscitation in an emergency.

(iii) Maintain ~~(b) The dentist and the delegatee, if any, maintain current certification~~ **certification** in ~~basic~~ **BSL** and ~~advanced cardiac life support~~ **ACLS** for health care providers with a hands-on component from an agency or organization that grants certification pursuant to standards substantially equivalent to the standards adopted in R 338.11603(2). A certification in ~~basic and advanced cardiac life~~**BSL and ACLS** for health care providers with a hands-on component from AHA **or BSL for the healthcare provider and pediatric advanced life support (PALS) with a hands-on component from AHA** meets the requirements of this subdivision.

(b) If general anesthesia or deep sedation is performed in a dental office any allied dental personnel and dental therapists that are directly involved in the procedure shall complete a course in managing medical emergencies that includes the following:

(i) Current monitoring guidelines for adults from the ADA or the ASA, or AAOMS for oral and maxillofacial surgeons, and for children from the ASA, the AAP, and the AAPD or AAOMS for oral and maxillofacial surgeons.

(ii) Equipment and materials used in an anesthesia or sedation emergency.

(iii) The personnel needed for anesthesia or sedation.

(iv) The drugs needed for resuscitation in an emergency.

EX. 1

(c) At no time is the RDA or RDH allowed to adjust medication levels during a procedure, other than nitrous oxide and oxygen, as allowed in R 338.11411(2).

~~(c) The facility in which the anesthesia is administered meets the equipment standards adopted in R 338.11603(3).~~

~~(d) The dentist shall be physically present with the patient who is given any general anesthesia until he or she regains consciousness and the dentist shall remain on the premises until the patient is capable of being discharged.~~

~~(2) A dentist who does not meet the requirements of subrule (1) of this rule shall not offer general anesthesia services for dental patients unless all of the following conditions are met.~~

~~(a) General anesthesia services are directly provided through association with, and by, either of the following individuals:~~

~~(i) A physician who is licensed under the provisions of part 170 or 175 of the code, MCL 333.17001 to 333.17097, and 333.17501 to 333.17556, and who is a member in good standing on the anesthesiology staff of a hospital accredited by the Joint Commission.~~

~~(ii) A dentist who meets the requirements of subrule (1)(a) and (b) of this rule.~~

~~(b) A person who administers anesthesia, under the provisions of subdivision (a) of this subrule, shall be physically present with the patient who is given any general anesthesia until he or she regains consciousness and the dentist shall remain on the premises where the general anesthesia is administered until the patient anesthetized is capable of being discharged.~~

~~(c) The provisions of subrule (1)(b) and (c) of this rule must be complied with.~~

~~(3) A dentist is in violation of section 16221(l)(h) of the code, MCL 333.16221, if he or she fails to comply with subrules (1) and (2) of this rule.~~

R 338.11602 ~~Intravenous conscious~~ **Moderate or minimal** sedation, ~~conditions, violations~~**requirements**.

Rule 1602. ~~(1)~~ A dentist shall not administer ~~intravenous conscious~~ **moderate or minimal** sedation to a dental patient or **collaboratively provide treatment with a physician anesthesiologist, another dentist, or nurse anesthetist, pursuant to section 17210 of the code, MCL 333.17210, in a dental office** ~~delegate and supervise the performance of any act or function involved~~ in the administration of ~~intravenous conscious~~ **moderate or minimal** sedation to a dental patient unless ~~:~~ **both** of the following **requirements are** ~~is~~ satisfied:

(a) The dentist ~~complies with R 338.11601(1) or (2).~~ has **demonstrated competency by having** ~~completed~~ **met all of the following requirements:**

~~(b) The dentist complies with all of the following provisions:~~

~~(i) The dentist has completed a minimum of 60 hours of training in intravenous conscious sedation and related academic subjects, including a minimum of 40 hours of supervised clinical instruction in which the dentist has sedated not less than 20 cases in a course that complies with the standards adopted in R 338.11603(1). A program that is accredited by CODA as meeting the accreditation standards for advanced dental education programs meets the standards in R 338.11603(1).~~

(i) Complete either of the following:

(A) A comprehensive training program in moderate sedation that satisfies the requirements described in the moderate sedation section of the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students at the time the

training was commenced, which must include 60 hours of classroom training and hands on interaction in moderate sedation with 20 patients.

(B) An advanced education program accredited by CODA that provides comprehensive training to administer moderate sedation.

(ii) **Maintain** ~~The dentist and the delegatee, if any, maintains current~~ certification in ~~basic~~ **BSL** ~~or~~ and ~~advanced cardiac life support~~ **ACLS** for health care providers with a hands-on component from an agency or organization that grants certification under standards substantially equivalent to the standards adopted in R 338.11603(2). A certification in ~~basic and advanced cardiac life support~~**BSL and ACLS** for health care providers with a hands-on component from AHA **or basic life support for the healthcare provider and PALS with a hands-on component from AHA** meets the requirements of this paragraph.

(iii) ~~The facility in which the anesthesia is administered complies with the equipment standards adopted in R 338.11603(3).~~ **Complete a course in managing medical emergencies that includes the following:**

(A) Current monitoring guidelines for adults from the ADA or the ASA, or AAOMS for oral and maxillofacial surgeons and for children from the ASA, the AAP, and the AAPD, or AAOMS for oral and maxillofacial surgeons.

(B) Equipment used in an anesthesia or sedation emergency.

(C) The personnel needed for anesthesia or sedation.

(D) The drugs needed for resuscitation in an emergency.

~~(2) A dentist is in violation of section 16221(1)(h) of the code, MCL 333.16221, if he or she fails to comply with subrule (1) of this rule.~~

(b) If moderate sedation is performed in a dental office any allied dental personnel and dental therapists that are directly involved in the procedure shall complete a course in managing medical emergencies that includes the following:

(i) Current monitoring guidelines for adults from the ADA or the ASA, or AAOMS for oral and maxillofacial surgeons and for children from the ASA, the AAP, and the AAPD, or AAOMS for oral and maxillofacial surgeons.

(ii) Equipment and materials used in an anesthesia or sedation emergency.

(iii) The personnel needed for anesthesia or sedation.

(iv) The drugs needed for resuscitation in an emergency.

(c) At no time is the RDA or RDH allowed to adjust medication levels during a procedure, other than nitrous oxide and oxygen, as allowed in R 338.11411(2).

R 338.11603 Adoption of standards; effect of certification of programs.

Rule 1603. (1) The board adopts by reference the CODA standards for anesthesiology educational programs in the publication titled "Accreditation Standards for Advanced Dental Education Programs in Anesthesiology," copyright ~~2018~~**2020**, and the standards for advanced training in anesthesia and pain control and training in intravenous conscious sedation and related subjects set forth by the ADA's publication titled "Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students," October 2016 edition. The guidelines may be obtained at no cost from the American Dental Association, 211 E. Chicago Avenue, Chicago, Illinois, 60611, or at no cost on the association's website at http://www.ada.org. A copy of the standards is available for inspection and distribution, at 10 cents per page from the Michigan Board of Dentistry, Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing, 611 West Ottawa, P.O. Box 30670, Lansing, Michigan, 48909.

Oral and maxillofacial surgeons: The experts in face, mouth and jaw surgery*

American Association of Oral and Maxillofacial Surgeons

AAOMS Advocacy

DENTAL SEDATION AND ANESTHESIA DELIVERY IN THE OFFICE-BASED SETTING

*The following statistics have been calculated by AAOMS using data from the U.S. Census Bureau and information provided by FAIR Health based on its privately insured dental claims data for the calendar years of 2018, 2019 and 2020 **

During 2018, 2019 and 2020, anesthesia services^ were delivered to 6,889,445 individuals insured by private dental insurance in the United States.*

- Of the total 6,240,366 **moderate** and **deep sedation / general anesthesia** (DS/GA) cases performed in 2018, 2019 and 2020, 79 percent – or 4,911,840 – were delivered by oral and maxillofacial surgeons (OMSs).
- In the 1- to 7-year-old age group, OMSs provided 44 percent (16,707) of the total DS/GA cases (38,257).
- In the 8- to 12-year-old age group, OMSs provided 81 percent (85,919) of the total DS/GA cases (105,791).
- For **moderate IV sedation:**
  - In the 1- to 7-year-old age group, OMSs provided 34 percent (1,439) of the total moderate IV sedation procedures (4,244).
  - In the 8- to 12-year-old age group, OMSs provided 76 percent (10,378) of the total moderate IV sedation services (13,698).

OMSs perform the majority of reported sedation in the dental setting

For more information, visit AAOMS.org or MyOMS.org

Conclusion

- Oral and maxillofacial surgeons are the dental specialists providing the overwhelming majority of DS/GA and IV sedation services in the United States to patients who have private dental insurance.
- Policy decisions on patient care should be based on data – not conjecture, supposition or prejudiced opinion. Data show a low rate of incident in OMS offices compared to the total anesthetics performed.
- OMSs provide the majority of dental office-based anesthetic care in the country and should be involved at every level of the decision-making process.
- The ability for patients to receive OMS-led anesthesia care is vital to overall access to care. Any change to OMSs' ability to offer anesthesia services will adversely affect patient treatment.

^ D9222, D9239 and D9248

* Research for this document is based on U.S. Census Bureau population estimates and statistical information based on dental claims data compiled and maintained by FAIR Health, Inc. AAOMS is solely responsible for the research and conclusions reflected in this document. FAIR Health is not responsible for the conduct of the research or any of the opinions expressed in this document.

EX-2

9700 West Bryn Mawr Avenue | Rosemont, Illinois 60018-5701 | 800.822.6637 | www.AAOMS.org/Advocacy | advocacy@aaoms.org

Oral and maxillofacial surgeons: The experts in face, mouth and jaw surgery®

American Association of Oral and Maxillofacial Surgeons

White Paper

Office-based Anesthesia Provided by the Oral and Maxillofacial Surgeon

Background and Purpose

The American Association of Oral and Maxillofacial Surgeons (AAOMS) and its Board of Trustees embrace safety as a core value. This white paper reflects this priority and is intended to highlight and summarize key elements of the OMS team approach to anesthesia delivery. AAOMS believes adhering to the principles outlined in this document will provide a solid foundation for the safe, effective and affordable delivery of anesthesia in the office setting – understanding these principles are not set absolute requirements nor do they guarantee specific outcomes.

A Special Committee on Office-based Anesthesia White Paper was appointed in October 2021 by the Board of Trustees to review and revise the 2016 paper. The special committee was tasked with reviewing relevant materials, including the *AAOMS Parameters of Care*, the American Society of Anesthesiologists' Practice Guidelines for Sedation and Analgesia by Non-anesthesiologists, AAOMS white papers and other publications related to anesthesia safety. The committee supplemented this foundation with other evidence-based resources and considered the opinions of experts in office-based anesthesia.

Oral and Maxillofacial Surgery Residency Education and Training

From the earliest days of the specialty, there has been an emphasis on outpatient anesthesia education, with ongoing updates to formal training requirements aimed at improving patient safety. The current standards for OMS resident anesthesia training provide for a progressive didactic and clinical learning experience. Combined, anesthesia and medical service rotation assignments are for a minimum of 32 weeks. Of those, at least 20 weeks must be spent on anesthesia service, and at least four weeks should be dedicated to pediatric anesthesia. As with other off-service rotations, the OMS resident must function as at least a Post-Graduate Year-1 (PGY-1) anesthesia resident with commensurate levels of responsibility. A minimum of eight weeks must be allocated toward medical / surgical subspecialty services, with a focus on preoperative risk assessment.

OMS ambulatory anesthesia delivery includes the administration of deep sedation or general anesthesia for procedures performed on pediatric, adult and geriatric patients. The cumulative experience of each graduating resident includes the competent administration of general anesthesia and deep sedation for a minimum of 300 cases, at least 50 of which must involve individuals younger than 13 years old. Training also includes treating children under age 8 using techniques such as behavior management, inhalation analgesia, sedation and general anesthesia.

The clinical experience is supported by a program that incorporates lectures and seminars emphasizing perioperative evaluation of all patients, risk assessment, anesthesia and sedation techniques, monitoring, and the diagnosis and management of complications. These experiences are intended to prepare the graduating resident to ensure favorable outcomes when treating the scope of patients typically seen in OMS offices.

History of Anesthesia in Oral and Maxillofacial Surgery

The role of oral and maxillofacial surgeons in providing anesthesia in an office-based setting has a long history, emanating from the time of Horace Wells' practice with nitrous oxide in the 1840s to contemporary techniques that utilize multiple agents.

In the mid-1900s, injectable anesthetics became more prominently used by the OMS community, allowing better control of the depth and duration of anesthesia without the need to intubate or otherwise use the oral or nasal pathways for delivery. Methohexital (Brevital), a barbiturate with a short duration of action, was reported in 1940 by Adrian O. Hubble, an OMS who used repeated doses to sufficiently abolish pain and recall in the office

EX-9

anesthesia AAOMS_ white paper 2022

setting. From 1945 to the 1960s, techniques started to combine methohexital with meperidine (Demerol) or other opiates, along with an anticholinergic drug, to achieve what became known as balanced anesthesia. The introduction of intravenous benzodiazepines, particularly diazepam (Valium) in 1963, marked the beginning of a broader continuum of anesthesia. As newer sedative agents were developed, many older drugs were replaced with more effective and shorter-acting agents with fewer side effects. For example, methohexital (Brevital) has mostly been replaced with propofol (Diprivan) in addition to diazepam with midazolam (Versed) and meperidine (Demerol) with fentanyl. Low-dose ketamine in combination with other agents is used by many OMSs.

To build on the already impressive safety record of the OMS anesthesia team model, AAOMS encourages its members to participate in the Dental Anesthesia Incident Reporting System (DAIRS), an anonymous, self-reporting registry system to collect and analyze anesthesia incidents.

OMS Team Model of Anesthesia Delivery

For any team to operate effectively, it must work as a cohesive unit that is trained to recognize potential problems before they arise and respond effectively to any crisis. The OMS team employs a minimum of three individuals: 1) a highly trained OMS, 2) a trained staff member whose sole responsibility is to monitor the patient and 3) a surgical assistant. The team is led by an OMS who has completed a minimum of 12 to 14 years of post-secondary education. The OMS must be certified in Advanced Cardiovascular Life Support (ACLS) in addition to completing the mandatory AAOMS Office Anesthesia Evaluation (OAE) program. The monitor, who must be certified in Basic Life Support (BLS), is responsible for maintaining the patient's head position to ensure a patent airway. They also must observe the patient's vital signs, EKG, EtCO2, pulse oximeter and other important monitoring information. Any deviation from normal is reported immediately. Additionally, certification in anesthesia assistance can be obtained through the Dental Anesthesia Assistant National Certification Examination (DAANCE), a psychometrically validated process. The third team member is the surgical assistant who is, at a minimum, a dental assistant with current certification in BLS.

Therapeutic Goals and Outcomes

Therapeutic goals revolve around the successful management of anxiety, fear and pain. Equally important is an understanding of expected therapeutic outcomes along with possible anesthesia-related risks and complications. The selection of appropriate techniques for the administration of local anesthesia, sedation, and general anesthesia to meet the specific needs of a given patient and procedure must be determined by the surgeon based on training, experience and an understanding of risks and benefits.

Providers must be trained and skilled in rescuing a patient whose level of anesthesia becomes deeper than originally intended. Following are the recognized levels of anesthesia that may be employed in an effort to manage anxiety, fear and pain:

- **Minimal Sedation (Anxiolysis):** Patient responds normally to verbal commands, although cognitive function and coordination may be impaired. Airway reflexes and ventilatory and cardiovascular functions are unaffected.
- **Moderate Sedation/Analgesia:** Patient responds purposely to verbal commands, either alone or with light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation and cardiovascular function are usually maintained.
- **Deep Sedation/Analgesia:** Patient not easily aroused but responds purposely following repeated or painful stimulation. The ability to independently maintain airway patency and ventilation may be impaired. Cardiovascular function is usually maintained.
- **General Anesthesia:** Patient not arousable, even with painful stimulation. The ability to maintain ventilatory function independently is often impaired, and patients may require assistance. Cardiovascular function may be impaired.

Techniques

An individual patient's medical conditions and physiology, responses to medications, the doses administered, and the technique used influence the level of anesthesia. A variety of administration routes can be employed to achieve the desired therapeutic goals, including local, enteral, parenteral and inhalation. The level of anesthesia achieved is independent of the administration method.

Local anesthetics minimize the amount of other anesthetic agents necessary to achieve therapeutic goals. They commonly contain vasoconstrictors to maintain higher drug concentrations at the target site and minimize surgical bleeding. Enteral anesthetic agents typically include benzodiazepines, non-benzodiazepine hypnotics and alpha-2 agonists. Many variables confound the ability to predict the behaviors of drugs when administered via the enteral route. Common parenteral agents include opioids, benzodiazepines, propofol, ketamine, barbiturates and alpha-2 agonists. Parenteral routes include intravenous, intramuscular, and subcutaneous – with the intravenous route providing the most rapid onset and bioavailability. All parenterally administered medications should follow Centers for Disease Control and Prevention (CDC) Safe Injection Practices to Prevent Transmission of Infections to Patients as well as American Society of Anesthesiologists labeling guidelines.

Anesthesia Risks and Complications

Known risks and complications of the planned anesthetic must be discussed with the patient and family as a part of the informed consent process, with all related questions answered as accurately as possible. For healthy patients, office-based anesthesia has been demonstrated over time to be safe and effective. There are rare instances where serious complications occur, and the OMS team must be prepared to appropriately recognize, diagnose and manage them. Constant vigilance in patient selection and appropriate anesthetic planning are essential in minimizing and preventing anesthesia-related risks.

Patient Evaluation

The provision of local anesthesia, deep sedation or general anesthesia involves the administration of agents with potentially significant systemic effects. It is important to identify patients with varying degrees of physical and medical compromise and adjust the anesthetic plan accordingly. Consultation with other healthcare providers and additional diagnostic testing to appropriately risk-stratify the patient may be indicated. At times, it may be appropriate for a patient to be treated in an ambulatory surgical center or hospital operating room.

Patient assessment begins with a thorough medical history that includes specific questions about previous surgical and anesthetic experiences. The initial office visit should include obtaining vital signs such as blood pressure, heart rate and oxygen saturation (SpO2), which serves as a surrogate monitor of cardiopulmonary function. All abnormal values should be flagged for review. Based on the above, patients should be classified using the American Society of Anesthesiologists (ASA) physical status system. In an ideal setting, patients within ASA I and II classes are the best candidates for office-based anesthesia.

Since the ability to establish an airway remains critical, the Mallampati classification is a good tool for predicting difficulty related to establishing and maintaining an airway in addition to intubating patients. BMI also is a useful parameter to help predict anesthesia-related complications, with patients who fall into a normal or overweight category posing limited risk. Challenges related to maintaining a patent airway or establishing one when it is lost are compounded not only by the BMI but also length and diameter of the neck. Sternomental distance is an important predictor for difficult intubation.

Cardiac Disease – A history of cardiac disease may require further evaluation and consultation with the patient's primary care physician or cardiologist. Important subtypes include the following:

- **Coronary artery disease and myocardial infarction:** Angina or shortness of breath with exercise may suggest ischemic heart disease. Determining functional status using metabolic equivalents (METs) helps assess disease severity, and the use of chronic and episodic vasodilator medications (including nitroglycerine) provides additional insight.
- **Cardiac arrhythmias:** Cardiac arrhythmias can result in significant morbidity during anesthesia. The use of epinephrine-containing local anesthetics, endogenous

epinephrine and certain anesthetic agents – such as ketamine and inhalational agents – can result in arrhythmias. Patients with Wolff-Parkinson-White syndrome and those with second-degree Type II or third-degree heart blocks are not ideal candidates for office-based deep sedation or general anesthesia. Atrial fibrillation may predispose to a rapid ventricular rate that can lead to acute decompensation and heart failure. Patients with implanted pacemakers and internal defibrillators warrant cardiac consultation.

- **Congestive failure:** Congestive heart failure is a progressive loss of the normal cardiac output. Symptoms of non-compensated failure may include shortness of breath, peripheral edema or fatigue. The functional status provides valuable insight into disease severity. Patients with moderate to severe congestive heart failure are not candidates for office-based deep sedation or general anesthesia.
- **Valvular heart disease and prosthetic valves:** Patients may be referred for multiple extractions prior to a planned valve replacement. Depending on the complexity of the extractions, individuals may not be suitable for treatment in an office-based setting. Once valve replacement has occurred, patients are typically more stable.

Respiratory Disease – One of the major risks of office-based anesthesia delivery is the development of apnea or hypopnea. Improvements in surveillance with end-tidal carbon dioxide (EtCO2) monitors and a precordial stethoscope alert the anesthetic team to the development of apnea in real time. Obese, pediatric or patients with comorbid medical conditions have reduced functional residual capacity and may desaturate relatively rapidly.

Asthma – Patients with asthma require particular attention in light of the potential for anesthesia-related complications and should be screened with questions such as: In the past four weeks, has the patient had: 1) Daytime symptoms more than two times per week? 2) Night waking due to asthma? 3) Use of short-acting beta agonists for symptoms more than two times per week? 4) Any activity limitations due to asthma? In general, the patient can be considered well-controlled if he or she answers no to all questions, partly controlled if yes to one or two questions, and uncontrolled if they report yes to three or more. Mild intermittent asthmatics and mild persistent asthmatics are reasonable candidates for office-based deep sedation and general anesthesia. Moderate and severe asthmatics are better managed in an ambulatory surgery center or hospital operating room. Avoidance of known triggers for histamine release such as non-steroidal anti-inflammatory medications (NSAIDs) and morphine is important. Patients with an upper respiratory infection in the previous month are not good candidates for deep sedation or general anesthesia given the increased risk of bronchospasm.

Hepatic Disease – Various causes of hepatic disease include viral hepatitis, chronic alcoholism and hepatotoxicity from drugs. Since many anesthetic drugs are bound to plasma proteins that are produced in the liver, hepatic disease may result in increased free-drug within the body's circulation and the potential for enhanced and prolonged drug activity. Since the liver is responsible for metabolism of many agents, there may be an increased half-life and prolonged anesthetic effects.

Renal Disease – Urinary excretion is a major mechanism for drug elimination. Therefore, renal disease can result in prolonged drug action, particularly when metabolites also have a therapeutic effect. Since the kidney is responsible for electrolyte and fluid homeostasis, renal disease can result in significant electrolyte abnormalities and fluid shifts, which may decrease cardiovascular reserve as predispose to arrhythmias.

Pediatric Patients – Children are not simply small adults. They have many unique and constantly changing anatomic, physiologic, pharmacologic and psychologic differences with their medical and surgical history typically derived completely from the caregiver. Systemic diseases and prescription medications are uncommon, and past anesthetic experiences may be rare. A targeted physical exam should include an airway, heart and lung evaluation. Recent upper respiratory infection, fever, mucopurulent nasal drainage, audible wheezing or a productive cough should prompt further evaluation. Small nares, large tongue and enlarged tonsils or adenoids can cause passive airway obstruction. The pediatric airway is far more reactive to stimuli such as secretions or foreign bodies than an adult airway. As a result, laryngospasm must be anticipated, quickly identified and skillfully managed.

Pediatric cardiac output can be maintained over a wide range of preloads without failing, but young patients rely solely on heart rate to maintain blood pressure. As a result, bradycardia must be immediately detected and corrected. Properly sized equipment is vital to the delivery of anesthesia and rescue in the instance of an emergency. Prior to anesthetic administration, calculating emergency dosages of commonly used drugs can facilitate a smooth, coordinated and successful outcome.

Pregnant Patients – Although elective surgery can usually be delayed, there are situations in which a pregnant female will require urgent surgery. In addition to maternal safety, anesthetic management must maintain fetal safety, which includes avoiding intrauterine fetal asphyxia and preterm labor. Most local anesthetics are considered safe during pregnancy, and single exposure to the commonly used sedatives (benzodiazepines, opioids and nitrous oxide) have undetermined risk of teratogenicity. Consultation with the practitioner managing the patient's prenatal care may be helpful in determining appropriate timing for surgery and the optimal perioperative care.

Obese Patients – Obese patients present with special anatomic and physiologic problems. Obesity, defined by body mass index, is associated with increased risk for Type 2 diabetes, hypertension and cardiovascular disease relative to normal weight and waist circumference. Airway management may be difficult due the overabundance of soft tissue or anatomic deficiencies. Comorbid conditions, decreased functional residual capacity, complex airways and difficult intravenous access place obese patients at higher risk for complications. Practitioners should be experienced in airway management, including endotracheal intubation and supraglottic device placement. The use of opioids should be considered with caution.

Geriatric Patients – It is prudent to consider age, frailty and comorbidities as anesthetic risk factors. Medical consultation may be necessary. Determination of the geriatric patient's mental status is important as postoperative delirium is more common in patients with dementia or preoperative mental status changes. Assessing the level of exercise tolerance can be integral to estimating the patient's ability to tolerate the combined stress of anesthesia and surgery. The anesthetic plan should consider reduced dosing with an expectation for longer elimination half-lives of anesthetic drugs. Medications with anticholinergic effects should be limited and preference should be given to reversible anesthetic agents.

Monitoring

Continuous real-time monitoring should reflect the OMS team model's shared patient safety responsibilities. Monitoring should be started before the administration of anesthesia and continue throughout the procedure and the post-anesthetic recovery period. In addition to diligent surveillance through direct observation, electronic monitors should include EKG, pulse oximetry, blood pressure, and pulse and end-tidal CO2. Pre-cordial and pre-tracheal stethoscopes also may be used as deemed useful. Despite the advancements offered by today's high-tech monitors, the maxim of "treat the patient, not the monitor" should be respected.

Office Anesthesia Evaluation

The Office Anesthesia Evaluation (OAE) is a unique peer review process that has been in existence since 1975. The OAE was conceived, developed, implemented and mandated by AAOMS through its state societies to benefit the public its members serve. The AAOMS OAE digital app (available on Apple Store or Google Play) can be used to assist with this process. To maintain AAOMS membership, all member oral and maxillofacial surgeons must complete this mandatory program at least every five years. The process involves a thorough inspection of the member's practice locations, team, equipment and patient care skills particularly as they pertain to the delivery of anesthesia and preparedness to manage office emergencies. Inspections are typically conducted by outside surgeons or state dental board designates.

The program consists of four parts: 1) evaluation of office facilities, medications and emergency equipment; 2) management of simulated office emergencies; 3) debriefing; and 4) observation of the anesthesia and surgeries performed in the office, subject to state laws and patient consent. The *AAOMS Office Anesthesia Evaluation Manual* published periodically (9th edition available) guides the process. Among other things, the *OAE Manual* provides sample forms, checklists and a variety of emergency scenarios to guide crisis drills and scrimmages for the anesthetic team.

Mobile Anesthesia

Mobile anesthesia is a model where a qualified individual delivers services in a facility where the anesthesia provider does not practice or have input into office design or staffing. Anyone involved in the mobile anesthesia model should be aware of applicable state laws, rules and regulations, professional resources, and the scope of their professional training and experience. Mobile anesthesia providers retain the responsibility of providing coordinated and patient-focused care and must maintain the same standards as someone delivering anesthesia in their home office. This includes, but is not limited to, being responsible for patient selection, the anesthetic plan, monitoring and recovery, emergency preparedness, record keeping and overall patient safety.

Emergency Preparedness

Despite the best efforts of all concerned, crisis events can and do occur. It is important to have a process in place to prevent as well as recognize and respond to potential crises. Preparation has two components: systems and practice.

Systems are deliberate strategies to limit risk and enhance outcomes. Examples include written patient assessment protocols, standardized clinical documentation forms or electronic medical record templates, pre-procedure timeout checklists, and crash cart checks to ensure all supplies are available and functioning.

Practice is an effective approach to improving outcomes. It has two components: drills and scrimmages. Drills are used to develop the skills necessary to perform effectively, while scrimmages require the application of knowledge and skills during simulated challenges. Together, they help the team to progress through stages of learning from unconscious incompetence (unable to do something with little idea what needs to do done), to conscious incompetence (understand what needs to be done but unable to do it), conscious competence (aware of what needs to be done and able to do it with conscious effort), and unconscious competence (know what to do and able to act without conscious effort).

Practices should be conducted on a regular basis, be challenging, mimic real-life situations, include constructive feedback, emphasize a growth mindset and incorporate an element of engaging team building.

Scenarios should emphasize the types of patients the office typically treats, including age, medical and physical status, and procedure types. While focusing on events where anesthetics are most likely to be administered, they also should include other spaces such as the recovery room, waiting room, hallway and bathroom. Algorithms should be creative rather than formulaic and allow for progression through a variety of workable solutions. To make sessions realistic, the team should use a manikin and carry out tasks in a manner that approximates reality, such as performing CPR, managing the airway, connecting IV tubing and drawing up mock drugs. AAOMS members and their offices must conduct quarterly mock crisis drills.

Provider Training/Continuing Education

Active engagement in lifelong learning from multiple sources supports the efficiency and effectiveness of both the OMS and his or her staff. AAOMS supports the OMS team in keeping abreast of the latest knowledge and techniques through the efforts of the AAOMS Committee on Continuing Education and Professional Development and the Committee on Anesthesia. Together, they are responsible for creating high-level contemporary lectures, webinars and symposia on anesthesia topics offered as in-person and online programs. Examples for members include but are not limited to the Anesthesia Update lecture series delivered before the AAOMS Annual Meeting and the AAOMS Anesthesia Patient Safety Conference. Courses intended for members and their staff include Advanced Protocols for Medical Emergencies in the OMS Office, Anesthesia Assistants Skills Lab and the Anesthesia Assistants Review Course.

Simulation Training

AAOMS has created a simulation-based learning experience intended to provide every OMS and their staff training in Office-Based Emergency Airway Management (OBEAM) and Office-Based Crisis Management (OBCM). Modules in the program include didactic and hands-on mastery-based skills training and adult cooperative learning modules that allow participants to learn and update their airway skills as well as improve team dynamics.

Ongoing Quality Assessment and Lifelong Learning

Ongoing quality assessment and lifelong learning are signature elements in practice efficiency, procedural effectiveness, the delivery of high-quality state-of-the-art patient care, and optimized patient safety and emergency response. Given that oral and maxillofacial surgery spans both medicine and dentistry, ongoing quality assessment has been an integral part of the specialty from both process and quality improvement perspectives.

Lifelong learning continues beyond the completion of formal education and results in the growth of important knowledge and skills. The results should be monitored using objective measures. AAOMS and the American Board of Oral and Maxillofacial Surgery fully support this process in tangible ways.

Conclusion

AAOMS expects this white paper will be revised over time as warranted, as is the case where there is ongoing evolution of knowledge, technology and practice preferences. Reality informs AAOMS that there is a necessary balance between what is ideal and what is practical, particularly in communities where resources are limited and access to care is challenged. While it is understood the choice of agents and techniques is dependent upon the experience, training and preferences of individual practitioners, safety can never be sacrificed.

Related Readings

Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery. Available at https://coda.ada.org/~/media/CODA/Files/oms.pdf?la=en

American Association of Oral, & Maxillofacial Surgeons. Committee on Anesthesia. (2018). Office Anesthesia Evaluation Manual, 9th edition. American Association of Oral and Maxillofacial Surgeons.

American Association of Oral, & Maxillofacial Surgeons. Committee on Anesthesia. (2017). Parameters of Care to Clinical Practice, 6th edition. Sections: Patient Assessment, Miloro, Basi, Halpern, Kang, and Anesthesia in Outpatient Facilities, Rollert, Busaidy, Krishnan, Van Heukelom, published in Journal of Oral and Maxillofacial Surgery, 75 (8), e15-49.

American Dental Association. (2016). Guidelines for the use of sedation and general anesthesia by dentists. Adopted by the ADA House of Delegates.

American Society of Anesthesiologists (ASA). Continuum of depth of sedation: definition of general anesthesia and levels of sedation/analgesia. (Approved by the ASA House of Delegates on October 13, 1999 and last amended on October 15, 2014). Available at: https://www.asahq.org/standards-and-guidelines/continuum-of-depth-of-sedation-definition-of-general-anesthesia-and-levels-of-sedationanalgesia

American Society of Anesthesiologists (ASA). Standards for basic anesthetic monitoring. Developed By: Committee on Standards and Practice Parameters (CSPP) Last Amended: October 28, 2015 (original approval: October 21, 1986). Available at: https://www.asahq.org/standards-and-guidelines/standards-for-basic-anesthetic-monitoring

Arora, S., Sevdalis, N., Nestel, D., Woloshynowych, M., Darzi, A., & Kneebone, R. (2010). The impact of stress on surgical performance: a systematic review of the literature. Surgery, 147(3), 318-330.

Bennett, J. D., Kramer, K. J., & Bosack, R. C. (2015). How safe is deep sedation or general anesthesia while providing dental care?. The Journal of the American Dental Association, 146(9), 705-708.

Bosack, R. (2018). The failed sedation: solutions for the oral and maxillofacial surgeon, Oral and Maxillofacial Surgery Clinics, 30(2), 165-170.

Bosack, R. C., & Lieblich, S. (Eds.). (2015). Anesthesia complications in the dental office. John Wiley & Sons.

Chung, W. L. (2013). Anesthesia equipment for the oral and maxillofacial surgery practice. Oral and Maxillofacial Surgery Clinics, 25(3), 373-383.

Cillo, J. E., Jr., Aghaloo, T., Basi, D., Bouloux, G. F., Campbell, J. A., Chou, J., Peacock, Z. (2018) Proceedings of the American Association of Oral and Maxillofacial Surgeon's 2017 Clinical and Scientific Innovations in Oral and Maxillofacial Surgery (CSIOMS). J Oral Maxillofac Surg, 76(2), 248–257.

Coté, C. J., Wilson, S., American Academy of Pediatrics, & American Academy of Pediatric Dentistry. (2019). Guidelines for monitoring and management of pediatric patients before, during, and after sedation for diagnostic and therapeutic procedures. Pediatrics, 143(6).

Drew, S. J. (2018). Oral and maxillofacial surgery team anesthesia model and anesthesia assistant training. Oral and Maxillofacial Surgery Clinics, 30(2), 145-153.

Ericsson, A., & Pool, R. (2016). Peak: Secrets from the new science of expertise. Houghton Mifflin Harcourt

Fain, D. W., Ferguson, B. L., Indresano, A. T., Johnson Jr, J. D., Rafetto, L. K., Farrell, S., & Egbert, M. A. (2017). The oral and maxillofacial surgery anesthesia team model. Journal of Oral and Maxillofacial Surgery, 75(6), 1097-1100.

Gaba, D. M., Fish, K. J., Howard, S. K., & Burden, A. (2014). Crisis Management in Anesthesiology E-Book. Elsevier Health Sciences.

Herlich, A. (2013). Anesthesia and Dentistry: Improving Patient Safety Through Education. ASA Monitor, 77(8), 22-24.

Indresano, A. T., Nannini, V. L., Tiner, B. D., Johnson, J. D., Ferguson, B. L., Shafer, D., & Egbert, M. A. (2019). AAOMS response to recent challenges to OMS office-based anesthesia for pediatric patients. Journal of Oral and Maxillofacial Surgery, 77(12), 2372-2376.

Inverso, G., Dodson, T. B., Gonzalez, M. L., & Chuang, S. K. (2016). Complications of moderate sedation versus deep sedation/general anesthesia for adolescent patients undergoing third molar extraction. Journal of Oral and Maxillofacial Surgery, 74(3), 474-479.

Hines, R. L., & Jones, S. B. (Eds.). (2021). Stoelting's Anesthesia and Co-existing Disease E-book. Elsevier Health Sciences.

Krishnan, D. (2018). Anesthesia for the pediatric oral and maxillofacial surgery patient, Oral and Maxillofacial Surgery Clinics, 30(2), 171-182.

LeBlanc, V. R. (2009). The effects of acute stress on performance: implications for health professions education. Academic Medicine, 84(10), S25-S33.

Lieblich, S. (2018). Providing anesthesia in the oral and maxillofacial surgery office: a look back, where we are now and a look ahead. Journal of Oral and Maxillofacial Surgery, 76(5), 917-925.

Leiblich, S. (2018). Preoperative Evaluation and Patient Selection for Office-Based Oral Surgery Anesthesia. Oral and Maxillofacial Surgery Clinics, 30(2), 145-153.

Lemov, D., Woolway, E., & Yezzi, K. (2012). Practice perfect: 42 rules for getting better at getting better. John Wiley & Sons.

Lipshy, K. A. (2013). Crisis Management Leadership in the Operating Room-Prepare Your Team to Survive Any Crisis. Creative Team Publishing.

Makary MA, Segev DL, Pronovost PJ, et al. Frailty as a predictor of surgical outcomes in older patients. J Am Coll Surg 2010;210:901-8.

McDonald, J., & Orlick, T. (1994). Excellence in surgery: psychological considerations. Contemporary Thought on Performance Enhancement, 3(1), 13-22.

Morrow S, Forsythe J, Afriat S, et al: Pediatric anesthesia study, December 2016. Dental Board of California. https://www.dbc.ca.gov/formspubs/anesthesia_study.pdf. Accessed July 16, 2019

Perrott, D. H., Yuen, J. P., Andresen, R. V., & Dodson, T. B. (2003). Office-based ambulatory anesthesia: outcomes of clinical practice of oral and maxillofacial surgeons. Journal of oral and maxillofacial surgery, 61(9), 983-995.

Rafetto A, Rafetto LK. Office Anesthesia in Dentistry: Assuring Safety While Reducing Anxiety. Dela J Public Health. 2018 Jan 9;4(1):42-47. doi: 10.32481/djph.2018.01.010. PMID: 34466953; PMCID: PMC8396579.

Robert, R and Patel, C. (2018). Oral surgery patient safety concepts in anesthesia, Oral and Maxillofacial Surgery Clinics, 30(2), 183-194.

Sims, P. G. (2003). Adverse events with outpatient anesthesia in Massachusetts. Journal of Oral and Maxillofacial Surgery, 61(7), 800.

Sims, P. G. (2013). Preoperative, intraoperative, and postoperative anesthesia assessment and monitoring in oral surgery. Oral and Maxillofacial Surgery Clinics, 25(3), 367-371.

Swartz, A. (2018). Airway management for the oral surgery patient, Oral and Maxillofacial Surgery Clinics, 30(2), 145-153.

Todd, D. W. (2013). Pediatric sedation and anesthesia for the oral surgeon. Oral and Maxillofacial Surgery Clinics, 25(3), 467-478.

Todd, D. W., Weber, C. R., Krishnan, D. G., & Egbert, M. A. (2021). Oral-Maxillofacial Surgery Anesthesia Team Model at a Crossroads Safety in Office-Based Anesthesia–Lessons We Can Learn from Aviation. Journal of Oral and Maxillofacial Surgery, 79(9), 1812-1814.

Todd, D. W., & Schaefer, J. J. (2018). The American Association of Oral and Maxillofacial Surgeons simulation program. Oral and Maxillofacial Surgery Clinics, 30(2), 195-206.

Verma, P., & Krishnan, D. G. (2021). Office-Based Anesthesia in Oral and Maxillofacial Surgery-The American Model and Training. In Oral and Maxillofacial Surgery for the Clinician (pp. 79-93). Springer, Singapore.

Wachter, R. M. (2012). Understanding patient safety. 2. New York, NY: McGraw-Hill Medical.

Wiemer, S. J., Nathan, J. M., Heggestad, B. T., Fillmore, W. J., Viozzi, C. F., Van Ess, J. M., & Ettinger, K. S. (2021). Safety of outpatient procedural sedation administered by oral and maxillofacial surgeons: the Mayo Clinic Experience in 17,634 Sedations (2004 to 2019). Journal of Oral and Maxillofacial Surgery, 79(5), 990-999.

Commission on Dental Accreditation

Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery

EX. 4

Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery

Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, Illinois 60611
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Document Revision History

Date	Item	Action
February 12, 2021	Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery	Adopted and Implemented
February 12, 2021	Revised Standards 4-4 and 4-6 through 4-8; Deletion of Standard 4-6.1; and Addition of 4-8.2 and 4-18 through 4-20	Adopted
January 1, 2022	Revised Standards 4-4 and 4-6 through 4-8; Deletion of Standard 4-6.1; and Addition of 4-8.2 and 4-18 through 4-20	Implemented

Table of Contents

Mission Statement of the Commission on Dental Accreditation

The Commission on Dental Accreditation serves the public and profession by developing and implementing accreditation standards that promote and monitor the continuous quality and improvement of dental education programs.

Commission on Dental Accreditation
Adopted: August 5, 2016

Examples of evidence to demonstrate compliance may include:

- Education in the diagnosis, imaging, surgical and non-surgical management, including instruction in biomaterials.
- Didactic Schedules
- Resident case logs
- Clinic Schedules

GENERAL ANESTHESIA AND DEEP SEDATION

4-9 **The off-service rotation in anesthesia must be supplemented by longitudinal and progressive experience throughout the training program in all aspects of pain and anxiety control. The ambulatory oral and maxillofacial anesthetic experience must include the administration of general anesthesia/deep sedation for oral and maxillofacial surgery procedures to pediatric, adult, and geriatric populations, including the demonstration of competency in airway management.**

Examples of evidence to demonstrate compliance may include:

- Resident's anesthetic log
- Clinical tracking system
- Anesthesia records
- Oral and Maxillofacial Surgery Benchmarks

4-9.1 **The cumulative anesthetic experience of each graduating resident must include administration of general anesthesia/deep sedation for a minimum of 300 cases. This experience must involve care for 50 patients younger than 13. A minimum of 150 of the 300 cases must be ambulatory anesthetics for oral and maxillofacial surgery outside of the operating room.**

Intent: *The cumulative experience includes time on the anesthesia rotation as well as anesthetics administered while on the oral and maxillofacial surgery service. Locations for ambulatory anesthesia may include dental school clinics, hospital clinics, emergency rooms, and oral and maxillofacial surgery offices.*

Examples of evidence to demonstrate compliance may include:

- Resident's anesthetic log.
- Clinical tracking system.
- Anesthesia records.
- Oral and Maxillofacial Surgery Benchmarks

4-9.2 The graduating resident must be trained to competence in the delivery of general anesthesia/deep sedation to patients of at least 8 years of age and older.

4-9.3 The graduating resident must be trained in the management of children younger than 8 years of age using techniques such as behavior management, inhalation analgesia, sedation, and general anesthesia.

Examples of evidence to demonstrate compliance may include:

- Didactic Schedules
- Resident Anesthetic Logs
- Detailed curriculum plans
- Patient charts
- Simulation experience

4-9.4 The graduating resident must be trained in the anesthetic management of geriatric patients.

Examples of evidence to demonstrate compliance may include:

- Didactic Schedules
- Resident Anesthetic Logs
- Detailed curriculum plans
- Patient charts
- Simulation experience

4-9.5 The clinical program must be supported in part by a core comprehensive didactic program on general anesthesia, deep sedation, moderate sedation, behavior management and other methods of pain and anxiety control. The didactic program must include lectures and seminars emphasizing:

a. Perioperative evaluation and optimization of patients of all ages,
b. Risk assessment,
c. Anesthesia and sedation techniques,
d. Monitoring, and
e. The diagnosis and management of complications.

4-9.6 Advanced Cardiac Life Support (ACLS) must be obtained in the first year of residency and must be maintained throughout residency training.

Examples of evidence to demonstrate compliance may include:

- ACLS certification records and cards

4-9.7 Each resident must be certified in Pediatric Advanced Life Support (PALS) prior to completion of training.

Examples of evidence to demonstrate compliance may include:

- PALS certification records and cards

ADMISSIONS

4-10 Inpatient surgical experience must ensure adequate training in a broad range of inpatient oral and maxillofacial surgery care, including admission and management of patients.

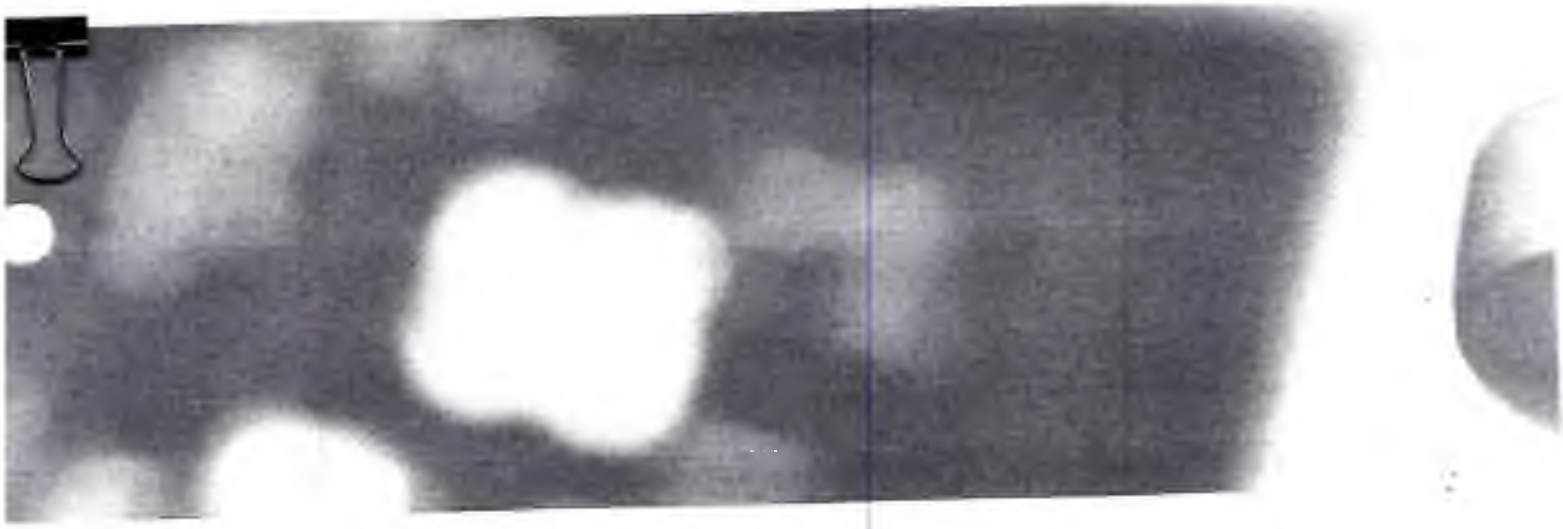
MAJOR SURGERY

4-11 For each authorized final year resident position, residents must perform 175 major oral and maxillofacial surgery procedures on adults and children, documented by at least a formal operative note. For the above 175 procedures there must be at least 20 procedures in each category of surgery. The categories of major surgery are defined as: 1) trauma 2) pathology 3) orthognathic surgery 4) reconstructive and cosmetic surgery. Sufficient variety in each category, as specified below, must be provided. Surgery performed by oral and maxillofacial surgery residents while rotating on or assisting with other services must not be counted toward this requirement.

Intent: *The intent is to ensure a balanced exposure to comprehensive patient care for all major surgical categories. In order for a major surgical case to be counted toward meeting this requirement, the resident serves as an operating surgeon or first assistant to an oral and maxillofacial surgery teaching staff member. The program documents that the residents have played a significant role (diagnosis, perioperative care and subsequent follow-up) in the management of the patient.*

Examples of evidence to demonstrate compliance may include:

- Department and institution general operating room statistics and logs
- Patient Medical Records
- Schedules showing that resident was present in pre- and post-operative visits



Office Anesthesia Evaluation Manual

American Association of Oral

EX. 5

Latest News | Events

WOMENS LEADERSHIP INITIATIVE Launched
Apr 07, 2021

Member Alert: Annual Meeting and Dental Implant Conference to go virtual
Jun 18, 2020

Telehealth Resources
May 01, 2020

Financial Steps to Take Now to Overcome a COVID-19 Business Downturn
Apr 28, 2020

States plead for volunteers, blood donations
Apr 13, 2020

All Member News

RELATED LINKS

AAOMS CENTENNIAL
BOARD OF TRUSTEES
GOVERNING RULES & REGULATIONS
CAREERS AT AAOMS
CONTACT US
BECOME A MEMBER
FIND A SURGEON AT MYOMS.ORG

About AAOMS

The American Association of Oral and Maxillofacial Surgeons (AAOMS), the professional organization representing more than 9,000 oral and maxillofacial surgeons in the United States, supports its members' ability to practice their specialty through education, research and advocacy. AAOMS members comply with rigorous continuing education requirements and submit to periodic office evaluations, assuring the public that office procedures and personnel meet stringent national standards.

AAOMS Membership Data
(as of Jan. 13, 2022)

Fellows/Members	6,024
Provisional Fellows/Members	243
Affiliate Members	230
Life Fellows/Members	2,277
Candidates for Membership	358
Resident Members	1,242
Retired Fellows/Members	929
Honorary Fellows	30
Inactive Fellows/Members	81
Allied Staff Members	899
Total Membership	11,313

The mission of AAOMS is to advance patient access to safe and effective oral and maxillofacial surgery by advancing, promoting and preserving the specialty of oral and maxillofacial surgery and the skill and professionalism of AAOMS members.

Related Organizations

American Board of Oral and Maxillofacial Surgery

American Board of Oral and

AAOMS Advantage℠

EX-6

Dental Anesthesia Assistant National Certification Examination (DAANCE)

dAANCE

FAQ's

Additional Suggested Readings

Tuition includes the DAANCE Study Materials and Examination fee only. The following additional suggested readings may be ordered separately through AAOMS Publications by phone at 800-366-6725 or online at AAOMSstore.com.

1. AAOMS Office Anesthesia Evaluation Manual, 9th Edition ©copyright 2018
2. Additional Office Anesthesia Products

The Dental Anesthesia Assistant National Certification Examination is a two-part continuing education program comprised of approximately 36 hours of self-study material and quizzes and a standardized, computer-based exam. This course is designed for oral and maxillofacial surgery assistants or assistants employed by other dental professionals with valid anesthesia permits. The American Association of Oral and Maxillofacial Surgeons is an ADA CERP Recognized Provider. ADA CERP is a service of the American Dental Association to assist dental professionals in identifying quality providers of continuing dental education. ADA CERP does not approve or endorse individual courses or instructors, nor does it imply acceptance of credit hours by boards of dentistry. The American Association of Oral and Maxillofacial Surgeons designates this activity for 36 continuing education credits. Upon successful completion of the final examination, the assistant will receive proof of certification and a program completion lapel pin.

All course registrants receive a syllabus, study guide, a suggested reading list, and practice quizzes. Registrants work through the material at their own pace over a six-month time period, reviewing materials and quizzes with their sponsoring surgeons. After completing the self-study materials, participants take a 2-hour, computerized exam at designated testing centers. There are over 100 testing sites located throughout the country. This self study course is available year round.

The self-study materials and the final exam cover 5 major areas:

1. Basic sciences
2. Evaluation and preparation of patients with systemic diseases
3. Anesthetic drugs and techniques
4. Anesthesia equipment and monitoring
5. Office anesthesia emergencies

To be eligible to participate in DAANCE, an assistant must be:

1. Employed for at least six months by either an AAOMS fellow/member or by a dental professional who holds a valid anesthesia permit
2. CPR or BLS certified*

In addition, please submit the following documents:

** applicants must provide a copy of a current CPR or BLS certification with their registration form in order to receive their study materials and to schedule an examination. The CPR or BLS certification must be current through your examination date (a minimum of six months or your registration will not be processed and you will not receive your registration materials).*

EX-7

OBEAM module sessions in Rosemont, Ill.

OBEAM session 2022	Time (Central)	Session code	Availability	Hotel reservations
Oct. 8, 2022	8 a.m. - noon	SIM122100808	Register online	Hotel reservations
Oct. 8, 2022	1 - 5 p.m.	SIM122100813	Register online	Hotel reservations
Oct. 9, 2022	8 a.m. - noon	SIM122100908	CLOSED	CLOSED
Oct. 22, 2022	8 a.m. - noon	SIM122102208	Register online	Hotel reservations
Oct. 22, 2022	1 - 5 p.m.	SIM122102213	Register online	Hotel reservations
Oct. 23, 2022	8 a.m. - noon	SIM122102308	CLOSED	CLOSED
Nov. 12, 2022	8 a.m. - noon	SIM122111208	CLOSED	CLOSED
Nov. 12, 2022	1 - 5 p.m.	SIM122111213	CLOSED	CLOSED
Nov. 13, 2022	8 a.m. - noon	SIM122111308	Register online	Hotel reservations
Dec. 1, 2022	8 a.m. - noon	SIM122120108	Register online	Hotel reservations
Dec. 1, 2022	1 - 5 p.m.	SIM122120113	Register online	Hotel reservations

Annual Meeting OBEAM module sessions in New Orleans, La.

Five OBEAM modules will be available to Annual Meeting attendees. For more information on how to register for Annual Meeting and a ticketed OBEAM module session, visit AAOMS.org/AnnualMeeting

OBEAM module session information

The AAOMS National Simulation Program allows participants to practice and master critical techniques for administering and monitoring office-based anesthesia. Unlike previous anesthesia emergency simulation courses, this program is standardized to ensure every participant experiences the same simulated events. Its state-of-the-art technology enables AAOMS to automatically evaluate the performance of every participant and pinpoint those areas that may benefit from additional training. In short, this program offers oral and maxillofacial surgeons an effective method of assessing their readiness to meet an office anesthesia emergency situation.

At the conclusion of this activity, participants should be able to

- Review concepts and skills to obtain an understanding of sedation monitoring, supplemental oxygen techniques, techniques for opening an airway, bag mask ventilation using one- and two-person technique, proper laryngeal mask airway insertion technique and proper Airtraq insertion technique.
- Demonstrate mastery of bag mask ventilation using one- and two-person techniques for both normal and difficult simulated ventilation situations, laryngeal mask airway insertion using proper technique and Airtraq insertion using proper technique.

Office-Based Emergency Airway Management (OBEAM) Module

OBEAM Sessions 2022 | Annual Meeting OBEAM Sessions | OBEAM Sessions 2023

Registration

This program is being offered to AAOMS fellows and members at a rate of $800 per participant. OBEAM modules are limited to AAOMS members and fellows. Sessions are not yet available for professional staff. Registration is available as specified in the list below. To be added to a session's wait list, please contact AAOMS event registration staff.

Attendees are encouraged to register **online.** Those who prefer to mail or fax their registration may download and complete the PDF registration form.

OBEAM module sessions in Rosemont, Ill.

Parameters and Pathways:

Clinical Practice
Guidelines for Oral and Maxillofacial Surgery
(AAOMS ParPath 01)

Version 3.0
Supplement to the Journal of Oral and Maxillofacial Surgery

American Association of Oral and Maxillofacial Surgeons

Catlin, Kimberly (LARA)

From: BPL-BoardSupport
Sent: Monday, August 22, 2022 3:38 PM
To: Ditschman, Andria (LARA)
Subject: FW: BoD Comments
Attachments: Board of Dentistry Comments.pdf

-----Original Message-----
From: Ellen Sugrue Hyman <Hyman@mohc.org>
Sent: Monday, August 22, 2022 3:30 PM
To: BPL-BoardSupport <BPL-BoardSupport@michigan.gov>
Cc: Emily Henderson <emily@mccallhamilton.com>
Subject: FW: BoD Comments

Please see attached.

Warm Regards,

Ellen Sugrue Hyman
Executive Director

MICHIGAN Oral Health Coalition

Board of Directors

Contact Us

August 22, 2022

Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing– Boards and Committees Section
P.O. Box 30670
Lansing, MI 48909-8170

Attention: Departmental Specialist

Thank you for the opportunity to comment on the Board of Dentistry General rules.

We applaud the inclusion of a Dental Public Health (R 338.115040) specialty in the rules.

We are glad to see the inclusion of telehealth options for teledentistry (PART 6B. TELEHEALTH) and have the following comments:

(1) We want to ensure that an individual does not need to be a patient of record of the provider to have a teledentistry appointment. Often, individuals in an emergency dental situation (injury to or infection of a tooth) do not have a dental home and may need to be seen by a dental professional who has not yet seen them in person.
(2) We would like to encourage additional options for/uses of teledentistry such as asynchronous teledentistry that would allow a dentistry to review the record of a patient taken by a RDH.

Please let me know if you have any questions.

Warm Regards,

Ellen Sugrue Hyman
Executive Director

Catlin, Kimberly (LARA)

From: BPL-BoardSupport
Sent: Monday, August 22, 2022 3:31 PM
To: Ditschman, Andria (LARA)
Subject: FW: Letter of Support: Proposed Changes to the Dentistry General Rules Set
Attachments: CMDS Dentistry General Rules Set _ Support Letter.pdf

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From: Katie Whitman-Herzer <katie.l.whitman@gmail.com>
Sent: Monday, August 22, 2022 3:30 PM
To: BPL-BoardSupport <BPL-BoardSupport@michigan.gov>
Subject: Letter of Support: Proposed Changes to the Dentistry General Rules Set

Good afternoon -

Please see the attached letter from Quadrant Consulting on behalf of the Council of Michigan Dental Specialties, Inc. regarding the proposed changes to the Dentistry General Rules set.

Warm regards,

Katie Whitman-Herzer
Quadrant Consulting Group

Council of Michigan Dental Specialties, Inc.

Michigan Association of Endodontics
Michigan Society of Oral and Maxillofacial Pathology
Michigan Society of Oral and Maxillofacial Surgeons
Michigan Association of Orthodontists
Michigan Academy of Pediatric Dentistry
Michigan Periodontal Association
Michigan Section of the American College of Prosthodontists

August 22, 2022

Katie Whitman-Herzer
Quadrant Consulting Group, LLC
230 N. Washington Square, Suite 100
Lansing, MI 48933

To Whom It May Concern:

With regard to the proposed changes to the Dentistry General Rules Set, the Council of Michigan Dental Specialties, Inc. (CMDS) supports:

- Changes in the delegation of assignment for DAs/UDAs assisting procedures involved with orthodontic treatment. Changes in the existing rules and the proposed rules in Part 4A and Table I to support the current state of dental care in Michigan as well as accurately reflect current dental education, and address the shortfalls happening with access to care and restricting meaningful employment in our State.

- Updating Rule 1811(2)c from "Oral pathologists" to "Oral & maxillofacial pathologists" for consistency throughout the rules.

- Adding AAOMS to the anesthesia rules, R-338.11601 and R-338.11602 as one of the national organizations authorized to give the mandatory course on addressing medical emergencies during anesthesia and for monitoring guidelines for both adults and children. The ADA, ASA and pediatric groups are listed, but those organizations do not teach courses that are based on the CODA residency training and OMS standards: only AAOMS provides these courses. This is important because OMSs provide 78% of dental office deep sedation and general anesthesia nationally and in Michigan, so OMSs rely heavily on AAOMS for CE courses designed to bring licensed specialists updated courses based on their model to protect the public.

- Incorporating any/all comments pertaining to General Rules Set 2021-40 LR from specialists/members from the following specialties: Michigan Association of Endodontics, Michigan Society of Oral and Maxillofacial Pathology, Michigan Society of Oral and Maxillofacial Surgeons, Michigan Association of Orthodontists, Michigan Academy of Pediatric Dentistry, Michigan Periodontal Association, and Michigan Section of the American College of Prosthodontists.

Thank you for your time and consideration.

Dentistry General Rules - ORR 2021-040 LR
Public Comment Summary
Rules Committee's Recommendations and Board of Dentistry's Response to August 22, 2022, Public Comments

Testimony/Comments Received:

Brent Accurso
Marc Bernard Ackerman, American TeleDentistry Association (ATDA)
Heather Beavers, Michigan Oral Health Program, Department of Health and Human Services (DHHS)
Vincent Benivegna, Michigan Dental Association (MDA)
Richael Cobler, Central Regional Dental Testing Service, Inc. (CRDTS)
Misty Davis, Michigan Primary Care Association (MPCA)
Tyler Diers, TechNet
Heather Gietzen
Kim Hoppes, Michigan Dental Assistants Association, (MDAA)
Peter Horkan, Governmental Affairs, SmileDirectClub
Ellen Sugrue Hyman, Michigan Oral Health Coalition (MOHC)
Representative Bronna Kahle, 57th District
Shirley Kim, Byte
J. David Johnson, American Association of Oral and Maxillofacial Surgeons (AAOMS)
Mark Johnston, DDS
Nathan Mick and Nathan Thomas, American Association of Orthodontists (AAO) and Michigan Association of Orthodontists (MAO)
Richard Small and Frank Farbod, Michigan Society of Oral and Maxillofacial Surgeons (MSOMS)
Kathryn Swan
Irene Tseng, DDS
Senator Curtis VanderWall, 35th District
Katie Whitman-Herzer, Council of Michigan Dental Specialties, Inc.

Representative Angela Witwer, 71st District
Amy Zaagman, Michigan Council for Maternal and Child Health (MCMCH)

The following 50 individuals sent the same letter regarding R 338.11411 (delegation of duties): Katherine Beard, Marsha Beattie, Jashleen Bedi, Michael Behnan, Sara Bergsma, Mark Bieszki, Steven Bowman, George Bork, Rick Bruno, Jason Charnley, Te Chen, David Copus, Spencer Crouch, Andrew DeHaan, Richard Friedman, Kevin Hallgren, Renee Geran, Cameron George, Heather Gietzen, Sindy Goodman, Christian Groth, Eric Hannapel, Travis Harshman, Gregory Hummon, Amy Isenberg, Ludia Kim, Maureen Kuhta, Michel Lanzetta, Kathryn Marks, Laurie McClatchey, Lathe Miller, John Monticello, Mark Powell, Nicholas Rafaill, Tracie Resler, Jamie Sage, Dina Salman, Scott Schulz, Thomas Shannon, Lainie Shapiro, Brandon Shoukri, Nicole Siara-Olds, Ritu Singh, Kathryn Swan, Lauren Sytek, Nathan Thomas, Nicole Teifer, James Williams, and Gabrielle Zuzo

Typographical changes in green

General Comment

Rule Numbers	Commenter	Comment
	Beavers/DHHS	All pronouns be changed to they or their to be gender neutral.
338.11247 338.11263 338.11265 338.11267 338.11269 338.11411 338.11701 338.11703 338.11704	Beavers/DHHS	Regarding the new infection control requirement, we suggest adding "the current version" before the Centers for Disease Control and Prevention's infection control guidelines.
	Tseng	Modify references from CDCA-WREB to CDCA-WREB-CITA throughout the document.
Rules Committee Response	• The Rules Committee agrees with the comment to modify the pronouns in the document as allowed by the rule making requirements. • The Rules Committee agrees that the most up to date version of the Centers for Disease Control and Prevention's	

	infection control guidelines should be referenced in the rules. • The Rules Committee agrees with the comment to update CDCA-WREB-CITA throughout the document to reflect the merger of these entities.

Board Response	• The Board agrees with the comment to modify the pronouns in the document as allowed by the rule making requirements. • The Board agrees that the most up to date version of the Centers for Disease Control and Prevention's infection control guidelines should be referenced in the rules. The definitions in R 338.11101 will be modified as follows: **"CDC infection control guidelines" means the Centers for Disease Control and Prevention infection control guidelines established by the CDC in effect on the effective date of the rules and any amendments adopted by the CDC.** • The Board agrees with the comment to update CDCA-WREB-CITA throughout the document to reflect the merger of these entities.

Rule 338.11101 Definitions.

Rule Numbers	Commenter	Comment
Section (1)	Johnston	Include the following in the definition of "dental ethics and jurisprudence with inclusion of delegation of duties to allied dental personnel:" Dental providers must be aware of the legal and ethical principles that guide patient care, professional interactions, and record keeping. The first portion of any presentation should review core ethical principles and their guidance to address frequently encountered ethical dilemmas. The second portion of any presentation should discuss critical legal concepts, including contracts, intentional and unintentional torts, informed consent, and informed refusal. Ethical principles often serve as the foundation of legal obligations. Thus, the intersection of law and ethics will be integrated into the presentations. Presentation objectives:

		1. Describe five key ethical principles; autonomy, beneficence, justice, veracity, and non-maleficence, and the guidance they provide to dental providers. 2. Describe fundamental legal principles important to dental providers, including contracts, intentional and unintentional torts, informed consent, and informed refusal. 3. Emphasize the importance of record keeping, include specific examples of what content should be included, including a template that can be modified to meet individual needs. 4. Present a framework to resolve frequently encountered ethical dilemmas.
(1)	Tseng	Consider adding more explanation of what is required in the jurisprudence and ethics courses or consider allowing the Board CE committee to review the contents of all courses that are offered to fulfill this requirement.
(1)(nn)	Gietzen	I do have concerns regarding the change from DA to UDA.
(1)(nn)	Swan	I object to the creation of the new title "unregistered dental auxiliary." This terminology is insulting to our well trained, dedicated, and often long-term employees who do not have an RDA license. This term appears to have been created not to solve a problem in the dental workplace, but rather to stroke the egos of certain dental personnel. While Registered Dental Assistants are valuable, they do not own the descriptor of "dental assistant." This, by pure grammar and English language, is any person who assists the dentist. There is no need to introduce this confusing additional terminology.
Rules Committee Response	**Section 1:** The Rules Committee agrees with the comment to add a definition for "dental ethics and jurisprudence with inclusion of delegation of duties to allied dental personnel course or program" to include: Presentation objectives: 1. Describe five key ethical principles; autonomy, beneficence, justice, veracity, and non-maleficence, and the guidance they provide to dental providers. 2. Describe fundamental legal principles important to dental providers, including contracts, intentional and unintentional torts, informed consent, and informed refusal. 3. Emphasize the importance of record keeping, include specific examples of what content should be included, including a template that can be modified to meet individual needs. 4. Present a framework to resolve frequently encountered ethical dilemmas. 5. Present the delegation and assigned duties in Table 1 of the board rules and explain the levels of supervision. **Section (1)(nn):** The Rules Committee does not agree with the comment that the term "unregistered dental auxiliary" should be modified to "dental assistant" as "dental assistant" is a protected term in the Public Health Code, therefore,	

	only licensed dental assistants can use the “dental assistant.”

Board Response	**Section 1:** The Board agrees with the comment to add a definition for “dental ethics and jurisprudence with inclusion of delegation of duties to allied dental personnel course or program” to include: Presentation objectives: 1. Describe five key ethical principles; autonomy, beneficence, justice, veracity, and non-maleficence, and the guidance they provide to dental providers. 2. Describe fundamental legal principles important to dental providers, including contracts, intentional and unintentional torts, informed consent, and informed refusal. 3. Emphasize the importance of record keeping, include specific examples of what content should be included, including a template that can be modified to meet individual needs. 4. Present a framework to resolve frequently encountered ethical dilemmas. 5. Present the delegation and assigned duties in Table 1 of the board rules and explain the levels of supervision. **Section (1)(nn):** The Board does not agree with the comment that the term “unregistered dental auxiliary” should be modified to “dental assistant” as “dental assistant” is a protected term in the Public Health Code, therefore, only licensed dental assistants can use the “dental assistant.”

Rule 1101. (1) As used in these rules:

“AAOMS” means American Association of Oral and Maxillofacial Surgeons.

(a)“AAP” means the American Academy of Pediatrics.

(b) “AAPD” means the American Academy of Pediatric Dentistry.

(c) “ACLS” means advanced cardiac life support.

(d) “ADA” means the American Dental Association or a successor organization.

(e) “ADA CERP” means the American Dental Association Continuing Education Recognition Program.

(f) “ADEX” means the American Board of Dental Examiners, Inc. examination that is conducted by the CDCA-WREB.

(g) “AGD” means the Academy of General Dentistry.

(h) “AHA” means the American Heart Association.

(~~a~~**i**)“Allied dental personnel” means the supporting team ~~who~~**that** receives appropriate delegation from a dentist or dental therapist to participate in dental treatment.

~~(b)~~**(j)** "Analgesia" means the diminution or elimination of pain in the conscious patient as a result of the administration of an agent including, but not limited to, local anesthetic, nitrous oxide, and pharmacological and non-pharmacological methods.

~~(c)~~**(k)** "Approved course" means a course offered by either a dental, dental therapy, dental hygiene, or dental assistant program accredited by the Commission on Dental Accreditation ~~(CODA)~~ of the American Dental Association ~~(ADA)~~ that meets the requirements in section 16611 of the code, MCL 333.16611.

(l) "ASA" means the American Society of Anesthesiologists.

~~(d) "Assistant" means a nonlicensed person who may perform basic supportive procedures under the supervision of a dentist as provided in these rules.~~

(m) "BLS" means basic ~~advanced~~ cardiac life support.

(~~e~~**n**) "Board" means the Michigan ~~board of dentistry~~**Board of Dentistry**.

(o) "CDAC" means the Commission on Dental Accreditation of Canada.

(p) "CDC" means the Centers for Disease Control and Prevention.

(q) "CDCA-WREB" means the Commission on Dental Competency Assessments Western Regional Examining Board or a successor organization.

(r) "CODA" means the Commission on Dental Accreditation or a successor organization.

(~~g~~**s**) "Code" means the public health code, 1978 PA 368, MCL 333.1101 to 333.25211.

(~~f~~**t**) "Conscious sedation" means a minimally depressed level of consciousness that retains a patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command and that is produced by a pharmacological or a non-pharmacological method or a combination of both.

(u) "DDS" means doctor of dental surgery degree.

"Dental ethics and jurisprudence with inclusion of delegation of duties to allied dental personnel course or program" means the program or course will include the following presentation objectives:

1. Describe five key ethical principles; autonomy, beneficence, justice, veracity, and non-maleficence, and the guidance they provide to dental providers.

2. Describe fundamental legal principles important to dental providers, including contracts, intentional and unintentional torts, informed consent, and informed refusal.

3. Emphasize the importance of record keeping, include specific examples of what content should be included, including a template that can be modified to meet individual needs.

4. Present a framework to resolve frequently encountered ethical dilemmas.

5. Present the delegation and assigned duties in Table 1 of the board rules and explain the levels of supervision.

(~~h~~**w**) "Dental therapist" means a person licensed under part 166 of the code, MCL 333.16601 to 333.16659, to provide the care and services and perform any of the duties described in section 16656 of the code, MCL 333.16656.

(~~i~~**x**) "Dentist" means, except as otherwise provided in R 338.11801 **and R 338.11218**, a person licensed by the board under the code and these rules to engage in the practice of dentistry.

(~~j~~**y**) "Department" means the department of licensing and regulatory **affairs**.

(z) "DMD" means doctor of dental medicine degree.

~~(k) "Enteral" means any technique of administration in which the agent is absorbed through the gastrointestinal or oral mucosa.~~

(~~l~~**aa**) "General anesthesia" means the elimination of all sensations accompanied by a state of unconsciousness and loss of reflexes necessary to maintain a patent airway.

(bb) "INBDE" means the Integrated National Board Dental Examination.

(cc) "JCNDE" means the Joint Commission on National Dental Examinations.

(~~m~~**dd**) "Licensed" means the possession of a full license to practice, unless otherwise stated by the code or these rules.

(~~n~~**ee**) "Local anesthesia" means the elimination of sensation, especially pain, in 1 part of the body by the topical application or regional injection of a drug.

(ff) "NBDE" means the National Board Dental Examination.

(gg) "NBDHE" means the National Board Dental Hygiene Examination.

(hh) "NDEB" means the National Dental Examining Board of Canada.

(~~o~~**ii**) "Office" means the building or suite in which dental treatment is performed.

~~(p) "Parenteral" means a technique of administration in which the drug bypasses the gastrointestinal (gi) tract, including intramuscular (im), intravenous (iv), intranasal (in), submucosal (sm), subcutaneous (sc), and intraocular (io).~~

(jj) "PALS" means pediatric advanced life support.

(~~q~~**kk**) "~~Registered dental assistant~~**RDA**" ~~(RDA)~~ means a person licensed as a registered dental assistant by the board under the code and these rules **who performs dental procedures as specified in R 338.11411, Table 1**. A ~~dental hygienist~~**RDH** may perform the functions of ~~a registered dental assistant~~**a RDA** if he or she is licensed by the board as ~~a registered dental assistant~~**a RDA**.

(~~r~~**ll**) "~~Registered dental hygienist~~**RDH**" ~~(RDH)~~ means a person licensed as ~~such~~ a registered dental hygienist by the board under the code and these rules, **who performs basic supportive dental procedures as specified in R 338.11411, Table 1**.

(~~s~~**mm**) "Second pair of hands" means acts, tasks, functions, and procedures performed by ~~a dental assistant~~**a UDA**, ~~registered dental assistant~~**RDA**, or ~~registered dental hygienist~~**RDH** at the direction of a dentist, dental therapist, or ~~registered dental hygienist~~RDH who is in the process of rendering dental services and treatment to a patient. The acts, tasks, functions, and procedures performed by a ~~dental assistant~~**UDA**, ~~registered dental assistant~~**RDA**, or ~~registered dental hygienist~~**RDH** are ancillary to the procedures performed by the dentist, dental therapist, or ~~registered dental hygienist~~**RDH** and intended to provide help and assistance ~~at the time~~**when** the

procedures are performed. This definition does not expand the duties of ~~the dental assistant~~**a UDA**, ~~registered dental assistant~~**RDA**, or ~~registered dental hygienist~~**RDH** as provided by the code and rules promulgated by the board.

(~~t~~**nn**) "Sedation" means the calming of a nervous, apprehensive individual, without inducing loss of consciousness, through the use of systemic drugs. Agents may be given orally, parenterally, or by inhalation.

(oo) "UDA" means an unregistered dental auxiliary, who is unlicensed and performs basic supportive dental procedures as specific in R 338.11411, Table 1.

(2) Unless otherwise defined in these rules, the terms defined in the code have the same meaning ~~when~~**as** used in these rules. ~~treatment is performed upon a patient.~~

Rule 338.11120 Dental treatment records; requirements.

Rule Numbers	Commenter	Comment
Section (1)	Spangler	Does the word "maintain" mean write and enter or does it mean keep physical possession of the record. Can this be clarified?
(2)(d)	Spangler	This should read "Diagnosis and treatment plan as determined by the dentist." No other dental professional can diagnose. Without a diagnosis, there is no treatment plan. CODA standards dictate that dental therapists are trained to identify, evaluate, and assess. The word diagnose is never used in the CODA standards for Dental Therapy Programs. Diagnosis and treatment planning is a duty that cannot be delegated, or may be delegated. I believe there is a conflict between what the law says and what dental therapists are trained to do. The alternative is to put a training requirement regarding treatment planning in the rules for dental therapists. It would be unsafe to have any dental professional licensed to do something they are not trained to do especially if they are miles from the contractually obligated dentist. It is contrary to the intent of the administrative rules.
Rules Committee Response	**Section (1):** The Rules Committee agrees with the comment to clarify the meaning of "maintain." The Rules Committee recommends modifying "maintain" to "retain and preserve." **Section (2)(d):** The Rules Committee agrees with the comment that the term diagnosis should be clarified with "as determined by the supervising dentist." Although information was submitted to the Rules Committee that the CODA curriculum requirements do not include training in treatment planning, as the Code, in section 16655(2) includes treatment planning in the DT's scope of practice, the Code requires the supervising dentist to give written authorization to the DT, and the supervising dentist must review the patient records, the Rules Committee does not agree that	

	clarifying language is necessary regarding "treatment plan."

Board Response	**Section (1):** The Board agrees with the comment to clarify the meaning of "maintain." "maintain" will be modified to "retain and preserve." **Section (2)(d):** The Board agrees with the comment that the term diagnosis should be clarified with "as determined by the supervising dentist" as only the dentist can diagnose. The Board does not agree that clarifying language is necessary regarding "treatment plan."

R 338.11120 Dental treatment records; requirements.

Rule 1120. (1) A dentist or dental therapist shall make**,** ~~and maintain~~**retain, and preserve** a dental treatment record ~~on~~**of** each patient.

(2) A dental treatment record must include all of the following information:

(a) Medical and dental history.

(b) The patient's existing oral ~~health care~~**healthcare** status and the results of any diagnostic aids used.

(c) The patient's current health status as classified by the American Society of Anesthesiologists physical status classification system.

~~(c)~~**(d)** Diagnosis **as determined by the supervising dentist** and treatment plan.

~~(d)~~**(e)** Dental procedures performed upon the patient, including both of the following:

(i) The date the procedure was performed.

(ii) **The identity**~~Identity~~ of the dentist, dental therapist, or allied dental personnel performing each procedure.

~~(e)~~**(f)** Progress notes that include a chronology of the patient's progress throughout the course of all treatment.

~~(f)~~**(g)** The date, dosage, and amount of any drug prescribed, dispensed, or administered to the patient.

~~(g)~~**(h)** Radiographic **and photographic** images taken in the course of treatment. If radiographic **or photographic** images are transferred to another dentist, the name and address of that dentist must be entered in the treatment record.

(3) All dental treatment records must be maintained for not less than 10 years ~~from~~**after** the date of the last treatment.

Rule 338.11201 Licensure by examination to practice dentistry; graduate of programs in compliance with board standards.

Rule Numbers	Commenter	Comment
(c)	Cobler/CRDTS	Modify the rule to continue to accept substantially equivalent examinations for initial licensure.

		Accept CRDTS as a substantially equivalent examination for initial licensure. I am the Executive Director for Central Regional Dental Testing Service, Inc. (CRDTS) and recently came across this document Acceptable-Dentistry-Exams.pdf (michigan.gov) under Licensing Information on the Michigan Board of Dentistry website. CRDTS was unaware of this recent change to exclude the CRDTS examinations as a pathway toward dental and dental hygiene licensure. As the CRDTS dental and dental hygiene exams are "substantially equivalent to the ADEX examination" pursuant to R 338.11255 and R 338.11259, we formally request that Michigan revisit this matter. As you know portability for candidates seeking licensure is an important matter. Restricting acceptance of licensure examinations to one agency creates an undue burden for candidates. With the merger of CDCA, WREB and CITA, we at CRDTS have a deep concern about monopolization of the testing industry. I'm sure the board will agree that a monopoly is not in the best interest of the Dental Board, the candidates, or the professions.
Rules Committee Response	**Section (c):** The Rules Committee does not agree with the comment to accept substantially equivalent examinations for initial licensure as the rules already accept the American Board of Dental Examiners, Inc**.** (ADEX) examination conducted by the CDCA**-**WREB-CITA or a regional entity, which is a national examination offered in all states, Puerto Rico, Virgin Islands, and Jamaica. The Rules Committee accepts the grading, anonymity in grading, and standards of testing used in the ADEX examination.	

Board Response	**Section (c):** The Board does not agree with the comment to accept substantially equivalent examinations for initial licensure as the rules already accept the American Board of Dental Examiners, Inc**.** (ADEX) examination conducted by the CDCA**-**WREB-CITA or a regional entity, which is a national examination offered in all states, Puerto Rico, Virgin Islands, and Jamaica. The Rules Committee accepts the grading, anonymity in grading, and standards of testing used in the ADEX examination.

Rule 1201. In addition to meeting the requirements of **R 338.7001 to R 338.7005; any other rules promulgated under the code; and** section 16174 of the code, MCL 333.16174, an applicant for dentist licensure by examination shall submit a completed application, on a form provided by the department, together with the requisite fee and ~~shall~~ meet all of the following requirements:

(a) Graduate from a dental educational program that complies with the standards in R 338.11301, in which he or she has obtained a ~~doctor of dental surgery (~~DDS~~)~~ degree or ~~doctor of dental medicine (~~DMD~~)~~ degree.

(b) Pass all parts of the ~~national board examination~~ **NBDE, or the INBDE if the INBDE replaces the NBDE,** that is conducted and scored by the ~~Joint Commission on National Dental Examinations (~~JCNDE~~)~~, to qualify for the licensing examination in subdivision (c) ~~or (d)~~ of this rule.

~~(c) Subject to subdivision (d) of this rule, pass a dental simulated clinical written examination that is conducted the Commission on Dental Competency Assessments (CDCA), previously known as North East Regional Board (NERB), or a successor organization, and 1 of the following:~~

~~(i) Pass all parts of a clinical examination that is conducted and scored by the CDCA or a successor organization, or pass all parts of a clinical examination that is conducted by a regional testing agency if the examination is substantially equivalent, as provided in R 338.11255(5) and (6), to the dental simulated clinical written examination conducted by the CDCA, or a successor organization.~~

~~(ii) Pass all parts of a clinical examination, developed and scored by a state, or other entity, that is substantially equivalent, as provided in R 338.11255(5) and (6), to the clinical examination of the CDCA or a successor organization.~~

~~(d)~~**(c)** Pass all parts, written and clinical, of the ~~American Board of Dental Examiners, Inc. (~~ADEX~~)~~ ~~clinical~~ examination that is conducted by the CDCA**-WREB**, ~~a successor organization,~~ or by another regional testing agency. ~~Beginning 1 year after the effective date of this subdivision, an applicant shall meet the requirements of this subdivision instead of the requirements under subdivision (c) of this rule.~~

(d) Submit proof of current certification in BLS or ACLS for healthcare providers with a hands-on component from an agency or organization that grants certification pursuant to standards equivalent to those established by the AHA, earned within the 2-year period before receiving the license, beginning 6 months after the effective date of this rule.

~~(e)Beginning January 6, 2022, complete a 1-time training identifying victims of human trafficking as required in R 338.11271 and section 16148 of the code, MCL 333.16148.~~

~~(f) Complete a 1-time training in opioids and other controlled substances awareness as required in R 338.3135.~~

Rule 338.11209 Licensure by examination to practice dental therapy.

Rule Numbers	Commenter	Comment
Section (b)	Davis/MPCA	I would like to submit the following proposed change to rule R 11209:

	Zaagman/MCMCH	(b) Pass **all parts,** ~~the comprehensive, competency-based clinical examination developed and scored by~~ **written and clinical, of the ADEX examination that is conducted by** the CDCA-**WREB, a successor organization, or by another regional testing agency,** or an examination that is substantially similar as determined by the Board to the ADEX examination, with a passing converted score of not less than 75 on each component of the examination. Justification: Language limited to a specific entity can potentially create unnecessary barriers for dental therapists graduating from regions that use other entities. For example, dental therapists graduating from the CODA-accredited dental therapy program at Ilisagvik Tribal College are not required to take CDCA-WREB exams. An accessible pathway to Michigan licensure should allow for the Board to accept substantially similar exams conducted by other entities.
Rules Committee Response	**Section (b):** The Rules Committee agrees with the comment to accept a substantially equivalent examination for initial licensure for the following reasons: the profession is new; the need to address access to oral care in Michigan; limited or no DT educational training in Michigan; desire to encourage DT's from outside of Michigan who have taken another examination that is substantially equivalent to the ADEX to obtain licensure and practice in Michigan.	

Board Response	**Section (b):** The Board agrees with the comment to accept a substantially equivalent examination for initial licensure for the following reasons: the profession is new; the need to address access to oral care in Michigan; limited or no DT educational training in Michigan; desire to encourage DT's from outside of Michigan who have taken another examination that is substantially equivalent to the ADEX to obtain licensure and practice in Michigan.

R 338.11209 Licensure by examination to practice dental therapy.

Rule 1209. In addition to meeting the requirements of **R 338.7001 to R 338.7005, any other rules promulgated under the code, and** section 16174 of the code, MCL 333.16174, an applicant for dental therapist licensure by examination shall submit a completed application, on a form provided by the department, together with the requisite fee and ~~shall~~ meet all of the following requirements:

(a) Graduate from a dental therapy educational program that meets the standards in R 338.11302.

(b) Pass **all parts,** ~~the comprehensive, competency-based clinical examination developed and scored by~~ **written and clinical, of the ADEX examination that is conducted by** the CDCA-**WREB, a successor organization, or by another regional testing agency, or an examination that is substantially equivalent to the ADEX examination as determined by the board pursuant to R 338.11257(5) and (6),** with a passing converted score of not less than 75 on each component of the examination.

(c) Complete ~~at least~~**not less than** 500 hours of clinical practice as required under R 338.11218.

(d) Beginning 6 months after the effective date of this subdivision, submit proof of current certification in BLS or ACLS for healthcare providers with a hands-on component from an agency or organization that grants certification pursuant to standards equivalent to those established by the AHA, earned within the 2-year period before receiving the license.

~~(d) Beginning January 6, 2022, complete a 1-time training identifying victims of human trafficking as required in R 338.11271 and section 16148 of the code, MCL 333.16148.~~

~~(e) Complete a 1-time training in opioids and other controlled substances awareness as required in R 338.3135.~~

Rule 338.11221 Licensure by examination to practice dental hygiene.

Rule Numbers	Commenter	Comment
Section (c)	Cobler/CRDTS	Modify the rule to continue to accept substantially equivalent examinations for initial licensure. Accept CRDTS as a substantially equivalent examination for initial licensure. I am the Executive Director for Central Regional Dental Testing Service, Inc. (CRDTS) and recently came across this document Acceptable-Dentistry-Exams.pdf (michigan.gov) under Licensing Information on the Michigan Board of Dentistry website. CRDTS was unaware of this recent change to exclude the CRDTS examinations as a pathway toward dental and dental hygiene licensure. As the CRDTS dental and dental hygiene exams are "substantially equivalent to the ADEX examination" pursuant to R 338.11255 and R 338.11259, we formally request that Michigan revisit this matter. As you know portability for candidates seeking licensure is an important matter. Restricting acceptance of licensure examinations to one agency creates an undue burden for candidates. With the merger of CDCA, WREB and CITA, we at CRDTS have a deep concern about monopolization of the testing industry. I'm sure the board will agree that a monopoly is not in the best interest of the Dental Board, the candidates, or the professions.
Rules Committee Response	**Section (c):** The Rules Committee does not agree with the comment to accept substantially equivalent examinations for initial licensure as the rules already accept the American Board of Dental Examiners, Inc**.** (ADEX) examination conducted by the CDCA-WREB or a regional entity, which is a national examination offered in all states, Puerto Rico,	

	Virgin Islands, and Jamaica. The Rules Committee accepts the grading, anonymity in grading, and standards of testing used in the ADEX examination.

Board Response	**Section (c):** The Board does not agree with the comment to accept substantially equivalent examinations for initial licensure as the rules already accept the American Board of Dental Examiners, Inc**.** (ADEX) examination conducted by the CDCA**-**WREB or a regional entity, which is a national examination offered in all states, Puerto Rico, Virgin Islands, and Jamaica. The Rules Committee accepts the grading, anonymity in grading, and standards of testing used in the ADEX examination.

Rule 1221. In addition to meeting the requirements of **R 338.7001 to R 338.7005, any other rules promulgated under the code, and** section 16174 of the code, MCL 333.16174, an applicant for dental hygienist licensure by examination shall submit a completed application, on a form provided by the department, together with the requisite fee**, and** ~~shall~~ meet all of the following requirements:

(a) Graduate from a dental hygiene educational program in compliance with the standards in R 338.11303.

(b) Pass all parts of the ~~dental hygiene national board examination~~ **NBDHE** that is conducted and scored by the JCNDE to qualify for the licensing examination provided for in subdivision (c) ~~or (d)~~ of this rule. The requirement does not apply to an applicant who graduated from a dental hygiene program before 1962.

~~(c) Subject to subdivision (d) of this rule, pass a dental hygiene simulated clinical written examination conducted by the CDCA or a successor organization, and 1 of the following:~~

~~(i) Pass all parts of a clinical examination that is conducted and scored by the CDCA or a successor organization or pass all parts of a clinical examination that is conducted by a regional testing agency if the examination is substantially equivalent, as provided in R 338.11255(5) and (6), to the dental hygiene simulated clinical written examination conducted by CDCA or a successor organization.~~

~~(ii) Pass all parts of a clinical examination developed and scored by a state or other entity that is substantially equivalent as provided in R 338.11255(5) and (6), to the clinical examination of the CDCA or a successor organization.~~

~~(d)~~**(c)** Pass all parts written and clinical, of the ADEX ~~clinical~~ examination that is conducted ~~and scored~~ by the CDCA**-WREB**, a successor organization, or by another regional testing agency. ~~Beginning 1 year after the effective date of this subdivision, an applicant shall meet the requirements of this subdivision instead of the requirements under subdivision (c) of this rule.~~

(d) Beginning 6 months after the effective date of this subdivision, submit proof of current certification in BLS or ACLS for healthcare providers with a hands-on component from an agency or organization that grants certification pursuant to standards equivalent to those established by the AHA, earned within the 2-year period before receiving the license.

~~(e) Beginning January 6, 2022, complete a 1-time training identifying victims of human trafficking as required in R 338.11271 and section 16148 of the code, MCL 333.16148.~~

Rule 338.11247 Limited licenses; issuance; requirements.

Rule Numbers	Commenter	Comment
Section (3)	Spangler	(1) Limited licensees should also have to complete the same Dental Continuing Courses as the unrestricted license holder in each professional category. While these licenses are for one year, they should be responsible for one third of the CE requirements for the full license holder in the category. As many of the license holders in this category are dental school faculty, they become insulated from knowledge in other areas of dentistry and dental practice. This hinders their ability to work with predoctoral students and have current information in all areas of dentistry, not just the area in which they work. This has led to a group of faculty that are not invested in helping predoctoral students successfully transition to private practice. (2) We need to restrict the number of academic license holders sponsored by any one educational institution to 50. This licensure category has been abused to the detriment of the dental students in Michigan dental schools. Predoctoral students are seeking mentors who have practiced in a clinical setting in Michigan. If we are to provide more dentists to the State of Michigan, it will be by having full time faculty as role models that have worked in private practice in Michigan. Most of the licensees in this category are not invested in understanding and developing what is good for the people of the State of Michigan. This over reliance on Academic Clinical licenses also hinders the opportunities of dentists who have actively practiced in Michigan, passed the ADEX/CDCA or its equivalent, and wish to teach predoctoral students.
Rules Committee Response	**Section (3):** The Rules Committee agrees with the comment that clinical academic limited licensees should meet a portion of the continuing education hours required for the full license holder (1/3 for a dentist, hygienist, and dental assistant as they have a 3-year term, and 1/2 for a dental therapist as they have a two-year term.) **Section (3):** The Rules Committee did not come to a consensus regarding the comment that the number of academic clinical limited licenses should be limited to 50 licensees per institution, to encourage the dental schools to develop a clinical pathway for practicing dentists with full licensure. The members in support of the comment stated that full licensed dentists, who are trained at CODA institutions, will bring their knowledge of practice in Michigan to educational institutions. This change will provide role models and	

	mentors for students and help illustrate that private practice in Michigan is a good option, which should help increase the number of dentists staying in Michigan. The members who did not support the comment stated that this change did not clearly benefit the public and if, as suggested, it is detrimental to the public to have over 50 academic clinical limited licenses at an institution, then allowing any number of such licenses does not benefit the public. The Department recommends that the Board decline to limit the number of clinical academic limited licenses per institution. The Department recommends that if the Board is concerned with the process of granting these licenses that it review the requirements for licensure during the next rule set.

Board Response	**Section (3):** The Board agrees with the comment that clinical academic limited licensees should meet a portion of the continuing education hours required for the full license holder (1/3 for a dentist, hygienist, and dental assistant as they have a 3-year term, and 1/2 for a dental therapist as they have a two-year term.) **Section (3):** The Board does not agree with the comment to limit the number of clinical academic limited licenses to 50 per institution, as limiting the number of clinical academic limited licenses does not clearly benefit the public.

Rule 1247. (3) The board may issue a limited license, under section 16182(2)(c) of the code, MCL 333.16182, for clinical academic services, to an applicant who is a graduate of a dental, dental therapy, dental hygiene, or dental assistant program, who practices the health profession only in connection with his or her employment or other contractual relationship with that academic institution. ~~All of the following apply to a clinical limited license:~~

~~(a)~~ An applicant for a clinical limited license shall comply with all of the following:

~~(i)~~**(a)** Submit the required fee and a completed application on a form provided by the department.

~~(ii)~~**(b)** Meet **the requirements of R 338.7001 to R 338.7005, any other rules promulgated under the code, and** the requirements of section 16174 of the code, MCL 333.16174.

~~(iii)~~**(c)** Submit proof of graduation from a dental, dental therapy, dental hygiene, or dental assistant program in the form of a certified copy of a diploma and transcript. If the transcript is issued in a language other than English, the applicant shall submit an original, official translation.

~~(iv)~~**(d)** Submit documentation verifying that the applicant has been offered and accepted employment in an academic institution.

(e) Beginning 6 months after the effective date of this subdivision, submit proof of current certification in BSL or ACLS for healthcare providers with a hands-on component from an agency or organization that grants certification pursuant to standards equivalent to those established by the AHA, earned within the 2-year period before receiving the license.

(f) Beginning 6 months after the effective date of this subdivision, submit proof of having attended training of at least 1 hour in infection control, which must include sterilization of hand pieces, personal protective equipment, and the CDC's infection control guidelines.

~~(b)~~**(g)** A clinical limited license holder shall not hold himself or herself out to the public as being engaged in the practice of dentistry, dental therapy, dental hygiene, or as a dental assistant other than in connection with his or her employment or other contractual relationship with an academic institution, or provide dental services outside his or her employment or other contractual relationship with an academic institution.

~~(c)~~**(h)** A clinical academic limited licensed dentist, dental therapist, or dental hygienist may perform dental procedures ~~upon~~**on** patients in connection with his or her employment or contractual relationship with an academic institution if the procedures are performed under the general supervision, as **that term is** defined in R 338.11401(d), of a fully licensed dentist.

~~(d)~~**(i)** A clinical academic limited licensed dental assistant may perform dental procedures ~~upon~~**on** patients in connection with his or her employment or contractual relationship with an academic institution if he or she complies with all of the following:

(i) The procedures are performed under the direct supervision, as **that term is** defined in R 338.11401(c), of a fully licensed dentist.

(ii) The limited licensed dental assistant has satisfied the 35 hours of additional education in an approved course as required under section 16611(7), and (11) to (13) of the code, MCL 333.16611.

(iii) The limited licensed dental assistant has successfully completed a course in dental radiography that is substantially equivalent to a course taught in a program approved by the board pursuant to R 338.11303 or R 338.11307.

(4) Limited licenses must be renewed annually and are issued at the discretion of the department.

(5) An applicant for renewal of an academic clinical limited license who has been licensed for twelve months immediately preceding the expiration date of the license shall complete not less than 20 hours of continuing education for a dentist, 18 hours of continuing education for a dental therapist, and 12 hours of continuing education for a dental hygienist or a dental assistant, which is approved by the board under R 338.11704a and incurred during the 12 months before the end of the license cycle. The continuing education shall comply with the following:

(a) Complete not less than 1 hour of the required continuing education hours in pain and symptom management. Continuing education hours in pain and symptom management may include, but are not limited to, courses in behavior management, psychology of pain, pharmacology, behavior modification, stress management, clinical applications, and drug interactions. Hours earned through volunteer patient or supportive dental services provided for in R 338.11704a(1)(m) do not count toward the required hours for pain and symptom management.

(b) Complete at least 1 hour of the required continuing education hours in dental ethics and jurisprudence with inclusion of delegation of duties to allied dental personnel, which may be completed in 1 or more courses. Hours earned through volunteer patient or supportive dental services provided for in R 338.11704a(1)(m) do not count toward the required hours for dental ethics and jurisprudence with inclusion of delegation of duties to allied dental personnel.

(c) Complete a minimum of 6 hours for a dentist or dental therapist, or 4 hours for a dental hygienist or dental assistant, of the required continuing education hours in programs directly related to clinical issues including delivery of care, materials used in delivery of care, and pharmacology. Hours earned through volunteer patient or supportive dental services provided for in R 338.11704a(1)(m) do not count toward the required hours for clinical issues.

(d) Complete at least 1 hour of the required continuing education hours in infection control, which must include sterilization of hand pieces, personal protective equipment, and the CDC's infection control guidelines. Hours earned through volunteer patient or supportive dental services provided for in R 338.11704a(1)(m) do not count toward the required hours for infection control.

(e) Complete a minimum of 6 hours for a dentist or dental therapist, or 4 hours for a dental hygienist or dental assistant, of the required continuing education hours by attending synchronous, live courses or programs, in-person or virtual, that provide for the opportunity of direct interaction between faculty and participants including, but not limited to, lectures, symposia, live teleconferences, workshops, and participation in volunteer patient or supportive dental services provided for in R 338.11704a(1)(m). These courses, with the exception of the volunteer services in R 338.11704a(1)(m), may be counted toward the required courses in clinical issues, including delivery of care, materials used in delivery of care, and pharmacology.

(f) Complete no more than 1/2 of the required continuing education hours asynchronously, noninteractive.

(g) Except for the 1-time training in human trafficking, which may be used to comply with the requirement for the 1-time training and a continuing education requirement, an applicant may not earn continuing education credit for implicit bias training required by R 338.7004, and may not earn credit for a continuing education program or activity that is identical to a program or activity an applicant has already earned credit for during that renewal period.

(h) The submission of the application for renewal constitutes the applicant's certification of compliance with the requirements of this rule. The board may require an applicant or a licensee to submit evidence to demonstrate compliance with this rule. An applicant or licensee shall maintain evidence of complying with the requirements of this rule for a period of 5 years after the date of the submission for renewal. Failure to comply with this rule is a violation of section 16221(h) of the code, MCL 333.16221.

(i) A request for a waiver under section 16205 of the code, MCL 333.16205, must be received by the department for the board's consideration not less than 30 days before the last regularly scheduled board meeting before the expiration date of the

license. The public notice for the board meetings can be found at: https://www.michigan.gov/lara/bureau-list/bpl/.health/hp-lic-health-prof/dental.

Rule 338.11255 Licensure by endorsement of dentist; requirements.

Rule Numbers	Commenter	Comment
Section (2)(c)(d) and (4) to (6)	Cobler/CRDTS	Modify the rule to continue to accept substantially equivalent examinations for licensure by endorsement. Accept CRDTS as a substantially equivalent examination for licensure by endorsement. I am the Executive Director for Central Regional Dental Testing Service, Inc. (CRDTS) and recently came across this document Acceptable-Dentistry-Exams.pdf (michigan.gov) under Licensing Information on the Michigan Board of Dentistry website. CRDTS was unaware of this recent change to exclude the CRDTS examinations as a pathway toward dental and dental hygiene licensure. As the CRDTS dental and dental hygiene exams are "substantially equivalent to the ADEX examination" pursuant to R 338.11255 and R 338.11259, we formally request that Michigan revisit this matter. As you know portability for candidates seeking licensure is an important matter. Restricting acceptance of licensure examinations to one agency creates an undue burden for candidates. With the merger of CDCA, WREB and CITA, we at CRDTS have a deep concern about monopolization of the testing industry. I'm sure the board will agree that a monopoly is not in the best interest of the Dental Board, the candidates, or the professions.
Rules Committee Response	The Rules Committee agrees with the comment to continue to accept substantially equivalent examinations for licensure by endorsement, which requires modifications to (c), (h), (i), and (j) below.	

Board Response	The Board agrees with the comment to continue to accept substantially equivalent examinations for licensure by endorsement, which requires modifications to (c), (h), (i), and (j) below.

Rule 1255. (1) An applicant who has never held a dental license in this state**, who is licensed in another state,** and who is not applying for licensure by examination may apply for licensure by endorsement by submitting a completed application on a form provided by the department, together with the requisite fee.

(2) An applicant who is licensed in another state as a dentist is presumed to have met the requirements of section 16186 of the code, MCL 333.16186, if he or she meets **the requirements of the code, R 338.7001 to R 338.7005, any other rules promulgated under the code, and** all of the following requirements in subdivisions (a) to ~~(e)~~**(g) of this subrule**, subject to subdivisions ~~(f)~~**(h) to (j) of this subrule** ~~and (g)~~:

(a) **An applicant for licensure by endorsement shall meet 1 of the following requirements:**

(i) Has graduated from a dental educational program that meets the standards in R 338.11301**, in which he or she has obtained at least a 2-year DDS degree or DMD degree. The completion of the program must be confirmed by official transcripts from the school,** ~~and provides the department with the original, official transcripts of professional education and~~ **with** documentation of graduation.

(ii) If the applicant graduated from a dental educational program that does not comply with the standards provided in R 338.11301, the applicant shall meet 1 of the following requirements for licensure by endorsement in this state:

(A) Has graduated from a minimum 2-year master's degree or certificate program in dentistry that complies with the standards in R 338.11301, in which he or she has obtained a degree or certificate in a specialty branch of dentistry recognized in R 338.11501, with proof as required in part 5 of these rules.

(B) Has graduated from a minimum 2-year master's degree or certificate program in dentistry that complies with the standards in R 338.11301, in which he or she has obtained a degree or certificate in a specialty branch of dentistry that has not been recognized in R 338.11501 but is approved by the board.

(b) Has passed all phases of the ~~national board examination~~ ~~examination~~**NBDE or INBDE if the INBDE replaces the NBDE** for dentists~~, in sequence~~.

(c) ~~Verifies his or her license, on a form supplied by the department, by the licensing agency of any state in which the applicant holds a current license or ever held a license as a dentist, including the record of any disciplinary action taken or pending against the applicant.~~ ~~**Until 6 months after the effective date of these rules, the**~~ **Subject to (h) and (i) of this rule, the applicant submits proof of successful completion of** ~~**a regional examination or state board examination that was required as part of the licensing process of the state where the applicant holds his or her license and that is substantially equivalent under R 338.11257(5), to**~~ **all parts, written and clinical, of the ADEX examination required in R 338.11223(2) and (3) that is conducted by the CDCA-WREB, a successor organization, or by another regional testing agency. If the applicant has passed a regional or state board examination the applicant may petition the board for review of the regional examination or a state board examination for a determination that it is substantially equivalent under R 338.11257(5) and (6), to all parts, written and clinical, of the ADEX**

examination that is conducted by the CDCA-WREB. A passing score on a substantially equivalent examination is the score recommended by the sponsoring organization. However, an applicant shall present evidence to the department of a converted score of 75 or higher on each component of the examination. ~~Beginning 6 months after the effective date of these rules, the applicant shall have passed all parts, written and clinical, of the ADEX examination that is conducted by the CDCA-WREB, a successor organization, or by another regional testing agency required in R 338.11203(2) and (3).~~

(d) Has held a license as a dentist in good standing in another state for ~~30 days~~**1 year** before filing an application in this state.

(e) ~~Submits proof of successful completion of 1 of the regional examinations described in subrule (4) of this rule. This requirement is waived for individuals who were licensed initially in another state before 2002 and who were not required to complete a regional examination as part of the initial licensing process as confirmed by the state in which the initial license was awarded.~~ **Discloses each license, registration, or certification in a health profession or specialty issued by any another state, the United States military, the federal government, or another country on the application form.**

(f) Satisfies the requirements of section 16174(2) of the code, MCL 333.16174, which includes verification from the issuing entity showing that disciplinary proceedings are not pending against the applicant and sanctions are not in force at the time of application.

(g) Submits proof of current certification in BSL or ACLS for healthcare providers with a hands-on component from an agency or organization that grants certification pursuant to standards equivalent to those established by the AHA, earned within the 2-year period before receiving the license.

~~(f)~~**(h) ~~Until January 1, 2029,~~** ~~If~~ ~~an~~**An** applicant ~~was~~ **who is** licensed **and practicing** as a dentist in another state that required the successful completion of a regional examination **or state board,** ~~and the~~ **who** ~~applicant~~ has been practicing for a minimum of 5 years ~~in the United States~~ immediately preceding the application for licensure in this state, ~~it is presumed that the applicant~~ meets the requirements of subdivisions (a), (b), and ~~(d)~~**(c)** of this subrule.

~~(g)~~**(i) ~~Until January 1, 2029,~~** ~~If~~ ~~an~~**An** applicant ~~is~~ **who is** licensed **and practicing** as a dentist in another state that does not require the successful completion of a regional examination**,** ~~and the applicant~~ **and who** has been practicing for a minimum of 5 years ~~in the United States~~ immediately preceding the application for licensure in this state, ~~it is presumed that the applicant~~ meets the requirements of subdivisions (a) and (b) of this subrule. **The applicant may petition the board for a determination that the applicant's credentials are substantially equivalent to the requirements for licensure by endorsement instead of taking an examination.**

(j) ~~Beginning January 1, 2029, an applicant who is licensed and has been practicing as a dentist in another state for a minimum of 5 years immediately preceding the application for licensure in this state, and who passed the ADEX examination, meets the requirements of subdivisions (a), (b), and (c) of this subrule.~~

(3) The board may deny an application for licensure by endorsement upon finding the existence of a board action in ~~any other~~**another** state for a violation related to applicable provisions of section 16221 of the code, MCL 333.16221, or upon determining that the applicant does not fulfill the requirements of section 16186 of the code, MCL 333.16186.

~~(4) For purposes of this rule, subject to subrules (5) and (6) of this rule, the board approves and adopts the clinical examinations of other regional testing agencies or state boards if the examinations are substantially equivalent to all parts, written and clinical, of the ADEX clinical examination that is conducted and scored by the CDCA, a successor organization, or another regional testing agency. A passing score on the clinical examination is the score recommended by the sponsoring organization. An applicant shall present evidence to the department of a converted score of 75 or higher on each component of the examination.~~

~~(5) To determine substantial equivalency as specified in subrule (4) of this rule, the board shall consider at least the following factors:~~

~~(a) Subject areas included.~~

~~(b) Detail of material.~~

~~(c) Comprehensiveness.~~

~~(d) Length of an examination.~~

~~(e) Degree of difficulty.~~

~~(6) To demonstrate substantial equivalency as specified in subrule (4) of this rule, an applicant may be required to submit materials, including the following:~~

~~(a) A copy of the examination booklet or description of the examination content and examination scores issued by the testing agency.~~

~~(b) An affidavit from the appropriate state licensing agency that describes the examination and sets forth the legal standards that were in effect at the time of the examination.~~

~~(c) An affidavit from a state licensing board or examination agency that describes the examination.~~

Rule 338.11257 Licensure by endorsement of dental therapist; requirements.

Rule Numbers	Commenter	Comment
Section (4) to (6)	Cobler/CRDTS	Modify the rule to accept substantially equivalent examinations from regional entities for licensure by endorsement. As you know portability for candidates seeking licensure is an important matter. Restricting acceptance of licensure examinations to one agency creates an undue burden for candidates. With the merger of CDCA, WREB and CITA, we at CRDTS have a deep concern about monopolization

		of the testing industry. I'm sure the board will agree that a monopoly is not in the best interest of the Dental Board, the candidates, or the professions.
Rules Committee Response	The Rules Committee agrees with the comment to accept substantially equivalent examinations for licensure by endorsement, which requires a modification to (4) below.	

Board Response	The Board agrees with the comment to accept substantially equivalent examinations for licensure by endorsement, which requires a modification to (4) below.

Rule 1257. (1) An applicant who has never held a dental therapy license in this state and who is not applying by examination may apply for licensure by endorsement by submitting a completed application on a form provided by the department, together with the requisite fee.

(2) An applicant who is licensed as a dental therapist in another state is presumed to have met the requirements of section 16186 of the code, MCL 333.16186, if he or she meets **the requirements of the code, R 338.7001 to R 338.7005, any other rules promulgated under the code, and** all of the following requirements:

(a) ~~Has graduated~~**Graduated** from a dental therapy educational program that meets the standards in R 338.11302 and provides the department with the original, official transcripts of professional education and documentation of graduation for board evaluation.

(b) ~~Has~~ **Passed all parts, written and clinical, of the ADEX examination that is** ~~the comprehensive, competency-based clinical examination developed and~~ **conducted** ~~scored~~ by the CDCA**-WREB, a successor organization, or by another regional testing agency,** with a converted passing score of not less than 75 on each component of the examination.

(c) Verifies completion of ~~at least~~**not less than** 500 hours of clinical practice in dental therapy~~,~~ that substantially meets the requirements of R 338.11218, in a dental therapy educational program that meets the standards in R 338.11302.

(d) ~~Verifies his or her license, on a form supplied by the department, by the licensing agency of any state in which the applicant holds a current license or ever held a license as a dental therapist, including the record of any disciplinary action taken or pending against the applicant.~~ **Discloses each license, registration, or certification in a health profession or specialty issued by another state, the United States military, the federal government, or another country on the application form.**

(e) Satisfies the requirements of section 16174(2) of the code, MCL 333.16174, which includes verification from the issuing entity showing that disciplinary proceedings are not pending against the applicant and sanctions are not in force at the time of application.

~~(e)~~**(f)** Has held a license as a dental therapist **that is active and** in good standing in another state ~~30 days~~**for 1 year** before filing an application in this state.

(g) Submits proof of current certification in BSL or ACLS for healthcare providers with a hands-on component from an agency or organization that grants certification pursuant to standards equivalent to those established by the AHA, earned within the 2-year period before receiving the license.

(3) The board may deny an application for licensure by endorsement upon finding the existence of a board action in ~~any other~~**another** state for a violation related to applicable provisions of section 16221 of the code, MCL 333.16221, or upon determining that the applicant does not fulfill the requirements of section 16186 of the code, MCL 333.16186.

(4) For purposes of this rule, subject to subrules (5) and (6) of this rule, the board may approve a dental therapist clinical **regional or state board** examination ~~of another state board~~ if the examination is substantially equivalent to all parts of the **ADEX examination, a** comprehensive, competency-based clinical examination developed ~~and scored~~ by the CDCA**-WREB,** or a successor organization. A passing score on a substantially equivalent examination is the score recommended by the sponsoring organization. ~~An~~ **However, an** applicant shall present evidence to the department of a converted score of 75 or higher on each component of the examination.

(5) To determine substantial equivalency as specified in subrule (4) of this rule, the board shall consider at least the following factors:

(a) Subject areas included.

(b) Detail of material.

(c) Comprehensiveness.

(d) Length of an examination.

(e) Degree of difficulty.

(6) To demonstrate substantial equivalency as specified in subrules (4) and (5) of this rule, an applicant may be required to submit materials, including **any of** the following:

(a) A copy of the examination booklet or description of the examination content and examination scores issued by the testing agency.

(b) An affidavit from the appropriate state licensing agency that describes the examination and sets forth the legal standards that were in effect at the time of the examination.

(c) An affidavit from a state licensing board or examination agency that describes the examination.

Rule 338.11259 Licensure by endorsement of dental hygienists; requirements.

Rule Numbers	Commenter	Comment
Section (2)(c)(d) and (4) to (6)	Cobler/CRDTS	Modify the rule to continue to accept substantially equivalent examinations for licensure by endorsement. Accept CRDTS as a substantially equivalent examination for licensure by

		endorsement. I am the Executive Director for Central Regional Dental Testing Service, Inc. (CRDTS) and recently came across this document Acceptable-Dentistry-Exams.pdf (michigan.gov) under Licensing Information on the Michigan Board of Dentistry website. CRDTS was unaware of this recent change to exclude the CRDTS examinations as a pathway toward dental and dental hygiene licensure. As the CRDTS dental and dental hygiene exams are "substantially equivalent to the ADEX examination" pursuant to R 338.11255 and R 338.11259, we formally request that Michigan revisit this matter. As you know portability for candidates seeking licensure is an important matter. Restricting acceptance of licensure examinations to one agency creates an undue burden for candidates. With the merger of CDCA, WREB and CITA, we at CRDTS have a deep concern about monopolization of the testing industry. I'm sure the board will agree that a monopoly is not in the best interest of the Dental Board, the candidates, or the professions.
Rules Committee Response	The Rules Committee agrees with the comment to continue to accept substantially equivalent examinations for licensure by endorsement, which requires modifications to (c), (3), (4), and (5) below.	

Board Response	The Board agrees with the comment to continue to accept substantially equivalent examinations for licensure by endorsement, which requires modifications to (c), (3), (4), and (5) below.

Rule 1259. (1) An applicant who has never held a ~~registered dental hygienist~~**RDH** license in this state and who is not applying by examination may apply for licensure by endorsement by submitting a completed application, on a form provided by the department, together with the requisite fee.

(2) An applicant who is licensed in another state as a dental hygienist is presumed to have met the requirements of section 16186 of the code, MCL 333.16186, if he or she meets **the requirements of the code, R 338.7001 to R 338.7005, any other rules promulgated under the code, and** all of the following requirements in subdivisions (a) to ~~(e)~~**(g) of this subrule**, subject to ~~subdivisions (f) and (g)~~ **subrules (3) to (5) of this rule**:

(a) Has graduated from a dental hygiene educational program that meets the standards provided in R 338.11303 and provides the department with the original, official transcripts of professional education and documentation of graduation for board evaluation.

(b) Has passed all phases of the ~~national board examination for dental hygienists~~**NBDHE**. This requirement is waived for persons who graduated from an accredited school before 1962.

~~(c) Verifies his or her license, on a form supplied by the department, by the licensing agency of any state of the United States in which the applicant holds a current license or ever held a dental hygienist license including the record of any disciplinary action taken or pending against the applicant.~~

~~(d)~~**(c)** ~~Submits proof of successful completion of a written and clinical examination that is substantially equivalent to the examinations required~~**Until 6 months after the effective date of these rules, the The applicant submits proof of successful completion of ~~a regional examination or state board examination that was required as part of the licensing process of the state where the applicant holds his or her license, and is substantially equivalent per R 338.11257(5), to~~ all parts, written and clinical, of the ADEX examination required in R 338.11223(2) and (3) that is conducted by the CDCA-WREB, a successor organization, or by another regional testing agency. If the applicant has passed a regional examination or state board examination the applicant may petition the board for review of the regional examination or a state board examination for a determination that it is substantially equivalent under R 338.11257(5) and (6), to all parts, written and clinical, of the ADEX examination that is conducted by the CDCA-WREB. A passing score on a substantially equivalent examination is the score recommended by the sponsoring organization. However, an applicant shall present evidence to the department of a converted score of 75 or higher on each component of the examination. ~~Beginning 6 months after the effective date of these rules, the applicant shall have passed all parts, written and clinical, of the ADEX examination that is conducted by the CDCA-WREB, a successor organization, or by another regional testing agency~~ ~~required in R 338.11223(2).~~ ~~This requirement is waived for individuals who were licensed initially in another state of the United States before 2002 and who were not required to complete a regional examination as part of the initial licensing process as confirmed by the state of the United States in which the initial license was awarded.~~

~~(e)~~**(d)** ~~Has held~~**Holds** a license as a dental hygienist **that is active and** in good standing in another state ~~30 days~~**for at least 1 year** before filing an application in this state.

(e) Discloses each license, registration, or certification in a health profession or specialty issued by another state, the United States military, the federal government, or another country on the application form.

(f) Satisfies the requirements of section 16174(2) of the code, MCL 333.16174, which includes verification from the issuing entity showing that disciplinary proceedings are not pending against the applicant and sanctions are not in force at the time of application.

(g) Submits proof of current certification in BSL or ACLS for healthcare providers with a hands-on component from an agency or organization that grants certification pursuant to standards equivalent to those established by the AHA, earned within the 2-year period before receiving the license.

~~(f)~~**(3)** ~~**Until January 1, 2029,** If an~~**An** applicant ~~was~~ **who is** licensed **and is practicing** as a dental hygienist in another state that ~~requires~~ **required** the successful completion of a regional examination **or state board,** ~~and the applicant has been practicing in the United States~~ for a minimum of 3 years immediately preceding the application for licensure in this state, ~~it is presumed that the applicant~~ meets the requirements of ~~subdivisions (a), (b), and (d) of this subrule.~~ **subrule (2)(a), (b), and (c) of this rule.**

~~(g)~~**(4)** ~~**Until January 1, 2029,** If an~~**An** applicant ~~is~~ **who is** licensed **and is practicing** as a dental hygienist in another state that does not require the successful completion of a regional examination ~~and the applicant has been practicing in the United States~~ for a minimum of 3 years immediately preceding the application for licensure in this state, ~~it is presumed that the applicant~~ meets the requirement of ~~subdivisions (a) and (b) of this subrule.~~ **subrule (2)(a) and (b) of this rule. The applicant may petition the board for a determination that the applicant's credentials are substantially equivalent to the requirements for licensure by endorsement instead of taking an examination.**

~~**(5) Beginning January 1, 2029, an applicant who is licensed and is practicing as a hygienist in another state for a minimum of 3 years immediately preceding the application for licensure in this state, that passed the ADEX examination, meets the requirements of subrule (2)(a), (b), and (c) of this rule.**~~

(65) An applicant who currently holds a license as a dental hygienist in Canada but who has never been licensed as a dental hygienist in this state may apply for a license by endorsement and is presumed to meet the requirements of section 16186 of the code, MCL 333.16186, if he or she meets the requirements of the code, R 338.7001 to R 338.7005, any other rules promulgated under the code, requirements of section 16174 of the code, MCL 333.16174, submits a completed application on a form provided by the department together with the requisite fee, and provides proof of all of the following:

(a) The applicant's Canadian license is active and in good standing for at least 1 year before filing an application in this state.

(b) The applicant has passed 1 of the following:

(i) The National Dental Hygiene Canadian Exam written examination and the ADEX clinical examination.

(ii) All parts, written and clinical, of the ADEX examination that is conducted by the CDCA-WREB, a successor organization, or by another regional testing agency.

(c) The applicant has graduated from 1 of the following:

(i) A dental hygiene program accredited by CDAC with all training completed in Canada.

(ii) A dental hygiene educational program in compliance with the standards in R 338.11303.

(f) The applicant discloses each license, registration, or certification in a health profession or specialty issued by another state, the United States military, the federal government, or another country on the application form.

(g) The applicant satisfies the requirements of section 16174(2) of the code, MCL 333.16174, which includes verification from the issuing entity showing that disciplinary proceedings are not pending against the applicant and sanctions are not in force at the time of application.

(h) Submits proof of current certification in BSL or ACLS for healthcare providers with a hands-on component from an agency or organization that grants certification pursuant to standards equivalent to those established by the AHA, earned within the 2-year period before receiving the license.

~~(3)~~**(6)** The board may deny an application for licensure by endorsement upon finding the existence of a board action in ~~any other~~**another** state ~~of the United States~~ for a violation related to applicable provisions of section 16221 of the code, MCL 333.16221, or upon determining that the applicant does not fulfill the requirements of section 16186 of the code, MCL 333.16186.

~~(4) For purposes of this rule, subject to subrules (5) and (6) of this rule, the board approves and adopts the clinical examinations of other regional testing agencies or state boards if the examinations are considered to be substantially equivalent to all parts, written and clinical, of the ADEX clinical examination that is conducted and scored by the CDCA, a successor organization, or another regional testing agency. A passing score on the clinical examination is the score recommended by the sponsoring organization. An applicant shall present evidence to the department of a converted score of 75 or higher on each component of the examination.~~

~~(5) To determine substantial equivalency as specified in subrule (4) of this rule, the board shall consider at least the following factors:~~

~~(a) Subject areas included.~~

~~(b) Detail of material.~~

~~(c) Comprehensiveness.~~

~~(d) Length of an examination.~~

~~(e) Degree of difficulty.~~

~~(6) To demonstrate substantial equivalency as specified in subrule (4) of this rule, an applicant may be required to submit materials, including the following:~~

~~(a) A copy of the examination booklet or description of the examination content and examination scores issued by the testing agency.~~

~~(b) An affidavit from the appropriate state licensing agency that describes the examination and sets forth the legal standards that were in effect at the time of the examination.~~

~~(c) An affidavit from a state licensing board or examination agency that describes the examination.~~

Rule 338.11401 Definitions.

Rule Numbers	Commenter	Comment
Section (e)	Ackerman/ATDA	The ATDA has concerns that certain provisions of this proposed rule would inappropriately mandate in-person examination requirements for dentists utilizing teledentistry that would, in effect, defeat many of the benefits of teledentistry. Specifically, the new definition of "patient of record" found in proposed Rule 338.11401 would require that a patient must first have an in-person examination before a dentist may utilize teledentistry technologies in the delegation of duties to aid in the treatment of that patient. The proposed language is in direct conflict with the current standard of care for dentistry and would increase costs and decrease access to affordable, quality oral health care in Michigan. It is also inconsistent with ATDA guidelines on teledentistry. There is no clinical evidence to support the assertion that patients would be safer if an in-person exam is required – particularly given the seemingly arbitrary 24-month schedule. To the contrary, there are numerous clinical studies which prove that teledentistry is just as effective as traditional dentistry at diagnosing and treating many oral conditions and that many exams can be done effectively through teledentistry technology via appropriate delegation to dental auxiliary staff. The ATDA believes that these proposed rules not only run counter to good public policy generally, but actually also run counter to already established Michigan public policy as well as all the substantive data on oral health access in Michigan. Additional reasons for objection to the change is included in ATDA's letter.
(e)	Beaver/DHHS	Under definitions Section(e) Patient of Record – we recommend deleting "in-person". We are especially concerned with the dental workforce shortages and rural areas in Michigan that geographically limit access to care (including persons in nursing homes that have limited or no mobility). Including this requirement in the definition will negatively impact the people that need dental care the most.
(e)	Diers/TechNet	On behalf of TechNet, I am writing to you in opposition to the Department of Licensing and Regulatory Affairs' proposed rule change to the General Dentistry rules Part 4A, R338.11401 to add language requiring a patient first have an "in-person" examination before a dentist may utilize teledentistry to treat a patient.

		Innovative health care technologies like teledentistry reduce costs and improve access to care. By meeting the patient where they are, teledentistry can more efficiently and conveniently deliver care to patients, particularly those in underserved areas. Increased use of teledentistry during the COVID-19 pandemic exhibited the efficacy of this approach without the need for any in-person patient visit requirement. The proposed rule will reverse much of the positive impact made by teledentistry so far. Requiring an in-person visit prior to any teledentistry care undermines the convenience and cost benefits of remote care. The proposed rule links remote teledentistry to geography, undercutting the ability of teledentistry to reach patients in places that lack traditional, brickand-mortar dental services. Indeed, according to a 2015 American Dental Association Health Policy Institute study, Michiganders often forgo dental care due to inconveniences related to location and scheduling, or because they simply have trouble finding a dentist. It is our belief that teledentistry should be supported as a tool to practice dentistry and ensure consumers have access to affordable healthcare options within the standard of care in Michigan, without an in-person visitation requirement.
(e)	Horkan/SDC	The proposed "in-person" examination requirement will be an arbitrary barrier on access to treatment without any basis in evidence. In addition to cost, inadequate access to traditional in-person dental care is a leading factor preventing middle- and lower-income consumers from seeking dental and orthodontic services. To put it simply, having to visit a dentist in-person is a structural barrier to care for millions of Michiganders. Inarguably, remote treatment is safe and meets the standard of care for many patient presentations. Scientific and clinical literature regarding remote teledentistry models have found consistent efficacy and effectiveness for teledentistry approaches to patient care. Furthermore, the proposed amendment's 24-month evaluation period is an arbitrary burden on patients that is not grounded in any evidentiary justification. Every dentist, regardless of the method used to deliver care, is held to the same standard of care for the entire duration of the patient relationship. Decisions regarding care and when in-person visitation is needed should be made on a case-by-case basis by the treating provider. Finally, the amendment language creates uncertainty as to when the in-person visit is required to take place during the 24-month period in order to establish a "Patient of record" relationship. The Department of Licensing and Regulatory

		Affairs' proposed rule to add an in-person requirement and arbitrary time mandate for receiving teledentistry care in Michigan is a regressive step in the wrong direction. Additional reasons for objecting to the change is included in SDC's letter.
(e)	Representative Kahle	This proposed definition change to "patient of record" would require patients be examined "in-person" before any oral healthcare can be rendered regardless of the patient's unique presentation. I am concerned that this rule will add significant costs and will raise barriers to care for patients - particularly working-class and rural patients who already find it difficult to find a convenient and affordable dentist. If this rule is allowed to go into effect, it will - without any clinical justification - arbitrarily block access to oral healthcare that thousands of our constituents want, need, and deserve. By unnecessarily mandating an in-person examination — regardless of the standard of care — this proposed change will make accessing oral healthcare even more difficult for the hundreds of thousands of Michiganders that struggle to access regular dental care, instead of easier. Mandating an initial in-person encounter will only exacerbate the disparity in access to oral healthcare. Considering this, it is unclear as to the reversed course, especially given our COVID-19 pandemic experience and the success we experienced with tele-health. Whatever the cause, I believe that it is (1) not sound public policy, (2) will hurt my constituents by limiting their access to care, and (3) attempting to supplant the Legislature's decision on this issue. Additionally, this would make Michigan the only state in the country with this onerous anti-patient requirement.
(e)	Kim/Byte	As the Michigan Board of Dentistry (the "Board") is aware, the COVID-19 pandemic exacerbated longstanding inequities especially with respect to affordability and accessibility to health care. Many of the communities that faced social, economic, and geographic barriers to accessing dental care and prior to the pandemic were the same communities that were hardest hit by the pandemic. Fortunately, technology has been a powerful tool in reducing health disparities and profoundly changing the way providers deliver health care and the way patients expect to receive care. Acknowledging the pivotal role telehealth played in increasing access to health care throughout the pandemic, the Michigan Legislature passed and enacted a package of bills aimed at expanding

		telehealth in the state. See House Bills 5412-5416 (2020) ("Telehealth Package"). In her signing letter to the Legislature, Governor Whitmer emphasized that "the virtues of telemedicine are not unique this moment, so Michiganders will benefit from reduced costs, increased accessibility, and lower transmission rates of infectious diseases at the doctor's office for years to come." Unfortunately, the Proposed Rule could undermine the legislative intent of the Telehealth Package and effectively decrease access to safe and affordable oral health care currently available across the state. As drafted, Rule 338.11401(e) of the Proposed Rule could be interpreted to require an in-person examination before any dental care can be provided. However, any dentist who seeks to provide services—whether in person or via telehealth modality—to a Michigander would need to be licensed in the state and thus would already be subject to the Dental Board's oversight. Thus, this provision would unnecessarily inhibit access to dental and orthodontic services by implementing arbitrary and clinically unjustified administrative barriers that would make it much harder for patients to receive high-quality, affordable care via teledentistry in a safe and effective manner. Moreover, there does not appear to be any clinical or patient safety justification for imposing this requirement. In fact, the Board of Dentistry Rules Committee Work Group expressly rejected a previous attempt to make similar changes to the definition of "patient of record" in 2020. The American Association of Orthodontists proposed adding "in-person" to the definition of "patient of record" and the Rules Committee responded that it: does not agree with the comment to add "in person" to the definition of "patient of record" as this requirement is inconsistent with the concept of telemedicine and the dentist or dental therapist should be the professional to make the determination of whether they must examine and diagnose the patient "in person." Thus, as currently drafted, the Proposed Rule could protect brick-and-mortar practices at the expense of most pertinently low-income, marginalized, and traditionally underserved communities who have utilized teledentistry throughout the pandemic to access the dental and orthodontic care they want and need.
(e)	Mick/Thomas -	We propose adding language to Part 4, Delegation and Supervision, R 338.11401 Definitions, (e)

	AAO/MAO	"Patient of Record." The AAO supports language to clarify that performing an in-person examination must occur prior to dental, and especially orthodontic, treatment because it would allow the treating dentist to more fully understand what is going on beneath the gums (impacted teeth, bone loss, etc.), seek to avoid complications, and in the case of orthodontists, determine if patients are suitable candidates for orthodontic treatment. The AAO believes there are certain diagnoses and evaluations that can only be performed in-person or are best performed in-person (x-rays, etc.) during an examination, and the AAO believes that dental treatment, especially the movement of teeth via orthodontic treatment, should not be undertaken without sufficient diagnostic information obtained during such an examination. The AAO's proposed revisions are in red. (e) "Patient of record" a patient who has been examined**, evaluated,** and diagnosed **with a resulting treatment plan** by a dentist**, or dental therapist to the extent authorized by the supervising dentist, in-person at least once every 24 months.** 12 months.
(e)	Senator VanderWall	This proposed definition change to "patient of record" would require patients be examined "in-person" before any oral healthcare can be rendered regardless of the patient's unique presentation. I am concerned that this rule will add significant costs and will raise barriers to care for patients - particularly working-class and rural patients who already find it difficult to find a convenient and affordable dentist. If this rule is allowed to go into effect, it will - without any clinical justification - arbitrarily block access to oral healthcare that thousands of our constituents want, need, and deserve. By unnecessarily mandating an in-person examination – regardless of the standard of care – this proposed change will make accessing oral healthcare even more difficult for the hundreds of thousands of Michiganders that struggle to access regular dental care, instead of easier. Mandating an initial in-person encounter will only exacerbate the disparity in access to oral healthcare. The Board of Dentistry Rules Committee considered this very same definition change in 2020. At the September 29, 2020 Board of Dentistry Rules Committee Work Group on these rules, they summarily dismissed an American Association of Orthodontists' proposal to add "in-person" to the definition of "patient of record." In dismissing the amendment, the Rules Committee stated the

		following: "The Rules Committee does not agree with the comment to add "in person" to the definition of "patient of record" as this requirement is inconsistent with the concept of telemedicine and the dentist or dental therapist should be the professional to make the determination of whether they must examine and diagnose the patient in person." Considering this, it is unclear as to the reversed course, especially given our COVID-19 pandemic experience and success with tele-health. Whatever the cause, I believe that it is (1) not sound public policy, (2) will hurt my constituents by limiting their access to care, and (3) attempting to supplant the Legislature's decision on this issue. Additionally, this would make Michigan the only state in the country with this onerous anti-patient requirement.
(e)	Representative Witwer	This proposed definition change to "patient of record" would require patients be examined "in-person" before any oral healthcare can be rendered regardless of the patient's unique presentation. I am concerned that this rule will add significant costs and will raise barriers to care for patients - particularly working-class and rural patients who already find it difficult to find a convenient and affordable dentist. If this rule is allowed to go into effect, it will - without any clinical justification - arbitrarily block access to oral healthcare that thousands of our constituents want, need, and deserve. By unnecessarily mandating an in-person examination – regardless of the standard of care – this proposed change will make accessing oral healthcare even more difficult for the hundreds of thousands of Michiganders that struggle to access regular dental care. According to Pew Research, more than 1.7 million residents of the state live in areas with dentist shortages. Furthermore, the Centers for Medicare & Medicaid Services reports that 58% of Michigan children on Medicaid—more than 630,000 kids—did not see a dentist in 2019. The American Dental Association's Health Policy Institute, in a survey study of Michigan patients, found that 25% of Michiganders avoided smiling due to the condition of their mouth and teeth – with that number jumping to 41% for low-income residents. And for those Michiganders who have not seen a dentist in the past 12 months, 51% did not do so because of cost and 34% did not do so because they could not find a convenient location or time to visit the dentist. Similarly, these categories have even more drastic disparities for low-income residents.

		Mandating an initial in-person encounter will only exacerbate the disparity in access to oral healthcare. The Board of Dentistry Rules Committee considered this very same definition change in 2020. At the September 29, 2020 Board of Dentistry Rules Committee Work Group on these rules, they summarily dismissed an American Association of Orthodontists' proposal to add "in-person" to the definition of "patient of record." In dismissing the amendment, the Rules Committee stated the following: "The Rules Committee does not agree with the comment to add "in person" to the definition of "patient of record" as this requirement is inconsistent with the concept of telemedicine and the dentist or dental therapist should be the professional to make the determination of whether they must examine and diagnose the patient in person." It is unclear why the Board has reversed course, especially given our COVID-19 pandemic experience and success with tele-health. Whatever the cause, I believe that it is (1) not sound public policy, (2) will hurt my constituents by limiting their access to care, and (3) attempting to supplant the Legislature's decision on this issue. Additionally, this would make Michigan the only state in the country with this onerous anti-patient requirement. It is my hope that the Board will make the necessary amendment to this section of the proposed rules and will remove the in-person examination mandate.
Rules Committee Response	**(e):** The Rules Committee discussed the comments to remove the in-person requirement. There is not a consensus to modify the provision. However, as many of the comments stated that the in-person requirement would limit telehealth, which was not the intent of the Board, the Rules Committee recommends that language be added to the telehealth section that states: **The requirement in R 338.11401 to have an "in-person" contact with the dentist or dental therapist once every 24 months does not apply to telehealth services unless the dentist or dental therapist delegates or assigns duties, other than radiographic images, to allied dental personnel.**	

	The Rules Committee discussed the options available to a provider following a telehealth visit as follows: 1) Prescribe medication; 2) refer the individual to a dental office or a specialist; 3) refer to a hospital (ER possibly); 4) do nothing other than educating the patient and answering their concerns; and 5) provide education or instruction or provide information on how to obtain the education or instruction. In all cases the telehealth visit must be documented, and the documentation must be retained and maintained. Bentley was concerned that the in-person requirement would limit access to care. **(e):** The Rules Committee does not agree with the comment to require an in-person contact with a dentist once every 12 months because 12 months is too restrictive.

Board Response	**(e):** The Board does not agree with the comments to remove the in-person requirement in the definition of "patient of record." However, as many of the comments stated that the in-person requirement limits telehealth, which was not the intent of the Board, a provision shall be added to the definition of telehealth services in R 338.11611(b) that states: The requirement in R 338.11401 to have an "in-person" contact with the dentist or dental therapist once every 24 months does not apply to telehealth services unless the dentist or dental therapist delegates or assigns duties, other than radiographic images, to allied dental personnel. **(e):** The Rules Committee does not agree with the comment to require an in-person contact with a dentist once every 12 months because 12 months is too restrictive.

Rule 1401. As used in this part:
(e) "Patient of record" means a patient who has been examined**, evaluated,** and diagnosed **with a resulting treatment plan** by a dentist**, or dental therapist to the extent authorized by the supervising dentist, in-person at least once every 24 months.** ~~and whose treatment has been planned by a dentist or a patient who has been examined, evaluated, assessed, and treatment planned by a dental therapist to the extent authorized by the supervising dentist.~~ A patient of record includes a patient getting radiographic images by allied dental personnel with training pursuant to R 338.11411(a) after receiving approval from the assigning dentist or dental therapist.

Rule 338.11411 Delegated and assigned dental procedures for allied dental personnel.

Rule Numbers	Commenter	Comment
Part 4A and Table	Gietzen	I would like to officially submit comments regarding the Administrative Rules for Dentistry – General Rules Set 2021-40 LR. I have noticed several areas of concern throughout the existing rules and the proposed draft rules. Most notably the areas of dental assisting and dental auxiliaries. I do have concerns regarding the change from DA to UDA. There are also concerns regarding the area of specialty licensing and advertising rules. The current rules were made before the internet and current technology. They are out of sink with today's practice environment and current dental education particularly when it comes to assisting duties and assignment of those duties. With safety in mind, the rules and proposed rules changes do not address the best interests of the public and do not meaningfully protect the public. Most notable are the rules and assigned delegations laid out in Part 4A and Table 1. The rules are also restricting able bodied people from accessing employment that could provide meaningful wages and provide more access to care in the State of Michigan. The current format and content for educating RDAs and RDHs does not provide what is necessary for an orthodontic assistant. Any training in orthodontics has continued to decline since the addition of expanded functions for RDAs. The current schools in which one can become a licensed registered dental assistant are not graduating enough assistants to meet the current needs of our state. Also there is no reason for a person trained as an RDA to be an orthodontic assistant. It is rare to even get an RDA to apply for such a position because it is not their training and there is a difference in wages between an expanded function RDA in a general dental office and an assistant in an orthodontic office. To further restrict the duties of DAs/UDAs or to not take full consideration into the duties that can be safely done under the supervision of an orthodontist or licensed dentist is a detriment to the health, safety, and well-being of the people of the State of Michigan and also the economy in our State. The current rules and proposed rules do not take all of the above issues into consideration and need to be revised to reflect the current state of affairs in dentistry.
Part 4A and Table	Whitman-Herzer/Council of Michigan Dental Specialties, Inc.	Changes in the delegation of assignment for DAs/UDAs assisting procedures involved with orthodontic treatment. Changes in the existing rules and the proposed rules in Part 4A and Table I to support the current state of dental care in Michigan as well as accurately reflect current dental education, and address the shortfalls happening with access to care and restricting meaningful employment in our State.

Section (1)	Hoppes/MDAA	We commend the department and board for taking very seriously the need to assure that the public is being treated by knowledgeable and competent staff. MDAA feels that that there is a large disconnect which occurs when new on the job trained assistants are hired and feel that there is a need for them to know the duties they can perform and under what level of supervision. Rationale: Many on the job trained assistants never see a chart of allowable duties and this is considered a very weak link in our profession. In addition, this may assist in reducing the number of duties being performed outside their scope of practice and will in turn potentially reduce the potential for causing patient harm. The MDAA specifically wants this statement to say that the dentist must provide and explain the duties chart rather than put this off on another employee to do. Since review of duties annually is now required for all licensed dental professionals, it is important that the unlicensed also acquire this knowledge as well. We therefore recommend the following: Add a (c) "The employer dentist must provide the unregistered dental auxiliary with a current copy of the delegation of duties chart and the dentist must explain the levels of supervision."
(1)(a)	Hoppes/MDAA	MDAA is not in favor of lowering the level of supervision from General to Assignment allowing the unlicensed dental auxiliary to expose radiographs when the dentist is not on the premise unless the proposed change to Rule 338.11411 above remains in the language. Rationale: MDAA feels that if any dental professional is going to see a patient potentially alone in the office that they must have CPR training to be prepared to deal with medical emergencies, have infection control training and as mentioned above also know the allowable duties.
(2)	Tseng	Modify the last few words of the last sentence to – "under section 16611 of the code, MCL 333.16611, **and** as provided in Table 1."
(3)(bb)	Tseng	Change the reference to absorbent points to paper points for consistency with language used in the RDA test.
(3)(h), (i), (j), (k),	Monticello	Change items (h), (i), (j), (k), (l), and new (y) to "D", Direct Supervision, would allow

(l), and (y)		orthodontically trained Dental Assistants to safely perform these tasks under the direct supervision of their orthodontist. In 1992, the MAO Board discussed the 1978 Public Health Code Act 368. We reviewed licenses, dentists, specialists, assistants, hygienists and advertising in Michigan. I was instrumental in the re-licensure of Specialists vs. simple Certification. In 1992 the Rules were interpreted to have been created to be inclusive of all assistants while still recognizing those who chose to further their skill and knowledge in general dentistry to obtain their RDA status with additional procedures and supervisory privileges. Orthodontic assistants were trained by their specialist doctor and directly supervised. Times have changed since 1978 with evidenced based research, new materials, growth and development techniques, 3-D modeling, digital scanning, predictive outcomes, combined aligner/braces treatment, skeletal anchorage and functional appliance therapy. The orthodontic assistant of 2022 is not the same as 1978. In my practice I employ dental assistants that have completed 12 months of Grand Rapids Community College Dental Assistant education with radiology certification. I then provided specialty training and paid for the 6 month Trapezio orthodontic assistant training covering 12 chapters including anatomy, instramentation, techniques, infection control, PPE, band sizing and fitting, wire and elastic placement, tooth preparation, bonding techniques, indirect bonding protocols, orthopedic appliance placement, oral hygiene instruction and management and more. I then paid for their time, travel, housing and testing fee at Los Vegas, NV at the AAO annual session where they both passed the half-day clinical examination and earned their Certification The draft Rules would negate all this training and knowledge and 22 years of experience and not permit them to continue to work legally. RDAs have expanded general dentistry knowledge but not orthodontic specialty training or ability. They would require the same amount of additional orthodontic training to be safe and proficient for patient treatment. I understand RDA’s are ideal for a general dental practice with the expanded

		clinical training and privileges. However, they do not have training in many of the necessary tasks in an orthodontic practice. The current Rules and the Draft rules changes do not address these concerns and specifically prohibit dental assistants, who might be specifically trained in orthodontics, from safely completing tasks. These changes do not impact the defined privileges for Registered Dental Assistants or Hygienists, but they do allow for UDAs and trained dental assistants to accomplish tasks under the appropriate level of supervision. These modifications to the current Dentistry General Rules will help address workforce challenges while also enhancing access of patient care to specialty services.
(3)(h), (i), (j), (k), (l), and (y)	Mick/Thomas - AAO/MAO 50 individual letters supporting this change	Similar to orthodontists in many other states, Michigan dentists are feeling the effects of a shortage of workforce, and specifically, are having a difficult time finding and hiring dental assistants, and more specifically, orthodontic assistants. As the Dental Administrative Rules currently state, and present in the current Draft rule changes, only Registered Dental Assistants (RDAs) are allowed to carry out many of the tasks orthodontists require, and yet, RDAs are not trained to accomplish these tasks. Becoming an RDA requires a two-year degree or certificate from a CODA-accredited program in advanced general dentistry techniques, a Board exam, a background check, licensure application, annual CE requirements and associated costs. Dental assistants today who frequently complete a 12-month Dental Assisting class at a Community College at their own expense- and with specialty-specific training from the orthodontist/dentist or from a specific orthodontic assistant training program can be better suited for tasks specific to an orthodontist's office. Also, RDAs would need to complete additional specialty training to understand how to work for an orthodontist, and there are not enough RDAs available to serve as orthodontic assistants in Michigan. Becoming a dental assistant is a much easier path for the dental workforce. It requires a course in dental radiography (with equipment not used in a specialty office) but is part of the dental assisting classes before a dental assistant can begin on-the-job specialty training. All orthodontists became general dentists prior to completing a 2–3-year residency to become orthodontists. Dentists understand RDAs are ideal for general dental practice with expanded

		clinical training and privileges. However, RDA's do not have training in orthodontic band size selection and fitting; the clinical difference in twin brackets; clear brackets; acrylic verses ceramic brackets; auto-ligation brackets; lingual brackets; wire ties verses elastomeric modules; arch wire placement; safety/treatment concerns of round wire vs. rectangular wire; sizing and placement of coil spring; utilization of FORSUS and Carriere appliances; elastic placement; placement of Kobiashi hooks; placement of temporary aligner attachments; critical inspection of aligner fit; aligner hygiene instruction; retainer clasp adjustment; digital panorex; lateral and A-P cephalometric radiography; activation of temporary skeletal anchorage devices (TADs); and critical clinical photography. RDAs would need to complete additional specialty training to understand how to work for an orthodontist, and there are not enough RDAs available to serve as orthodontic assistants in Michigan. In an orthodontist's office, it is commonplace that both an RDA and dental assistant, without any specific training outside of the training and education required, would need the same amount of teaching and practice in orthodontic procedures once in an orthodontist's office. RDAs would need to complete additional specialty training to understand how to work for an orthodontist, and there are not enough RDAs available to serve as orthodontic assistants in Michigan. To better meet the needs of modern orthodontic practices, the AAO and MAO advance the following delegated and assigned dental procedures changes for Unlicensed Dental Auxiliaries (UDA). We believe that with the required education and proper training, UDAs can, and are able to, perform the outlined tasks under the direct supervision of a dentist without jeopardizing patient safety or care. RDAs would need to complete additional specialty training to understand how to work for an orthodontist, and there are not enough RDAs available to serve as orthodontic assistants in Michigan. We ask that you consider allowing orthodontic tasks to be delegated to the proposed UDA, currently Dental Assistant, (with Direct Supervision) rather than only RDAs. Currently, Dental Assistants are not permitted to do those tasks. This will help address the acute shortage of orthodontic assistants (RDAs) in the Michigan workforce and incentivize more individuals becoming a dental assistant We ask that you consider the following changes to Table 1 - Delegated and Assigned Dental Procedures for Allied Dental Personnel to allow dental assistants—or

		proposed unregistered dental auxiliaries- to perform certain orthodontic tasks under direct supervision. Our proposed changes are also displayed in Table 1 - Delegated and Assigned Dental Procedures for Allied Dental Personnel. These changes would not impact the defined privileges for Registered Dental Assistants or Hygienists. Instead, they would allow specialist dental assistants and trained dental assistants to accomplish tasks under the appropriate level of supervision. These modifications to the current Draft Changes of LARA's Dentistry General Rules help create workforce solutions will improve access of patient care to specialty services.
(3)(h), (i), (j), (k), (l), and (y)	Swan	Most important to me and my orthodontic colleagues is that the way the rules are currently written – as well as the proposed revisions – make the practice of orthodontics in Michigan virtually impossible. I am referring specifically to Rule 338.11411, which refers to MCL 333.1611 Table 1: Delegated and Assigned Dental Procedures for Allied Dental Personnel. I've been in practice for 15 years, and over that time have seen an expansion in the duties allowed for an RDA. These changes have undoubtedly been good for dental patients, and have expanded access as general dentists are able to delegate out more portions of procedures and increase the number of patients they can service on a given day. However, as more and more skills have been added to the RDA curriculum, available class time has run out. What has been eliminated has, in most cases, been specialty care. So as an orthodontic specialist, when I hire a recently graduated RDA, I still have to train them in almost every skill in my office before I can allow them to work on my patients. There is virtually no time or education savings for me to hire an RDA versus to train an on-the-job dental assistant. In addition, most general dentists utilize one or two chairside assistants. Due to the highly delegated nature of orthodontic work, each orthodontist might require four to eight chairside assistants. At our local community college, the RDA class has not even been full the last few years. And sadly, many of the graduates in my experience consider dental assisting to be a good career while they are young, and then "retire" to have a family. There are simply not enough RDAs to service our orthodontic offices. And while the CDA to RDA programs have been great for many of my general dentist colleagues, we are not equipped to teach packing amalgam and other general dentistry skills in our offices. Therefore, this pipeline is entirely closed to our

		specialty. This has been a challenge for years, and creates an unnecessary barrier to employment. (h) – There is no reason a dental assistant cannot be trained to safely remove bands, brackets, and adhesives with a rotary instrument. This is legal in several other states, and they do not see large numbers of patients with permanent harm after orthodontic appliance removal. Especially in this age of electric handpieces, where the top speed can be programmed in for each use, this does not present a significant risk. There are burs designed to remove only adhesive and not cut enamel. This can be done safely, and individual orthodontists are more than capable of providing this training on a one-on-one basis. (i) The above logic can also be applied to polishing of teeth. This is a necessary step in the orthodontic bonding process to remove the pellicle, and with currently available equipment the rotation of the prophy cup can be throttled at a very safe speed while still achieving the goal. Orthodontists are more than capable of providing this equipment and training to their assistants. (j) Etching the enamel prior to the application of brackets or aligner attachments is also something that is no longer taught in the RDA programs. The current table shows an asterisk indicating 10 hours of didactic and clinical training is needed before even an RDA can perform this task. This type of training does not exist. Our local program (GRCC) provides a half-day on orthodontic procedures, and that doesn't happen every year. Again, orthodontists are more than capable of training this skill on a one-on-one basis. No orthodontist wants an etch accident, and no orthodontist would let an assistant of any training level work on their patients without proper training in this as determined by that orthodontist. (k) and (l) I can think of no content in the RDA curriculum that would assist in performing either of these skills. Again, the individual orthodontist provides all relevant training. (y) Most orthodontic impressions – or digital scans – are used for dual purposes: first as a study model, and then for the appliance fabrication. It has long been unnecessary to require different levels of training or supervision when they are typically used for both purposes. This clearly

		indicates there is no difference in the quality level between the two for orthodontic purposes. Hopefully this has provided some enlightenment into why the current rules are unrealistic for orthodontists in Michigan. This artificial barrier to employment of capable people willing to work and be trained should not continue. There are simply not enough RDA educational seats, nor enough time in their curriculum to teach the orthodontic skills in addition to the other requirements. The CDA to RDA pathway is not an option for orthodontists. And in addition, the "extra" training courses for the RDAs to perform some of our most common procedures don't even exist. If anything, all of the orthodontic specialty tasks should be allowed to be performed by any dental assistant under either direct or general supervision, and the orthodontist should be solely responsible for the training. We are doing the training now anyway, and the results reflect on our professional licenses regardless. If the Board feels it is necessary, an endorsement policy could be put into place requiring certain hours of didactic and clinical instruction that the orthodontist could attest to. This would fill the gap that has been left, as no existing assistant training programs provide actual training for orthodontic assistants.
(3)(m)	Swan	(m) See the comments for (h) above. Also, it seems like RDA's are allowed to use hand instruments to remove cement, and then also not allowed to use hand instruments to remove cement? However, I have no objection to restricting their adhesive or cement removal to supragingival areas. (Though I'm sure some of my colleague would disagree...)
(3)(n)	Mick/Thomas - AAO/MAO 50 individual letters supporting this change	Change new item (n) to "A" would allow orthodontic assistants to provide counseling to patients for optimal oral health and diet with multiple orthodontic and orthopedic therapies.
(3)(n)	Swan	(n) Most of the nutritional counseling provided in orthodontic offices is to discuss foods that should be avoided to prevent bracket breakage, or to prevent decalcification. This is fairly straightforward, and any clinical or nonclinical employee in the office should be able to discuss this with patients. To make it any other way seems like it actually does more harm than good – I want patients hearing about these things in as many ways and from as many people as possible in my office.

(3)(p)	Swan	(p) Looking around with a mouth mirror and recording findings which will be verified by the doctor does not harm anyone. This is a skill that can be trained in office, since what the orthodontist is looking for is often much different than what a general dentist is looking for.
(3)(r)	Swan	(r) Again, due to the risk of decalcification, application of fluoride and fluoride varnishes is a routine part of orthodontic visits. There is no part of the RDA education (that can't be replicated with individual training by the orthodontist) that makes a licensed assistant more qualified to perform this task.
(3)(v)	Mick/Thomas - AAO/MAO 50 individual letters supporting this change	Modify item (v) and delete "and bands" as that is redundant to item (e).
(3)(v)	Swan	(v) Sizing of bands is a reversible procedure, and a dental assistant of any training only learns to do this well via repetition. Certainly, an on-the-job trained dental assistant can safely perform this procedure under at least direct supervision.
(3)(w)	Mick/Thomas - AAO/MAO 50 individual letters supporting this change	Keep (w) Temporarily cementing and removing temporary crowns and bands, and add "A", Assignment, to UDAs.
Rules Committee Response	**(1)**: The Rules Committee agrees with the comment to include language in the rule that the dentist must provide the UDA with a copy of the delegation of duties table and explain the levels of supervision. **(1)(a)**: The Rules Committee will not address this comment as it is moot if the recommendation above is made to the rules. **(3):** The Rules Committee agrees with the comment to modify the last few words of the last sentence to – "under section 16611 of the code, MCL 333.16611, and as provided in Table 1." **(3)(bb):** The Rules Committee agrees to modify the term "absorbent points" to "paper points" for consistency with language used in the RDA test. **(3)(h), (i), (j), (k), (n), (p), (r), (v), and (y)**: The Rules Committee agrees with the comments to modify the table and	

	allow UDA's to handle the functions in (h), (i), (j), (k), (n), (p), (r), (v), and (y) with direct supervision. Function (r) shall further state that UDA's may not place sealants. Functions (i), (j), (k), (n), (p), (r), (v), and (y) will require training as follows: A dentist shall delegate these procedures to a UDA only if the UDA has successfully completed an in-person or virtual training with performance evaluations on the following functions: • Polishing assigned teeth with a slow-speed rotary hand piece immediately before an acid etch procedure. • Etching and placing adhesives before placement of orthodontic brackets and attachment for aligners. • Cementing orthodontic bands or initial placement of orthodontic brackets and attachments for aligners. • Providing nutritional counseling for oral health and maintenance. • Inspecting and charting the oral cavity using a mouth mirror and radiographs including the classifying of occlusion. • Applying anticariogenic agents including, but not limited to, sealants, fluoride varnish, and fluoride applications. • Temporarily cementing and removing temporary crowns and bands. • Taking impressions for intraoral appliances including bite registrations. **(3)(v):** The Rules Committee agrees with the comment to modify (v), delete "sizing", as it is redundant to (e). **(3)(w):** The Rules Committee disagrees with the comment to make this function under assignment for the UDA, because training and direct supervision of the dentist are necessary. **(3)(l) and (m):** The Rules Committee does not agree with allowing the UDA to handle these functions as the doctor or orthodontist is present during the placement of the appliance and removal of excess cement.

Board Response	**(1):** The Board agrees with the comment to include language in the rule that the dentist must provide the UDA with a copy of the delegation of duties table and explain the levels of supervision. **(3):** The Board agrees with the comment to modify the last few words of the last sentence to "under section 16611 of the code, MCL 333.16611, and as provided in Table 1." **(3)(bb):** The Board agrees to modify the term "absorbent points" to "paper points" for consistency with language used in the RDA test. **(3)(h), (i), (j), (k), (n), (p), (r), (v), and (y):** The Board agrees with the comments to modify the table and allow UDA's to handle the functions in (h), (i), (j), (k), (n), (p), (r), (v), and (y) with direct supervision. Function (r) shall further state that UDA's may not place sealants. Functions (i), (j), (k), (n), (p), (r), (v), and (y) will require training as follows:

	A dentist shall delegate these procedures to a UDA only if the UDA has successfully completed an in-person or virtual training with performance evaluations on the following functions: • Polishing assigned teeth with a slow-speed rotary hand piece immediately before an acid etch procedure. • Etching and placing adhesives before placement of orthodontic brackets and attachment for aligners. • Cementing orthodontic bands or initial placement of orthodontic brackets and attachments for aligners. • Providing nutritional counseling for oral health and maintenance. • Inspecting and charting the oral cavity using a mouth mirror and radiographs including the classifying of occlusion. • Applying anticariogenic agents including, but not limited to, sealants, fluoride varnish, and fluoride applications. • Temporarily cementing and removing temporary crowns and bands. • Taking impressions for intraoral appliances including bite registrations. **(3)(v):** The Board agrees with the comment to modify (v), delete "sizing", as it is redundant to (e). **(3)(w):** The Board disagrees with the comment to allow a UDA to handle this function under assignment, as training and direct supervision is necessary. **(3)(l) and (m):** The Board does not agree with the comment to allow the UDA to handle these functions as the dentist or orthodontist is present during the placement of the appliance and removal of excess cement.

Rule. 1411. **(1) Before a dentist may delegate a function to a UDA ~~unregistered dental auxiliary~~ the UDA ~~unregistered dental auxiliary~~ shall meet both of the following:**

(a) Submit proof of current certification in BSL or ACLS for healthcare providers with a hands-on component from an agency or organization that grants certification pursuant to standards equivalent to those established by the AHA, earned within the 2-year period before ~~receiving the license~~ delegation or assignment.

(b) Submit proof of attending training of at least 1 hour in infection control, which must include sterilization of hand pieces, personal protective equipment, and the CDC's infection control guidelines.

(2) Before a dentist delegates functions to a UDA the dentist shall provide to the UDA a copy of the delegation and assigned duties in Table 1 and shall explain the levels of supervision.

(~~2~~3) Except for the functions a dentist may delegate to a dental therapist, ~~A~~ dentist **or dental therapist** may **only** assign or delegate procedures to an **unlicensed or licensed individual, including a ~~unlicensed dental assistant~~UDA**, **~~registered dental assistant~~RDA**, or **~~registered dental hygienist~~RDH** under **~~the provisions of~~** section 16611 of the code, MCL 333.16611, **and** as provided in Table 1**~~:~~.**

(3) Table 1 - Delegated and Assigned Dental Procedures for Allied Dental Personnel

	UDA	RDA	RDH	Procedure
(a)	~~G~~**A**	A	A	Operating of dental radiographic equipment. ~~A DA~~ **A UDA** shall ~~have~~ successfully ~~completed~~**complete** a course in dental radiography that is substantially equivalent to a course taught in a program approved by the board pursuant to R 338.11302, R 338.11303, or R 338.11307. A dentist may delegate necessary radiographs for a new patient to ~~an~~**a UDA**, RDA or RDH.
(b)	G	A	A	Instructing in the use and care of dental appliances.
(c)	G	A	A	Taking impressions **or digital scans** for study and opposing models **and matrices for temporary crowns and bridges**.
(d)	G	A	A	Applying nonprescription topical anesthetic solution.
(e)	G	A	A	Trial sizing of orthodontic bands.
(f)	D	A	A	Placing, removing, and replacing orthodontic elastic or wire separators, arch wires, elastics, and ligatures.
(g)	D	A	A	Dispensing orthodontic aligners.
(h)	**D**	D	A	Removing orthodontic bands, brackets, and adhesives with ~~non-tissue cutting~~ **hand** instruments **only**. **Use of high-speed rotary instruments is not in the scope of practice of a UDA, RDA, or RDH.**
(i)	**D****	A	A	Polishing ~~specific~~ **assigned** teeth with a slow-speed rotary hand piece immediately before ~~a~~ **an** ~~procedure that requires~~ acid **etch procedure** ~~etching before placement of sealants, resin-bonded orthodontic appliances, and direct restorations~~.
(j)	**D****	G*	G*	Etching and placing adhesives before placement of orthodontic brackets and attachment for aligners.
(k)	**D****	D	D	Cementing orthodontic bands or initial placement of orthodontic brackets and attachments for aligners.
(l)		A	~~A~~	Removing excess **temporary** cement from supragingival surfaces of a tooth with ~~a non-tissue cutting instrument~~**hand instruments only**.
(m)			**A**	**Removing orthodontic or other cements from supragingival or subgingival surfaces with**

				hand instruments or powered scaling instruments.
(~~m~~**n**)	**D****	A	A	Providing nutritional counseling for oral health and maintenance.
(~~n~~**o**)	A	A	A	~~Applying~~ **Providing** commonly accepted medical emergency procedures.
(~~o~~**p**)	**D****	A	A	Inspecting and charting the oral cavity using a mouth mirror and radiographs **including the classifying of occlusion**.
~~(p)~~		~~A~~	~~A~~	~~Preliminary examination including classifying occlusion.~~
(q)		A	A	Placing and removing dental dam.
(r)	**D****	A	A	Applying anticariogenic agents including, but not limited to, sealants, fluoride varnish, and fluoride applications. **UDAs may not place sealants.**
(s)		A	A	Polishing and contouring of sealants with a slow-speed rotary hand piece immediately following a procedure for occlusal adjustment.
(t)		A		Fabricating temporary restorations**,** ~~and~~ temporary crowns**,** and temporary bridges.
(u)		A	A	Placing ~~and removing~~ a nonmetallic temporary or sedative restoration with non-tissue cutting ~~instument~~ **instruments**.
(v)	**D****	A	A	~~Sizing~~ **Temporarily cementing and removing** ~~of~~ temporary crowns and bands.
~~(w)~~		~~A~~	~~A~~	~~Temporarily cementing and removing temporary crowns and bands.~~
(~~x~~**w**)		G*	A	Preliminary examination including performing pulp vitality testing.
(~~y~~**x**)		G*	A	Applying desensitizing agents.
(~~z~~**y**)	**D****	G*	A	Taking impressions for intraoral appliances including bite registrations.
(~~aa~~**z**)		G*		Placing and removing matrices and wedges.
(~~bb~~**aa**)		G*		Applying cavity liners and bases.
(~~cc~~**bb**)		G*		Drying endodontic canals with ~~absorbent~~ **paper** points.
(~~dd~~**cc**)		G*		Placing and removing nonepinephrine retraction cords or materials.
~~(ee)~~		~~A~~	~~A~~	~~Placing and removing post extraction and periodontal dressings.~~
(~~ff~~**dd**)		D	A	Removing sutures.
(~~gg~~**e**		D	A	Applying and dispensing in-office bleaching products.

e)				
(~~hh~~**ff**)		G	G	~~Prior to~~**Before** cementation by the dentist, adjusting and polishing contacts and occlusion of indirect restorations. ~~After cementation, removing excess cement from around restorations~~.
(~~ii~~**gg**)		D**		Placing, condensing, and carving amalgam restorations.
(~~jj~~**hh**)		D**		Placing Class I resin bonded restorations, occlusal adjustment, finishing and polishing with non-tissue cutting slow-speed rotary hand pieces.
(~~kk~~**ii**)		D**		Taking final impressions for ~~direct and~~ indirect restorations and prosthesis including bite **registration, intra-oral imaging, and in-office fabrication of restorations**.
(~~ll~~**jj**)		D	D	Assisting and monitoring the administration of nitrous oxide analgesia by a dentist or the RDH. A dentist shall assign these procedures only if the RDA or RDH has successfully completed an approved course that meets the requirements of section 16611(7) of the code, MCL 333.16611, with a minimum of 5 hours of didactic instruction. The levels must be preset by the dentist or RDH and must not be adjusted by the RDA except in case of an emergency, in which case the RDA may turn off the nitrous oxide and administer 100% oxygen. As used in this subdivision, "assisting" means setting up equipment and placing the face mask. Assisting does not include titrating and turning the equipment on or off, except in the case of an emergency in which circumstances the RDA may turn off the nitrous oxide and administer 100% oxygen.
(~~mm~~**kk**)			A	Removing accretions and stains from the surfaces of the teeth and applying topical agents essential to complete prophylaxis.
(~~nn~~**ll**)			A	Root planing, debridement, deep scaling, and removal of calcareous deposits.
(~~oo~~**mm**)			A	Polishing and contouring restorations.
(~~pp~~**nn**)			A	Charting of the oral cavity, including all the following: periodontal charting, intra oral and extra oral examining of the soft tissue, charting of radiolucencies or radiopacities, existing restorations, and missing teeth.
(~~qq~~**oo**)			A	Applying topical anesthetic agents by prescription of the dentist.
~~(rr)~~		~~A~~	~~A~~	~~Placing and removing surgical temporary sedative dressings.~~

(~~ss~~**pp**)			A	Removing excess cement from tooth surfaces.
(~~tt~~**qq**)			A	Placing subgingival medicaments.
(~~uu~~**rr**)			A	Micro abrasion of tooth surfaces to remove defects, pitting, or deep staining.
(~~vv~~**ss**)			D	Performing soft tissue curettage with or without a dental laser.
(~~ww~~**tt**)	D	G	G	Taking digital scans for final restorations or intra-oral appliances.
(~~xx~~**uu**)			D***~~*~~	Administering intra oral block and infiltration anesthesia, or no more than 50% nitrous oxide analgesia, or both, to a patient who is 18 years of age or older if the RDH has met all of the following requirements: (i) Successfully completed an approved course that meets the requirements in section 16611(4) of the code, MCL 333.16611, in the administration of local anesthesia, with a minimum of 15 hours didactic instruction and 14 hours clinical experience. (ii) Successfully completed a state or regional board administered written examination in local anesthesia within 18 months ~~of~~**after** completion of the approved course in paragraph (i) of this subdivision. (iii) Successfully completed an approved course that meets the requirements in section 16611(4) of the code, MCL 333.16611, in the administration of nitrous oxide analgesia, with a minimum of 4 hours didactic instruction and 4 hours clinical experience. (iv) Successfully completed a state or regional board administered written examination in nitrous oxide analgesia, within 18 months ~~of~~ **after** completion of the approved course in paragraph (iii) of this subdivision. (v) Maintains and provides evidence of current certification in ~~basic or advanced cardiac life support~~**BSL or ACLS** that meets the standards contained in R 338.11705.

(4) As used in subrule (3) of this rule:

(a) "A" = ~~Assignment~~**,means assignment,** as **that term is** defined in R 338.11401.

(b) "D" means direct supervision, as that term is defined in R 338.11401.

(c) "G**" means** ~~= General~~**general** supervision**,** as **that term is** defined in R 338.11401.

~~D = Direct supervision, as defined in R 338.11401.~~
~~**U**DA = Dental assistant.~~
~~RDA = Registered dental assistant as defined in R 338.11101.~~
* A dentist shall assign these procedures to ~~an~~**a UDA,** RDA**,** and RDH only if the ~~RDA~~**allied dental personnel** has successfully completed an approved course that meets the requirements in section 16611(12) and (13) of the code, MCL 333.16611, and contains a minimum of 10 hours of didactic and clinical instruction.
**** A dentist shall delegate these procedures to a UDA only if the UDA has successfully completed an in-person or virtual training with performance evaluations on the following functions:**

- **Polishing assigned teeth with a slow-speed rotary hand piece immediately before an acid etch procedure.**
- **Etching and placing adhesives before placement of orthodontic brackets and attachment for aligners.**
- **Cementing orthodontic bands or initial placement of orthodontic brackets and attachments for aligners.**
- **Providing nutritional counseling for oral health and maintenance.**
- **Inspecting and charting the oral cavity using a mouth mirror and radiographs including the classifying of occlusion.**
- **Applying anticariogenic agents including, but not limited to, sealants, fluoride varnish, and fluoride applications.**
- **Temporarily cementing and removing temporary crowns and bands.**
- **Taking impressions for intraoral appliances including bite registrations.**

*** A dentist shall assign these procedures to ~~an~~**a** RDA only if the RDA has successfully completed an approved course that meets the requirements in section 16611(11) of the code, MCL 333.16611, and contains a minimum of 20 hours of didactic instruction followed by a comprehensive clinical experience of sufficient duration that validates clinical competence through a ~~criterion based~~**criterion-based** assessment instrument.
~~RDH = Registered dental hygienist as defined in R 338.11101.~~
**** The department fee for certification of completion of the requirements is $10.

Rule 338.11501 Specialties; recognition by the board.

Rule Numbers	Commenter	Comment
Section (4)(c) an (d)	Tseng	Modify (c) and (d) or combine, as they seem repetitive. Modify as follows: "(c) Hold at least a master's degree in a specialty listed in subrule (4) of this rule, that is recognized in Canada, from a dental institution that is recognized through an accreditation process approved by the NDEB or CDAC, with all training completed in Canada."
	Mick/Thomas -	The AAO supports regulations that require those who are advertising as "specialists" to have

	AAO/MAO	successfully completed a post-doctoral program in a program that is accredited by an accreditation agency recognized by the U.S. Department of Education (U.S. DOE), i.e. CODA. CODA is the only nationally recognized accrediting body for educational institutions in dentistry and the related dental fields, receiving its accreditation authority from the acceptance of all stakeholders within the dental community and recognition by the United States Department of Education. The AAO is opposed to dentists with less education and training being able to advertise on the same level or in the same manner or with similar words used to describe those true specialists who have graduated from accredited programs that receive accreditation from an agency recognized by the U.S Department of Education (U.S. DOE), as the AAO believes it is not in the best interest of patients' health and safety. An accreditation standard backed by the U.S. DOE best assures Michigan citizens that an individual who truthfully designates himself or herself as a specialist has met high standards for education and training. Allowing a dentist to advertise as a "specialist" without completing a multi-year accredited program backed by the U.S. DOE, risks diluting Michigan's "specialty" laws and allowing certain providers, who do not have years of supervised clinical and didactic training and/or who have not satisfied extensive criteria, to advertise on par with those providers who have long term, comprehensive education and training through U.S. DOE accredited programs. Such dilution threatens the health and safety of Michigan patients by obscuring important distinctions between dental professionals as well as their respective educational and training backgrounds. As such, the AAO supports the proposed rule R 338.11501 Specialties (2) that require that, “Each branch of a dental specialist that is licensed by the board is defined in the rules, and by the standards set forth by CODA under R 338.11301.”
Rules Committee Response	**(4)(c) and (d):** The Rules Committee agrees with the comment to combine (c) and (d).	

Board Response	**(4)(c) and (d):** The Board agrees with the comment to combine (c) and (d).

R 338.11501 Specialties; recognition by the board.
Rule 1501. (1) The department on behalf of the board may issue a health profession specialty license in all of the following branches of dentistry as specialties:

(a) **Endodontics.** ~~Oral and maxillofacial surgery.~~
(b) **Oral and maxillofacial surgery.** ~~Orthodontics and dentofacial orthopedics.~~
(c) **Oral and maxillofacial pathology**. ~~Prosthodontics.~~
(d) **Orthodontics and dentofacial orthopedics.** ~~Periodontics.~~
(e) Pediatric dentistry.
(f) **Periodontics.** ~~Endodontics.~~
(g) **Prosthodontics.** ~~Oral pathology or oral and maxillofacial pathology.~~

(2) In addition to the specialties listed in subrule (1) of this rule, the department may issue a health profession specialty license in the following branches of dentistry:

(a) Dental anesthesiology.
(b) Dental public health.
(c) Oral and maxillofacial radiology.
(d) Oral Medicine
(e) Orofacial pain.

~~(2)~~**(3)** Each branch of a dental specialty that is licensed by the board is defined in these rules~~,~~ and by the standards set forth by CODA under R 338.11301.

(4) An applicant who currently holds a license as a dental specialist in endodontics, oral and maxillofacial surgery, oral and maxillofacial pathology, orthodontics and dentofacial orthopedics, periodontics, prosthodontics, dental public health, or oral and maxillofacial radiology from a province in Canada may apply for a license if he or she submits a completed application, on a form provided by the department, together with the requisite fee, and provides proof of all of the following:

(a) Meet the requirements of the code, R 338.7001 to R 338.7005, any other rules promulgated under the code, and the requirements of section 16174, of the code, MCL 333.16174.

(b) Hold a current license to practice dentistry in this state.

(c) Hold at least a master's degree in a specialty listed in subrule (4) of this rule, that is recognized in Canada, from a dental institution that is recognized through an accreditation process approved ~~accredited~~ by the NDEB or CDAC, with all training completed in Canada.

~~(d) Have graduated from a specialty program recognized by the CDAC with all training completed in Canada.~~

(~~e~~d) Have passed the National Dental Specialty Examination (NDSE) and have NDSE certification.

Rule 338.11601 General anesthesia; conditions; violation.

Rule Numbers	Commenter	Comment

	Johnson/AAOMS	Anesthesia is at the core of OMS training and practice. OMS residency education standards require a dedicated 32-week resident rotation on medical and anesthesia service as well as an ongoing outpatient experience in all forms of anesthesia throughout four- to six-years of residency training. OMSs are trained in medical assessment and emergency management on par with our medical colleagues. Our training and ability to deliver treatment safely and affordably to patients via our team model of practice in our offices is unparalleled. Given the unique training and experience of the OMS, it would be inappropriate to subject an OMS to the standard of any dentist much like it is inappropriate to stipulate an anesthesiologist must follow the standards of a CRNA. We urge the department to consider this point carefully as subjecting a profession to an inapplicable standard of care not only fosters confusion but can jeopardize patient care and access to care. The AAOMS Parameters of Care2 reflect the guidelines for treatment and outcome expectations for 11 designated areas of oral and maxillofacial surgery, including Anesthesia in Outpatient Facilities. It is updated regularly to reflect the latest scientific research, surgical technique and policy positions. Additionally, the AAOMS Office Anesthesia Evaluation3 was designed to ensure that each practicing AAOMS member maintains a properly equipped office and is prepared to use appropriate techniques for managing emergencies and complications of anesthesia in the treatment of the OMS patient in the office or outpatient setting. Further, these documents, in addition to CODA standards, form the basis of all OMS training, from residency through ongoing continuing education. It establishes the basis of not just the OMSs training, but the training of their staff and auxiliaries as well. Thus, the inclusion of these references enhances the standard for the practitioners and their staff. We would ask the Board to work with the Michigan Society of Oral and Maxillofacial Surgeons to revise 2021-40 LR to not only match other state requirements in this area, but also to recognize the unique expertise of the practitioners that match their level of education and daily practice.
Section (1)	Benivegna/MDA	It is not clear whether the use of the word “treatment” in the proposal would prohibit a dentist from providing dental treatment to a patient who has been anesthetized or put in deep sedation by a

		qualified professional if the dentist is not qualified to anesthetize or sedate the patient themselves. To avoid this confusion, the MDA proposes the following be adopted in place of the proposal for R338.11601(1): "A dentist shall not administer general anesthesia or deep sedation to a dental patient or collaboratively provide general anesthesia or deep sedation with a physician anesthesiologist, another dentist, or nurse anesthetist, under section 17210 of the code, MCL 333.17210, in a dental office unless the dentist complies with the following requirements:" Requiring dentists to be qualified to administer anesthesia or sedation to provide dental treatment to an anesthetized or sedated patient will significantly limit access to care. Dentists frequently work with qualified professionals, such as oral surgeons and anesthesiologists, to safely administer anesthesia while the dentist delivers the necessary dental care. The current proposal by the Board of Dentistry will cause confusion among dentists as to when and how they are able to treat their patients who require sedation or anesthesia, which will hurt the delivery of dental care to patients. The MDA strongly believes clarifying this language will achieve the desired result of protecting patients, while providing clear guidelines for dentists to follow.
(1)(a)	Whitman-Herzer/Council of Michigan Dental Specialties, Inc.	Add AAOMS to the anesthesia rules, R-338.11601 and R-338.11602 as one of the national organizations authorized to give the mandatory course on addressing medical emergencies during anesthesia and for monitoring guidelines for both adults and children. The ADA, ASA and pediatric groups are listed, but those organizations do not teach courses that are based on the CODA residency training and OMS standards: only AAOMS provides these courses. This is important because OMSs provide 78% of dental office deep sedation and general anesthesia nationally and in Michigan, so OMSs rely heavily on AAOMS for CE courses designed to bring licensed specialists updated courses based on their model to protect the public.
(1)(a)(i) and (ii) (b)(i)	Small/Farbod MSOMS	Add AAOMS to Rule 1601 and 1602 as a recognized provider of courses on managing medical emergencies associated with office-based anesthesia, plus monitoring guidelines. Rational and supporting documents are included in the written submission. Add language in bold: (a) The dentist has demonstrated competency by meeting all the following requirements: (i) Completing a minimum of 1 year of advanced training in general anesthesia and pain control in

		a program that meets the standards adopted in R 338.11603(l). A program that is accredited by CODA as meeting the accreditation standards for advanced dental education programs in anesthesiology**, or in oral and maxillofacial surgery,** meets the requirements of this subdivision. (ii) Completing a course in managing medical emergencies that includes all of the following: (A) Current monitoring guidelines for adults from the ADA or the American ASA**, or the American Association of Oral and Maxillofacial Surgeons (AAOMS) for oral and maxillofacial surgeons,** and for children from the ASA, **or AAOMS for oral and maxillofacial surgeons,** the AAP, and the AAPD. (B) Equipment and material used in an anesthesia or sedation emergency. (C) The personnel needed for anesthesia or sedation. (D) The drugs needed for resuscitation in an emergency. (b) If general anesthesia or deep sedation is performed in a dental office, any allied dental personnel and dental therapists who are directly involved in the procedure shall complete a course in managing medical emergencies that includes all of the following: (i) Current monitoring guidelines for adults from the ADA or the ASA, **or AAOMS for oral and maxillofacial surgeons,** and for children from the ASA, the AAP, and the AAPD **or AAOMS for oral and maxillofacial surgeons**. (ii) Equipment and materials used in an anesthesia or sedation emergency. (iii) The personnel needed for anesthesia or sedation. (iv) The drugs needed for resuscitation in an emergency.
Rules Committee Response	**(1):** The Rules Committee agrees with the comment to clarify when a dentist must have additional training regarding general anesthesia or deep sedation. To clarify the rule the Rules Committee recommends the following: • Separate the rules regarding a general dentist providing general anesthesia or deep sedation versus a general dentist who collaboratively provides general anesthesia or deep sedation with a physician anesthesiologist, oral surgeon, or nurse anesthetist. • If a physician anesthesiologist, another dentist, or nurse anesthetist is providing general anesthesia or deep sedation in the dental office, the general dentist providing the dental treatment, a dental therapist, and allied dental personnel only needs BLS training. • The term “dentist” should be modified to “general dentist who does not hold a specialty license in dental anesthesiology or oral and maxillofacial surgery.”	

	• Delete the term "treatment." **(1):** The Rules Committee agrees with the comment to add training provided by AAOMS.

Board Response	**(1):** The Board agrees with the comment to clarify when a dentist must have additional training regarding general anesthesia and deep sedation. The rule will be modified as follows: • Separate the rules regarding a general dentist providing general anesthesia or deep sedation versus a general dentist who collaboratively provides general anesthesia or deep sedation with a physician anesthesiologist, oral surgeon, or nurse anesthetist. • If a physician anesthesiologist, another dentist, or nurse anesthetist is providing general anesthesia or deep sedation in the dental office, the general dentist providing the dental treatment, a dental therapist, and allied dental personnel only needs BLS training. • The term "dentist" should be modified to "general dentist who does not hold a specialty license in dental anesthesiology or oral and maxillofacial surgery." • Delete the term "treatment." **(1):** The Board agrees with the comment to add training provided by AAOMS. The definition of AAOMS will also be added to R 338.1101.

Rule 1601. (1) A **general** dentist **who does not hold a specialty license in dental anesthesiology or oral and maxillofacial surgery,** shall not administer general anesthesia **or deep sedation** to a dental patient ~~**or collaboratively provide treatment with a physician anesthesiologist, another dentist, or nurse anesthetist, under section 17210 of the code, MCL 333.17210,**~~ **in a dental office** ~~delegate and supervise the performance of any act, task, or function involved in the administration of general anesthesia **or deep sedation** to a dental patient,~~ unless ~~all~~ **the dentist complies with** ~~of~~ the following ~~conditions~~ **requirements** ~~are satisfied~~:

(a) The dentist has **demonstrated competency by** ~~completed~~ **meeting all the following requirements:**

(i) Completing a minimum of 1 year of advanced training in general anesthesia and pain control in a program that meets the standards adopted in R 338.11603(l). A program that is accredited by CODA as meeting the accreditation standards for advanced dental education programs in anesthesiology **or oral and maxillofacial surgery** meets the requirements of this subdivision.

(ii) Completing a course in managing medical emergencies that includes all of the following:

(A) Current monitoring guidelines for adults from the ADA or the American ASA, or the AAOMS for oral and maxillofacial surgeons, and for children from the ASA, or AAOMS for oral and maxillofacial surgeons, the AAP, and the AAPD.

(B) Equipment and material used in an anesthesia or sedation emergency.

(C) The personnel needed for anesthesia or sedation.

(D) The drugs needed for resuscitation in an emergency.

(iii) Maintaining ~~(b) The dentist and the delegatee, if any, maintain current certification~~**certification** in ~~basic~~ **BSL** and ~~advanced cardiac life support~~ **ACLS** for ~~health care~~**healthcare** providers with a hands-on component from an agency or organization that grants certification pursuant to standards substantially equivalent to the standards adopted in R 338.11603(2). A certification in ~~basic and advanced cardiac life~~**BLS and ACLS** for ~~health care~~**healthcare** providers with a hands-on component from AHA **or BLS for the healthcare provider and PALS with a hands-on component from AHA** meets the requirements of this subdivision.

(b) If general anesthesia or deep sedation is performed in a dental office, any allied dental personnel and dental therapists who are directly involved in the procedure shall complete a course in managing medical emergencies that includes all of the following:

(i) Current monitoring guidelines for adults from the ADA or the ASA, or AAOMS for oral and maxillofacial surgeons, and for children from the ASA, the AAP, and the AAPD or AAOMS for oral and maxillofacial surgeons.

(ii) Equipment and materials used in an anesthesia or sedation emergency.

(iii) The personnel needed for anesthesia or sedation.

(iv) The drugs needed for resuscitation in an emergency.

(2) A general dentist who does not hold a specialty license in dental anesthesiology or oral and maxillofacial surgery, shall not collaboratively provide general anesthesia or deep sedation with a physician anesthesiologist, oral surgeon, or nurse anesthetist, under section 17210 of the code, MCL 333.17210, in a dental office, unless the dentist, and allied dental personnel and dental therapists who are directly involved in the procedure, maintain certification in BLS for healthcare providers with a hands-on component from an agency or organization that grants certification pursuant to standards substantially equivalent to the standards adopted in R 338.11603(2). A certification in BLS for healthcare providers with a hands-on component from AHA or BLS for the healthcare provider and PALS with a hands-on component from AHA meets the requirements of this subdivision.

(~~2~~3) At no time is a RDA or RDH allowed to adjust medication levels during a procedure, other than nitrous oxide and oxygen, as allowed in R 338.11411(2).

~~(c) The facility in which the anesthesia is administered meets the equipment standards adopted in R 338.11603(3).~~

~~(d) The dentist shall be physically present with the patient who is given any general anesthesia until he or she regains consciousness and the dentist shall remain on the premises until the patient is capable of being discharged.~~

~~(2) A dentist who does not meet the requirements of subrule (1) of this rule shall not offer general anesthesia services for dental patients unless all of the following conditions are met:~~

~~(a) General anesthesia services are directly provided through association with, and by, either of the following individuals:~~

~~(i) A physician who is licensed under the provisions of part 170 or 175 of the code, MCL 333.17001 to 333.17097, and 333.17501 to 333.17556, and who is a member in good standing on the anesthesiology staff of a hospital accredited by the Joint Commission.~~

~~(ii) A dentist who meets the requirements of subrule (1)(a) and (b) of this rule.~~

~~(b) A person who administers anesthesia, under the provisions of subdivision (a) of this subrule, shall be physically present with the patient who is given any general anesthesia until he or she regains consciousness and the dentist shall remain on the~~ ~~premises where the general anesthesia is administered until the patient anesthetized is capable of being discharged.~~

~~(c) The provisions of subrule (1)(b) and (c) of this rule must be complied with.~~

~~(3) A dentist is in violation of section 16221(l)(h) of the code, MCL 333.16221, if he or she fails to comply with subrules (1) and (2) of this rule.~~

Rule 338.11602 ~~Intravenous conscious~~ **Moderate or minimal** sedation; ~~conditions; violations~~**requirements**.

Rule Numbers	Commenter	Comment
Section (1)	Benivegna/MDA	It is not clear whether the use of the word "treatment" in the proposal would prohibit a dentist from providing dental treatment to a patient who has been put in sedation by a qualified professional if the dentist is not qualified to sedate the patient themselves. To avoid this confusion, the MDA proposes the following be adopted in place of the proposal for R338.11602(1): "A dentist shall not administer moderate or minimal sedation to a dental patient or collaboratively provide moderate or minimal sedation with a physician anesthesiologist, another dentist, or nurse anesthetist, under section 17210 of the code, MCL 333.17210, in a dental office unless the dentist complies with the following requirements:"
(1)(a)	Whitman-Herzer/Council of Michigan Dental Specialties, Inc.	Add AAOMS to the anesthesia rules, R-338.11601 and R-338.11602 as one of the national organizations authorized to give the mandatory course on addressing medical emergencies during anesthesia and for monitoring guidelines for both adults and children. The ADA, ASA and pediatric groups are listed, but those organizations do not teach courses that are based on the CODA residency training and OMS standards: only AAOMS provides these courses. This is important because OMSs provide 78% of dental office deep sedation and general anesthesia nationally and in

		Michigan, so OMSs rely heavily on AAOMS for CE courses designed to bring licensed specialists updated courses based on their model to protect the public.
(1)(a)(iii)(A) and	Small/Farbod MSOMS	Add AAOMS to Rule 1601 and 1602 as a recognized provider of courses on managing medical emergencies associated with office-based anesthesia, plus monitoring guidelines. Rational and supporting documents are included in the written submission. Add language in bold: (iii) Completing a course in managing medical emergencies that includes all of the following: (A) Current monitoring guidelines for adults from the ADA or the ASA, **or AAOMS for oral and maxillofacial surgeons** and for children from the ASA, the AAP, and the AAPD**, or AAOMS for oral and maxillofacial surgeons**. (B) Equipment used in an anesthesia or sedation emergency. (C) The personnel needed for anesthesia or sedation. (D) The drugs needed for resuscitation in an emergency. (b) If moderate sedation is performed in a dental office, any allied dental personnel and dental therapists that are directly involved in the procedure shall complete a course in managing medical emergencies that includes all of the following: (i) Current monitoring guidelines for adults from the ADA or the ASA, **or AAOMS for oral and maxillofacial surgeons** and for children from the ASA, the AAP, and the AAPD**, or AAOMS for oral and maxillofacial surgeons**. (ii) Equipment and materials used in an anesthesia or sedation emergency. (iii) The personnel needed for anesthesia or sedation. (iv) The drugs needed for resuscitation in an emergency. (2) At no time is a RDA or RDH allowed to adjust medication levels during a procedure, other than nitrous oxide and oxygen, as allowed in R 338.11411(2).
Rules Committee Response	**(1):** The Rules Committee agrees with the comment to clarify when a dentist must have additional training regarding moderate and minimal sedation. To clarify the rule, the Rules Committee recommends the following: • Separate the rules regarding a general dentist providing the moderate or minimal sedation versus a general dentist who collaboratively provides moderate or minimal sedation with a physician anesthesiologist, another dentist, or nurse anesthetist. • If a physician anesthesiologist, another dentist, or nurse anesthetist is providing moderate or minimal sedation in	

	the dental office, the general dentist providing the dental treatment, a dental therapist, and allied dental personnel only needs BLS. • The term "dentist" should be modified to "general dentist who does not hold a specialty license in dental anesthesiology or oral and maxillofacial surgery." • Delete the term "treatment." **(1):** The Rules Committee agrees with the comment to add training provided by AAOMS.

Board Response	**(1):** The Board agrees with the comment to clarify when a dentist must have additional training regarding moderate and minimal sedation. The rule shall be modified as follows: • Separate the rules regarding a general dentist providing the moderate or minimal sedation versus a general dentist who collaboratively provides moderate or minimal sedation with a physician anesthesiologist, another dentist, or nurse anesthetist. • If a physician anesthesiologist, another dentist, or nurse anesthetist is providing moderate or minimal sedation in the dental office, the general dentist providing the dental treatment, a dental therapist, and allied dental personnel only needs BLS. • The term "dentist" should be modified to "general dentist who does not hold a specialty license in dental anesthesiology or oral and maxillofacial surgery." • Delete the term "treatment." **(1):** The Board agrees with the comment to add training provided by AAOMS.

Rule 1602. (1) A **general** dentist **who does not hold a specialty license in dental anesthesiology or oral and maxillofacial surgery,** shall not administer ~~intravenous conscious~~ **moderate or minimal** sedation to a dental patient ~~or **collaboratively provide treatment with a physician anesthesiologist, another dentist, or nurse anesthetist, under section 17210 of the code, MCL 333.17210,**~~ **in a dental office** ~~delegate and supervise the performance of any act or function involved~~ ~~in the administration of~~ ~~intravenous conscious **moderate or minimal** sedation to a dental patient~~ unless ~~1~~ **all** of the following **requirements are** ~~is~~ satisfied:

(a) The dentist ~~complies with R 338.11601(1) or (2).~~ has **demonstrated competency by** ~~completed~~ **meeting all of the following requirements:**

~~(b) The dentist complies with all of the following provisions:~~

~~(i) The dentist has completed a minimum of 60 hours of training in intravenous conscious sedation and related academic subjects, including a minimum of 40 hours of supervised clinical instruction in which the dentist has sedated not less than 20 cases in a course that complies with the standards adopted in R 338.11603(1). A program that is accredited by CODA as meeting the accreditation standards for advanced dental education programs meets the standards in R 338.11603(1).~~

(i) Completing either of the following:

(A) A comprehensive training program in moderate sedation that satisfies the requirements described in the moderate sedation section of the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students when the training was commenced, which must include 60 hours of classroom training and hands-on interaction in moderate sedation with 20 patients.

(B) An advanced education program accredited by CODA that provides comprehensive training to administer moderate sedation.

(ii) **Maintaining** ~~The dentist and the delegatee, if any, maintains current~~ certification in ~~basic~~ **BLS** ~~or~~ and ~~advanced cardiac life support~~ **ACLS** for ~~health care~~**healthcare** providers with a hands-on component from an agency or organization that grants certification under standards substantially equivalent to the standards adopted in R 338.11603(2). A certification in ~~basic and advanced cardiac life support~~**BLS and ACLS** for ~~health care~~**healthcare** providers with a hands-on component from AHA **or basic life support for the healthcare provider and PALS with a hands-on component from AHA** meets the requirements of this paragraph.

(iii) ~~The facility in which the anesthesia is administered complies with the equipment standards adopted in R 338.11603(3).~~ **Completing a course in managing medical emergencies that includes all of the following:**

(A) Current monitoring guidelines for adults from the ADA or the ASA, or AAOMS for oral and maxillofacial surgeons and for children from the ASA, the AAP, and the AAPD, or AAOMS for oral and maxillofacial surgeons.

(B) Equipment used in an anesthesia or sedation emergency.

(C) The personnel needed for anesthesia or sedation.

(D) The drugs needed for resuscitation in an emergency.

~~(2) A dentist is in violation of section 16221(1)(h) of the code, MCL 333.16221, if he or she fails to comply with subrule (1) of this rule.~~

(b) If moderate sedation is performed in a dental office, any allied dental personnel and dental therapists that are directly involved in the procedure shall complete a course in managing medical emergencies that includes all of the following:

(i) Current monitoring guidelines for adults from the ADA or the ASA, or AAOMS for oral and maxillofacial surgeons and for children from the ASA, the AAP, and the AAPD, or AAOMS for oral and maxillofacial surgeons.

(ii) Equipment and materials used in an anesthesia or sedation emergency.

(iii) The personnel needed for anesthesia or sedation.

(iv) The drugs needed for resuscitation in an emergency.

(2) A general dentist who does not hold a specialty license in dental anesthesiology or oral and maxillofacial surgery, shall not collaboratively provide moderate or minimal sedation with a physician anesthesiologist, oral surgeon, or nurse anesthetist, under section 17210 of the code, MCL 333.17210, in a dental office, unless the dentist, and allied dental personnel and dental therapists who are directly involved in the procedure, maintain certification in BLS for healthcare providers with a hands-on component from an agency or organization that grants certification pursuant to standards substantially equivalent to the standards adopted in R 338.11603(2). A certification in BLS for healthcare providers with a hands-on component from AHA or BLS for the healthcare provider and PALS with a hands-on component from AHA meets the requirements of this subdivision.

(~~2~~3) At no time is a RDA or RDH allowed to adjust medication levels during a procedure, other than nitrous oxide and oxygen, as allowed in R 338.11411(2).

Rule 338.11613 Consent; scope of practice; standard of care.

Rule Numbers	Commenter	Comment
	Hyman/MOHC	We want to ensure that an individual does not need to be a patient of record of the provider to have a teledentistry appointment. Often, individuals in an emergency dental situation (injury to or infection of a tooth) do not have a dental home and may need to be seen by a dental professional who has not yet seen them in person. We would like to encourage additional options for/uses of teledentistry such as asynchronous teledentistry that would allow a dentistry to review the record of a patient taken by a RDH.
Section (1)(a)	Spangler	The use of "telehealth" should be limited to "patients of record" as defined elsewhere in the rules. This would define a "patient of record" as someone who has been examined in person within the past 3 years. If they are a patient of record of the dentist or dental therapist, they could be treated by telehealth.
(4)(c)	Spangler	The use of the word "diagnose" is inappropriate. No one can diagnose with an image (unless it is a microscopic image of the patient's biopsied tissue). The use of telehealth can "identify" but it cannot diagnose. If the word "diagnose" is included in the statement that starts "Verify that telemedicine is appropriate to evaluate, diagnose……..." this statement will never be true.
Rules Committee	The Rules Committee agrees with the comment that teledentistry is not subject to the "patient of record" definition that	

Response	requires an "in-person" contact every 24 months unless there is assignment or delegation. In addition, radiographic images may be taken by allied dental personnel pursuant to a teledentistry visit, and this activity is not subject to the "in-person" at least once every 24 months requirement. The following language will be added to the definition section in R 338.11611: **The requirement in R 338.11401 to have an "in-person" contact with the dentist or dental therapist once every 24 months does not apply to telehealth services unless the dentist or dental therapist delegates or assigns duties, other than radiographic images, to allied dental personnel.** **(4)(c):** The Rules Committee agrees that the term "diagnose" is not necessary as the provision also states evaluate and treat.

Board Response	The Board does not agree with the comment to limit telehealth to someone who has been examined in-person within the last 2 years. Teledentistry is not subject to the "patient of record" definition that requires an "in-person" contact every 24 months unless there is assignment or delegation. In addition, radiographic images may be taken by allied dental personnel pursuant to a teledentistry visit, and this activity is not subject to the "in-person" at least once every 24 months requirement. The following language will be added to the definition section in R 338.11611: The requirement in R 338.11401 to have an "in-person" contact with the dentist or dental therapist once every 24 months does not apply to telehealth services unless the dentist or dental therapist delegates or assigns duties, other than radiographic images, to allied dental personnel. **(4)(c)**: The Board agrees that "diagnose" may be deleted as the provision also states evaluate and treat.

Rule 1613. (1) The licensee shall obtain informed consent for treatment before providing a telehealth service under section 16284 of the code, MCL 333.16284. Informed consent requires all of the following:

(a) The licensee shall ensure that the patient understands he or she will be treated remotely using telehealth.

(b) At the inception of care, any licensee who has contact with the patient shall identify himself or herself to the patient as a dentist, dental therapist, UDA, RDA, or RDH consistent with R 338.11103(a).

(c) The licensee shall ensure that the patient is mentally capable of giving informed consent for diagnosis, care, or treatment.

(d) The licensee shall explain the alternatives, capabilities, and limitations of telemedicine and that the patient may decline to receive telehealth services.

(2) If the patient is less than 18 years of age, a parent or legal guardian must provide informed consent for the patient.

(3) The licensee shall keep proof of consent for a telehealth service in the patient's up-to-date medical record and satisfy section 16213 of the code, MCL 333.16213.

(4) A licensee who provides telehealth services shall comply with all of the following:

(a) Act within the scope of his or her practice.

(b) Exercise the same standard of care applicable to a traditional, in-person healthcare service.

(c) Verify that telemedicine is appropriate to evaluate~~, diagnose,~~ and treat the patient based on his or her unique presentation.

(5) The licensee shall be able to examine the patient via a health insurance portability and accountability act (HIPAA) of 1996, Public Law 104-191 compliant, secure interactive audio or video, or both, telecommunications system, or through the use of store and forward online messaging.

(6) Telehealth must be secure and compliant with federal and state security and privacy regulations.

Rule 338.11701 License renewal for a dentist, dental specialist, and special-retired volunteer dentist; requirements; applicability.

Rule Numbers	Commenter	Comment
Section (3)	Tseng	Address how many CE hours are required if a licensee holds two specialty licenses. I don't think it is unreasonable to require 20 hours of CE PER specialty license each licensing cycle.
Rules Committee Response	**(3):** The Rules Committee agrees with the comment to require a licensee with more than 1 specialty to have an additional 20 continuing education (CE) hours for each additional specialty. One specialty requires 20 CE hours of the 60 required hours to be in the specialty. Two specialties require 20 CE hours of the 60 required hours to be in the first specialty and an additional 20 hours in the second specialty for a total of 80 CE hours. For each additional specialty an additional 20 CE hours are required.	

Board Response	**(3):** The Board agrees with the comment to require a licensee with more than 1 specialty to have an additional 20 continuing education (CE) hours for each additional specialty. One specialty will require 20 CE hours of the 60 required hours to be in the specialty. Two specialties will require 20 CE hours of the 60 required hours to be in the first specialty and an additional 20 hours in the second specialty for a total of 80 CE hours. For each

	additional specialty, an additional 20 CE hours are required.

Rule 1701. (1) This rule applies to an application for the renewal of a dentist license, dental specialist license, and special retired volunteer dentist license under sections 16201 and 16184 of the code, MCL 333.16201 and 333.16184. **A dental specialist license must be renewed at the same time as the dentistry license.**

~~(2) Subject to subrule (8) of this rule, an applicant for a dentist license renewal who has been licensed for the 3-year period immediately preceding the expiration date of the license shall comply with both of the following during the 3-year period before the end of the license cycle:~~

~~(a) Possess current certification in basic or advanced cardiac life support from an agency or organization that grants certification pursuant to standards substantially equivalent to the standards adopted in R 338.11705(4).~~

~~(b) Complete at least 3 continuing education credits in pain and symptom management. Continuing education credits in pain and symptom management may include, but are not limited to, courses in behavior management, psychology of pain, pharmacology, behavior modification, stress management, clinical applications, and drug interactions.~~

~~(3) Subject to subrule (8) of this rule, in addition to the requirements of subrule (2) of this rule, an applicant for a dentist license renewal, who has been licensed for the 3-year period immediately preceding the expiration date of the license, shall comply with all of the following during the 3-year period before the end of the license cycle:~~

~~(a) Complete not less than 60 hours of continuing education approved by the board under R 338.11704a.~~

~~(b) Complete a minimum of 20 hours of the required continuing education hours in programs directly related to clinical issues including delivery of care, materials used in delivery of care, and pharmacology.~~

~~(c) Complete a minimum of 20 hours of the required continuing education hours by attending synchronous, live courses or programs that provide for direct interaction between faculty and participants, including, but not limited to, lectures, symposia, live teleconferences, workshops, and participation in volunteer patient or supportive dental services provided for in R 338.11704a(1)(m). These courses, with the exception of the volunteer services, may be counted toward the required courses in clinical issues such as delivery of care, materials used in delivery of care, and pharmacology.~~

~~(4) Subject to subrule (8) of this rule, in addition to the requirements of subrules (2) and (3) of this rule, a dental specialist shall complete 20 hours of the required continuing education hours in the dental specialty field in which he or she is certified during the 3-year period before the end of the license cycle.~~

~~(5) Subject to subrule (8) of this rule, in addition to the requirements of subrule (2) of this rule, an applicant for a special retired dentist license shall comply with the following during the 3-year period before the end of the license cycle:~~

~~(a) Complete not less than 40 hours of continuing education acceptable to the board in R 338.11704a.~~

~~(b) Complete a minimum of 14 hours of the required hours of continuing education in programs directly related to clinical issues such as delivery of care, materials used in delivery of care, and pharmacology.~~

~~(c) Complete a minimum of 14 hours of the required hours of continuing education by attending synchronous, live courses or programs that provide for direct interaction between faculty and participants, including but not limited to, lectures, symposia, live teleconferences, workshops, and providing volunteer clinical services provided for in R 338.11704a(1)(m) . These courses, with the exception of the volunteer clinical services, may be counted toward the required courses in clinical issues such as delivery of care, materials used in delivery of care, and pharmacology.~~

~~(d) Comply with the conditions for renewal in section 16184(2) of the code, MCL 333.16184.~~

~~(6) The submission of the application for renewal constitutes the applicant's certification of compliance with the requirements of this rule. The board may require an applicant or a licensee to submit evidence to demonstrate compliance with this rule. The applicant or licensee shall maintain evidence of complying with the requirements of this rule for a period of 5 years from the date of the submission for renewal. Failure to comply with this rule is a violation of section 16221(h) of the code, MCL 333.16221.~~

~~(7) A request for a waiver under section 16205 of the code, MCL 333.16205, must be received by the department before the expiration date of the license.~~

~~(8)~~**(2)** ~~Effective for an application for renewal that is filed for the renewal cycle that begins 1 year or more after the effective date of this subrule, an applicant shall meet the requirements of this subrule and subrules (1), (7), and (9) to (14) of this rule.~~ An applicant for a dentist license renewal who has been licensed for the 3-year period immediately preceding the expiration date of the license shall complete not less than 60 hours of continuing education approved by the board under R 338.11704a during the 3-year period before the end of the license cycle.

~~(9)~~**(3)** An applicant for a dental specialist license renewal who has been licensed for the 3-year period immediately preceding the expiration date of the license shall complete 60 hours of continuing education approved by the board under R 338.11704a**,** with not less than 20 ~~hours~~ of the required 60 hours in board-approved continuing education in the dental specialty field in which he or she is licensed**,** within the 3-year period before the end of the license cycle. **Each additional specialty license requires an additional 20 hours of continuing education in the dental specialty field of the specialty license in addition to the 60 required continuing education hours.**

~~(10)~~**(4)** In addition to meeting the requirements of section 16184 of the code, MCL 333.16184, an applicant for a special retired volunteer dentist license renewal who has been licensed for the 3-year period immediately preceding the expiration date of the license shall complete not less than 60 hours of continuing education approved by the board under R 338.11704a during the 3-year period before the end of the license cycle.

~~(11)~~**(5)** An applicant shall possess current certification in ~~basic or advanced cardiac life support~~**BSL or ACLS** for ~~health care~~**healthcare** providers with a hands-on component from an agency or organization that grants certification pursuant to standards substantially equivalent to the standards adopted in R 338.11705(4).

~~(12)~~**(6)** In complying with the requirements of subrules ~~(8)~~**(2)** to ~~(10)~~**(4)** of this rule, an applicant for a dentist license, dental specialist license, and special retired volunteer dentist license renewal who has been licensed for the 3-year period immediately preceding the expiration date of the license shall comply with all of the following before the end of the license cycle:

(a) Complete ~~at least~~**not less than** 3 hours of the required continuing education hours in pain and symptom management. Continuing education hours in pain and symptom management may include, but are not limited to, courses in behavior management, psychology of pain, pharmacology, behavior modification, stress management, clinical applications, and drug interactions. Hours earned through volunteer patient or supportive dental services provided for in R 338.11704a(1)(m) do not count toward the required hours for pain and symptom management.

(b) Complete at least 1 hour of the required continuing education hours in dental ethics and jurisprudence with inclusion of delegation of duties to allied dental personnel**, which may be completed in 1 or more courses**. Hours earned through volunteer patient or supportive dental services provided for in R 338.11704a(1)(m) do not count toward the required hours for dental ethics and jurisprudence with inclusion of delegation of duties to allied dental personnel.

(c) Complete a minimum of 20 hours of the required continuing education hours in programs directly related to clinical issues including delivery of care, materials used in delivery of care, and pharmacology. Hours earned through volunteer patient or supportive dental services provided for in R 338.11704a(1)(m) do not count toward the required hours for clinical issues.

(d) Complete at least 1 hour of the required continuing education hours in infection control, which must include sterilization of hand pieces, personal protective equipment, and the ~~Centers for Disease Control and Prevention's~~**CDC's** infection control guidelines. Hours earned through volunteer patient or supportive dental services provided for in R 338.11704a(1)(m) do not count toward the required hours for infection control.

(e) Complete a minimum of 20 hours of the required continuing education hours by attending synchronous, live courses or programs**, in-person or virtual,** that provide for **the opportunity of** direct interaction between faculty and participants including, but not limited to, lectures, symposia, live teleconferences, workshops, and participation in volunteer patient or supportive dental services provided for in R 338.11704a(1)(m). These courses, with the exception of the volunteer services in R 338.11704a(1)(m), may be counted toward the required courses in clinical issues**, including** ~~such as~~ delivery of care, materials used in delivery of care, and pharmacology.

(f) Complete no more than 30 hours of the required continuing education hours asynchronously, noninteractive.

~~(13)~~**(7)** Except for the 1-time training in human trafficking ~~and 1-time training in opioid and controlled substances awareness~~, which may be used to comply with the requirement for the 1-time training and a continuing education requirement, an applicant may not earn

continuing education credit for **implicit bias training required by R 338.7004, and may not earn credit for** a continuing education program or activity that is identical to a program or activity an applicant has already earned credit for during that renewal period.

~~(14)~~**(8)** The submission of the application for renewal constitutes the applicant's certification of compliance with the requirements of this rule. The board may require an applicant or a licensee to submit evidence to demonstrate compliance with this rule. An applicant or licensee shall maintain evidence of complying with the requirements of this rule for a period of 5 years ~~from~~**after** the date of the submission for renewal. Failure to comply with this rule is a violation of section 16221(h) of the code, MCL 333.16221.

(9) A request for a waiver under section 16205 of the code, MCL 333.16205, must be received by the department for the board's consideration not less than 30 days before the last regularly scheduled board meeting before the expiration date of the license. The public notice for the board meetings can be found at: https://www.michigan.gov/lara/bureau-list/bpl/.health/hp-lic-health-prof/dental.

R 338.11704a Acceptable continuing education for licensees, limitations.

Rule Numbers	Commenter	Comment
Section (1)	Beavers/DHHS	Anyone who is part of the dental team, has a license with LARA, and works at an underserved clinic (ex. FQHC) should receive a determined amount of CEUs for working with the underserved population. Although this statement is a bit vague, there are other disciplines where this already happens and the policy could be replicated.
(1)(a)	Hoppes/MDAA	MDAA takes providing CE to dental professionals very seriously and works hard to provide CE that increases dental knowledge. We would like to comment on the statement in the box that says "A continuing education program or activity is approved, regardless of the format in which it is offered, if it is approved or offered for continuing education credit by any of the following:" We feel that just having the word "approved" is kind of misleading when it is widely known that there are coursed provided by organizations that do not meet the states standard for acceptable continuing education. The word "approved" makes it sound as if anything MDA/MDAA/MDHA puts on would be accepted by the department if a dental professional was audited for CE compliance. This is addressed for other entities wanting to provide CE who have to go through a review of their CE program and the department can deny a program, but we feel that the statement used in R 338.11704 (3) (c) would also be appropriate in section (1)(a) in the chart:

		"(c) A course or program must substantially meet the standards and criteria for an acceptable category of continuing education under this rule and must be relevant to health carehealthcare and advancement of the licensee's dental education." Rationale: Inserting this statement would help better direct organizations to only provide CE that would be acceptable .
Rules Committee Response	**(1)(a):** The Rules Committee agrees with the comment that automatically approved continuing education in (a) should be relevant to healthcare and advancement of the licensee's dental education. **(1)(n):** The Rules Committee agrees that it would benefit the public to encourage licensees to work with underserved populations and that offering continuing education for this work would be an incentive for licensees. The Rules Committee recommends that for every 120 hours of patient care or supportive dental services with underserved populations a licensee may earn one hour of continuing education, for a maximum of 1/3 of the total hours required.	

Board Response	**(1)(a):** The Board agrees with the comment that automatically approved continuing education in (a) should be relevant to healthcare and advancement of the licensee's dental education. **(1)(n):** The Board agrees that it would benefit the public to encourage licensees to work with underserved populations and that offering continuing education for this work would be an incentive for licensees. The rule will be modified to allow 1 hour continuing education for every 120 hours of patient care or supportive dental services with underserved populations, for a maximum of 1/3 of the total hours required.

Rule 1704a. (1) The board shall consider any of the following as acceptable continuing education for dentists, dental therapists, dental specialists, special-retired volunteer dentists, special-retired volunteer dental therapists, ~~registered dental hygienists~~**RDH**, special-retired volunteer ~~registered dental hygienists~~**RDHs**, ~~registered dental assistants~~**RDAs**, and special-retired volunteer ~~registered dental assistants~~**RDAs**, unless otherwise noted:

Acceptable Continuing Education activities		
(a)	Completion of an approved continuing	The number of hours earned are

	education program or activity related to the practice of dentistry. **A course or program must substantially meet the standards and criteria for an acceptable category of continuing education under this rule and must be relevant to healthcare and advancement of the licensee's dental education.** A continuing education program or activity is approved, regardless of the format in which it is offered, if it is approved or offered for continuing education credit by any of the following: • A dental, dental therapy, dental hygiene, dental assistant, or a hospital-based dental specialty educational program approved by CODA. • A continuing education sponsoring organization, institution, or individual approved by ~~the Academy of General Dentistry (~~AGD~~)~~. • **The Commission on Continuing Education Provider Recognition ADA CERP.** **A continuing education program or activity is approved, regardless of the format in which it is offered, if it is offered for continuing education credit by any of the following:**	the number of hours approved by the sponsor or the approving organization. If the activity was not approved for a set number of hours, then 1 credit hour for each 50 minutes of participation may be earned. No limitation on the number of hours earned.

	~~• A continuing education national sponsoring organization, institution, or individual approved by the~~ American Academy of Dental Hygiene (AADH)~~,~~ ~~.the~~ • American Dental Hygienists' Association (ADHA)~~,~~**.** ~~the~~ • American Dental Assistants Association (ADAA)~~,. and the Commission on Continuing Education Provider Recognition ADA Continuing Education Recognition Program (ADA CERP) or its successor organization.~~ ~~A continuing education sponsoring organization, institution, or individual approved by the~~ • Michigan Dental Association (MDA)~~,~~**.** • Michigan Dental Hygienists Association (MDHA)~~,~~**.** ~~and~~ • Michigan Dental Assistants Association (MDAA)**.** • **Another**~~.Another~~ state board of dentistry. If audited, an applicant shall submit a copy of a letter or certificate of completion showing the applicant's name, number of hours earned, sponsor name or the name of the organization that approved the program or activity for continuing education credit, and the date ~~on~~	

	~~which~~ the program was held or activity completed.	
(b)	Completion of courses offered for credit in a dental, dental therapy, dental hygiene, dental assistant, or a hospital-based dental specialty educational program approved by CODA. If audited, an applicant shall submit an official transcript that reflects completion of the course and number of semester or quarter credit hours earned.	Ten hours ~~of continuing education~~ may be earned for each quarter credit earned and 15 hours may be earned for each semester credit earned. No limitation on the number of hours earned.
(c)	Attendance at a program or activity related to topics approved in R 338.2443(2) and R 338.143(2) for category 1 continuing education by the board of medicine or board of osteopathic medicine. If audited, an applicant shall submit a copy of a letter or certificate of completion showing the applicant's name, number of hours earned, sponsor name or the name of the organization that approved the program or activity for continuing education credit, and the date ~~on which~~ the program was held or activity completed.	One hour may be earned for each 50 minutes of program attendance. A maximum of 30 hours for a dentist, and 18 hours for a dental therapist, ~~registered dental hygienist~~**RDH**, and ~~registered dental assistant~~**RDA** may be earned in each renewal period.
(d)	For dentists, satisfactory participation for a minimum of 7 months in a hospital or institution through a postgraduate dental clinical training program approved by CODA. If audited, an applicant shall submit a copy of a	Twenty hours may be earned in each calendar year for 7 months of participation in the calendar year. A maximum of 20 hours per calendar year may be earned.

	letter or certificate of completion showing the applicant's name, number of hours attended, the name of the hospital or institution, the name of the clinical training program, the date of participation, and the activities completed.	
(e)	For dentists, successful completion of an American-board specialty examination. If audited, an applicant shall submit proof of a passing score on the examination.	Ten hours may be earned in the year in which the applicant achieves a passing score on a specialty examination. A maximum of 20 hours may be earned in each renewal period. Credit is not given for repeating the same examination in a renewal period.
(f)	Renewal of a dentist, dental therapist, ~~registered dental hygienist~~**RDH**, or ~~registered dental assistant~~**RDA** license held in another state that requires continuing education for license renewal that is substantially equivalent in subject matter and total amount of required hours required in these rules if the applicant resides and practices in another state. If audited, an applicant shall submit proof of current licensure in another state and a copy of a letter or certificate of completion showing the applicant's name, number of hours earned, sponsor name or the name of the organization that approved the program or activity for continuing education credit, type of program or	For a dentist, 60 hours may be earned. For a dental therapist, 35 hours may be earned. For a ~~registered dental hygienist~~**RDH** or ~~registered dental assistant~~**RDA**, 36 hours may be earned. A maximum of 60 hours for a dentist, 35 hours for a dental therapist, and 36 hours for a ~~registered dental hygienist~~**RDH** or ~~registered dental assistant~~**RDA** may be earned in each renewal period.

	activity, and the date ~~on which~~ the program was held or activity completed.	
(g)	For a ~~registered dental assistant~~**RDA**, meeting the requirements for recertification in R 338.11705(3). If audited, an applicant shall submit proof of current certification, other than emeritus certification, by the Dental Assisting National Board (DANB).	Thirty-six hours may be earned. A maximum of 36 hours may be earned in each renewal period.
(h)	Initial publication of an article or text related to the practice of dentistry, dental therapy, dental hygiene, or dental assisting in either of the following: • A textbook. • A journal of a national association of dentists, dental therapists, dental specialists, dental hygienists, or dental assistants. If audited, an applicant shall submit a copy of the publication that identifies the applicant as the author or a publication acceptance letter.	Twenty-five hours may be earned per publication. A maximum of 25 hours may be earned in each renewal period.
(i)	Initial publication of an article related to the practice of dentistry, dental therapy, dental hygiene, or dental assisting in either of the following: • A journal of an accredited dentistry, dental therapy, dental hygiene, or dental assisting school.	Twelve hours may be earned per publication. A maximum of 12 hours may be earned in each renewal period.

	• A state or state-component association of dentists, dental therapists, dental specialists, dental hygienists, or dental assistants. If audited, an applicant shall submit a copy of the publication that identifies the applicant as the author or a publication acceptance letter.	
(j)	Independent reading of articles or viewing or listening to media, other than online programs, related to dental, dental therapy, dental hygiene, or dental assisting education. If audited, an applicant shall submit an affidavit attesting to the number of hours the applicant spent participating in these activities that includes a description of the activity.	One hour for each 50 minutes of participation may be earned per activity. A maximum of 10 hours may be earned in each renewal period.
(k)	Development and presentation of a table clinical demonstration or a continuing education lecture offered in conjunction with the presentation of continuing education programs approved by the board pursuant to subrule (3) of this rule that is not a part of the licensee's regular job description. If audited, an applicant shall submit a copy of the curriculum and a letter from the program sponsor verifying the length and date of the presentation.	One hour for each 50 minutes devoted to the development and initial presentation. A maximum of 10 hours may be earned in each renewal period.
(l)	Attendance at a dental-related program that is approved by the board pursuant to subrule (3)	Ten hours ~~of continuing education~~ may be credited per year.

	of this rule and that is relevant to ~~health care~~**healthcare** and advancement of the licensee's dental education. If audited, an applicant shall submit a copy of a letter or certificate of completion showing the applicant's name, number of hours earned, sponsor name or the name of the organization that approved the program or activity for continuing education credit, and the date ~~on which~~ the program was held or activity completed.	A maximum of 10 hours may be earned in each renewal period.
(m)	Providing volunteer patient or supportive dental services in this state at a board-approved program pursuant to subrule (4) of this rule that is not a part of the licensee's regular job description ~~nor~~**or** required under a board order or agreement and that complies with the following: • The program is a public or nonprofit entity, program, or event, or a school or nursing home. • The program provides patient or supportive dental services to the indigent or dentally underserved populations. • The licensee does not receive direct or indirect remuneration of any kind including, but not limited to, remuneration for materials purchased or used.	One hour for each 120 minutes of providing patient or supportive dental services. A dentist or special-retired volunteer dentist may earn a maximum of 20 hours per renewal period. A dental therapist, ~~registered dental hygienist~~**RDH**, ~~registered dental assistant~~**RDA**, special-retired volunteer dental therapist, special-retired volunteer ~~registered dental hygienist~~**RDH**, and special-retired volunteer ~~registered dental assistant~~**RDA** may earn a maximum of 12 hours per renewal

	• The licensee shall sign in and sign out daily upon commencement and termination of the provision of services. • A dentist with a specialty license issued from this state shall limit volunteer clinical dental services to the specialty area in which the dentist is licensed. If audited, an applicant shall submit proof from the sponsor of the assignments and the hours of service provided.	period.
(n)	**Providing patient or supportive dental services in this state to indigent or dentally underserved populations that is part of the licensee's regular job description but is not required under a board order or agreement.** **If audited, an applicant shall submit proof from an employer of the assignments and the hours worked.**	**One hour for each 120 minutes of providing patient or supportive dental services.** **A dentist or special-retired volunteer dentist may earn a maximum of 20 hours per renewal period.** **A dental therapist, RDH, RDA, special-retired volunteer dental therapist, special-retired volunteer RDH, and special-retired volunteer RDA may earn a maximum of 12 hours per renewal period.**

Board Response	

(2) If an organized continuing education course or program is offered in segments of 50 to 60 minutes each, 1 hour of credit is given for each segment.

(3) The following requirements are established for ~~board approval of~~ continuing education, which includes, but is not limited to, any continuing education not otherwise approved by subrule (1) of this rule:

(a) The continuing education applicant shall submit a ~~complete~~**completed** application, on forms provided by the department**, which includes submission of a curriculum vitae or biography for all instructors and speakers**. ~~A licensee shall submit a "Patient Protection" form provided by the department to the department for each continuing education course or program involving treatment of live patients.~~

(b) A completed application form must be submitted to the department ~~at least~~**not less than** 70 days before the date the course or program is conducted and **not less than** 70 days before the next regularly scheduled board meeting for the proposed continuing education to be considered for approval by the board. Continuing education conducted before board consideration and approval will be denied approval.

(c) A course or program must substantially meet the standards and criteria for an acceptable category of continuing education under this rule and must be relevant to ~~health care~~**healthcare** and advancement of the licensee's dental education.

(d) Board approval is for a term of 3 years from the date of approval.

(e) Approved continuing education must be reevaluated by the board before any changes during the 3-year approval term including, but not limited to, changes in the following:

(i) Instructors and speakers.

(ii) Content, title, ~~and~~ **or** number of continuing education hours to be awarded to participants.

(f) Subject to subdivision (g) of this subrule, all changes to previously approved continuing education courses or programs must be submitted on required department forms ~~at least~~**not less than** 70 days before the date the continuing education course or program is offered to participants and **not less than** 70 days before the next regularly scheduled board meeting to be considered for approval by the board. Any changes to the submitted and previously approved courses or programs conducted before board reconsideration and approval will be denied approval.

(g) Emergency changes to instructors and speakers that are unable to be submitted to the board ~~at least~~**not less than** 70 days before the date of the continuing education may be reviewed by the department in consultation with the board chair when proof acceptable to the department is submitted with the change supporting the nature of the emergency.

(h) **Other than the beginning term of approval,** ~~The~~ specific dates of the continuing education course or program ~~does~~ **and the number of times the course or program are offered do** not require further board approval and may be changed without review by the board if the presentation dates are within the board's original 3-year term of approval.

(i) All of the following information must be recorded on a continuing education course or program certificate of completion or other proof prepared by the sponsor conducting the continuing education:

(i) The name of the applicant~~,/~~**sponsor, or both**.

(ii) Continuing education approval number issued by the board.

(iii) Course title.

~~(iv) Speaker or instructor.~~

~~(v)~~**(iv)** Date the approved continuing education course was conducted.

~~(vi)~~**(v)** Number of continuing education hours awarded.

~~(vii)~~**(vi)** ~~Approved sponsor's signature~~**Signature of the individual responsible for attendance**.

~~(viii)~~**(vii)** Dates of the current approval term.

~~(ix)~~**(viii)** Name of participant.

(j) The board may revoke the approval status of any approved continuing education course or program any time the course or program fails to comply with these rules.

(k) The continuing education applicant shall submit a "Patient Protection" form provided by the department to the department for each continuing education course or program involving treatment of live patients.

(4) The following requirements are established for board approval of a sponsor offering volunteer continuing education opportunities under subrule (1)(m) of this rule:

(a) A sponsor shall apply to the department to obtain approval as a sponsoring entity on the volunteer dental application form.

(b) A sponsor shall retain patient records.

(c) A sponsor shall retain documentation of all volunteer assignments and the hours of service provided.

(d) Upon request, a sponsor shall provide the board with the records, copy of the assignments, hours of service, and evidence of compliance with the requirements of subrule (1)(m) of this rule.

(e) A sponsor shall provide each licensee with verification of all volunteer hours of dental care provided by the licensee upon completion of the licensee's service.

(f) Upon request, a sponsor shall submit documentation to the department, evidencing compliance with the requirements of subrules (1)(m) and (5) of this rule.

(g) Board approval is for a term of 4 years from the date of approval.

(h) The board may revoke the approval status of any volunteer continuing education opportunity any time an approved continuing education program fails to comply with these rules.

(i) All of the following information must be recorded on a continuing education certificate of completion or other proof prepared by the sponsor conducting the volunteer continuing education course or program:

(i) The name of the sponsoring organization.
(ii) Continuing education approval number issued by the board.
(iii) Dates and times of volunteer services.
(iv) Number of continuing education hours earned.
(v) Signature of individual responsible for attendance.
(vi) Dates of the current approval term.
(vii) Name of participant.

(5) A continuing education sponsor shall maintain evidence of participation in continuing education, including signed continuing education certificates of completion issued to participants, for a period of 5 years from the date of the continuing education program or course.

Rule 338.11811 Amalgam separator; installation and operation; requirements.

Rule Numbers	Commenter	Comment
Section(2)(c)	Accurso	Rule 1811(2)c should be updated from "Oral pathologists" to "Oral & maxillofacial pathologists" for consistency throughout the rules.
(2)(c)	Whitman-Herzer/Council of Michigan Dental Specialties, Inc.	Update from "Oral pathologists" to "Oral & maxillofacial pathologists" for consistency throughout the rules.
Rules Committee Response	**(2)(c):** The Rules Committee agrees with the comment.	

Board Response	**(2)(c):** The Board agrees with the comment to modify oral pathologists to oral and maxillofacial pathologists for consistency.

Rule 1811. (1) ~~On or before December 31, 2013, a~~ dentist shall ~~install, or~~ have installed~~,~~ an amalgam separator on each wastewater drain in his or her dental office that is used to discharge dental amalgam waste. In addition to meeting the requirements of the code and these rules, a dentist who is required to install an amalgam separator, ~~pursuant to~~**under** section 16631 of the code, MCL 333.16631, shall comply with all of the following:

(a) Install an amalgam separator that meets the requirements of R 338.11813.
(b) Install, operate, and maintain the amalgam separator according to the manufacturer's instructions.

(c) Ensure the installed amalgam separator is properly sized to accommodate maximum dental amalgam wastewater flow rates at the dental office. The maximum allowable flow rate through an amalgam separator at a dental office must not exceed the maximum flow rate capacity at which the amalgam separator was tested under R 338.11813(1)(a).

(d) Ensure that all wastewater from the dental office containing dental amalgam waste passes through an installed and properly functioning and maintained amalgam separator before being discharged.

(2) Subrule (1) of this rule does not apply to any of the following:

(a) Oral and maxillofacial surgeons.

(b) Oral and maxillofacial radiologists.

(c) Oral **and maxillofacial** pathologists.

(d) Orthodontists.

(e) Periodontists.

(f) Dentists while providing services in a dental ~~school~~educational program, in a hospital, or through a local health department.

(g) Dentists who install and use a holding tank and do not discharge amalgam waste.

Archived: Tuesday, February 21, 2023 8:01:42 AM
From: BPL-BoardSupport
Sent: Mon, 22 Aug 2022 16:29:44
To: Ditschman, Andria (LARA)
Subject: FW: Board of Dentistry Public Comment Letter
Importance: Normal
Sensitivity: None
Attachments:
Witwer Letter - Board of Dentistry Rules[62][69].docx

From: Angela Witwer <AWitwer@house.mi.gov>
Sent: Monday, August 22, 2022 12:29 PM
To: BPL-BoardSupport <BPL-BoardSupport@michigan.gov>
Subject: Board of Dentistry Public Comment Letter

Good afternoon. Please find attached a comment letter for the board of dentistry proposed rules. Please let me know if you have any questions.

Sincerely,

Angela Witwer
State Representative

Archived: Tuesday, February 21, 2023 8:04:11 AM
From: BPL-BoardSupport
Sent: Fri, 12 Aug 2022 19:05:03
To: Ditschman, Andria (LARA)
Subject: Fwd: Proposed Administrative Rules for Dentistry-General Rules-Rule Set 2021-40LR
Importance: Normal
Sensitivity: None
Attachments:
ATDA Michigan Rule Letter.docx

From: Marc Ackerman <admin@americanteledentistry.org>
Sent: Friday, August 12, 2022 11:40:50 AM
To: BPL-BoardSupport <BPL-BoardSupport@michigan.gov>
Subject: Re: Proposed Administrative Rules for Dentistry-General Rules-Rule Set 2021-40LR

Please find my organization's public comment on the aforementioned proposed Rules.

Thank you,
Marc

Marc Bernard Ackerman, DMD, MBA, FACD
Executive Director
American Teledentistry Association
9 Roberts Road
Wellesley, MA 02481
admin@americanteledentistry.org
617-413-2740

Archived: Tuesday, February 21, 2023 8:03:03 AM
From: BPL-BoardSupport
Sent: Mon, 22 Aug 2022 19:19:17
To: Ditschman, Andria (LARA)
Subject: FW: Written Comment Submission on Proposed Rule 2021-40 LR (Dentistry – General Rules)
Importance: Normal
Sensitivity: None
Attachments:
2022-08-22 Byte - Public Comment re MI Dental Board Proposed Rule re Patient of Record[89].pdf

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From: Yaw Thompson <ythompson@forbes-tate.com>
Sent: Monday, August 22, 2022 3:14 PM
To: BPL-BoardSupport <BPL-BoardSupport@michigan.gov>
Cc: Kim, Shirley <Shirley.Kim@byteme.com>; Peter O'Keefe <pokeefe@forbes-tate.com>
Subject: Written Comment Submission on Proposed Rule 2021-40 LR (Dentistry – General Rules)

Dear Stephanie Wysack,

I would like to submit this comment on Proposed Rule 2021-40 LR (Dentistry – General Rules) on behalf of Byte.

Kindly confirm receipt of the written comment and please let me know if you have any issues or concerns accessing the attached document.

Thank you,
Yaw Thompson
Forbes Tate Partners
777 6th Street NW, 8th Floor
Washington, DC 20001
O: 202-638-0125
F: 202-638-0115
www.forbes-tate.com

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PARTNERS

Archived: Tuesday, February 21, 2023 8:01:56 AM
From: BPL-BoardSupport
Sent: Monday, August 22, 2022 7:12:15 AM
To: Ditschman, Andria (LARA)
Subject: FW: Comments on Proposed Rules 2021-40 LR
Importance: Normal
Sensitivity: None
Attachments:
AAOMS Comment on MI Proposed Revisions - 8-19-22.pdf

From: Srini Varadarajan <Sriniv@aaoms.org>
Sent: Saturday, August 20, 2022 8:29 AM
To: BPL-BoardSupport <BPL-BoardSupport@michigan.gov>
Cc: Richard Small <rich@rsmallagency.com>; Frank Farbod <frankfbd@gmail.com>; Karin Wittich <KarinW@aaoms.org>; Sandy Guenther <SGuenther@aaoms.org>
Subject: Comments on Proposed Rules 2021-40 LR

On behalf of the American Association of Oral and Maxillofacial Surgeons (AAOMS), please accept the attached comments on the proposed rules, Rule Set 2021-40 LR. Thank you.

Sincerely,

Srini Varadarajan

Srini Varadarajan, JD
Associate Executive Director, Practice Management, Health Policy and Governmental Affairs
American Association of Oral and Maxillofacial Surgeons
9700 W. Bryn Mawr Ave., Rosemont, IL 60018
Office: 800-822-6637, ext. 4303 | Fax: 847-678-4619
sriniv@aaoms.org | AAOMS.org | MyOMS.org

Save the date for the AAOMS Annual Meeting, Sept. 14 to 17, in New Orleans, La.

Archived: Tuesday, February 21, 2023 8:02:09 AM
From: BPL-BoardSupport
Sent: Tue, 16 Aug 2022 12:48:35
To: Ditschman, Andria (LARA)
Subject: FW: Letter on Behalf of Representative Kahle
Importance: Normal
Sensitivity: None
Attachments:
Rep. Kahle Letter on Dental Telehealth Rules.pdf

From: Nicholas Rossow <NRossow@house.mi.gov>
Sent: Tuesday, August 16, 2022 8:44 AM
To: BPL-BoardSupport <BPL-BoardSupport@michigan.gov>
Subject: Letter on Behalf of Representative Kahle

Good Morning,

On behalf of Representative Kahle, I submit a letter to the Board of Dentistry.

Sincerely,

Nicholas Rossow
Legislative Director
Representative Bronna Kahle
57th District
517-373-1706
Nrossow@house.mi.gov

Archived: Tuesday, February 21, 2023 8:02:26 AM
From: BPL-BoardSupport
Sent: Mon, 22 Aug 2022 19:42:54
To: Ditschman, Andria (LARA)
Subject: FW: Proposed Administrative Rules for Dentistry – General Rules – Rule Set 2021-40 LR
Importance: Normal
Sensitivity: None
Attachments:
TechNet Teleden Michigan Letter 8.22.2022.pdf

From: Tyler Diers <tdiers@technet.org>
Sent: Monday, August 22, 2022 3:40 PM
To: BPL-BoardSupport <BPL-BoardSupport@michigan.gov>
Subject: Proposed Administrative Rules for Dentistry – General Rules – Rule Set 2021-40 LR

Good Afternoon --

Please see attached for comments from TechNet on the proposed administrative rules for dentistry (2021-40 LR). If there is any further information needed please let me know.

Thanks,

Tyler

--
Tyler Diers
Executive Director | Midwest
TechNet | The Voice of the Innovation Economy
(c): 630.400.3439 | tdiers@technet.org
Twitter: @technetmidwest

Archived: Tuesday, February 21, 2023 8:02:39 AM
From: BPL-BoardSupport
Sent: Thu, 18 Aug 2022 18:57:54
To: Ditschman, Andria (LARA)
Subject: FW: Public Comment - Board of Dentistry
Importance: Normal
Sensitivity: None
Attachments:
SDC Michigan Letter[90].pdf

From: Matt Sowash <Matt@mlcmi.com>
Sent: Thursday, August 18, 2022 2:56 PM
To: BPL-BoardSupport <BPL-BoardSupport@michigan.gov>
Subject: Public Comment - Board of Dentistry

To Whom It May Concern:

Please find the attached public comment from Smile Direct Club regarding the proposed administrative rule changes by the board of dentistry.

Please let me know if you have any questions. Also, please confirm receipt of this letter.

Best wishes,

Matt Sowash

MLC
MICHIGAN LEGISLATIVE CONSULTANTS

Matt Sowash | Michigan Legislative Consultants

O: 517.372.2560
C: 734.730.3168
Website | LinkedIn | Twitter | Facebook
Michigan Member, National Association of State Lobbyists

Knowledge. Influence. Distinctive Expertise.

Archived: Tuesday, February 21, 2023 8:06:11 AM
From: BPL-BoardSupport
Sent: Mon, 22 Aug 2022 18:53:15
To: Ditschman, Andria (LARA)
Subject: FW: Public Comment Regarding Proposed Changes to Dentistry General Rules Set
Importance: Normal
Sensitivity: None

From: Heather Gietzen <hzablocki@gmail.com>
Sent: Monday, August 22, 2022 2:05 PM
To: BPL-BoardSupport <BPL-BoardSupport@michigan.gov>
Subject: Public Comment Regarding Proposed Changes to Dentistry General Rules Set

Dear LARA and Board of Dentistry,

Thank you for your service to our State. I am officially submitting the comments in this email to be considered during the rules change process.

I would like to officially submit comments regarding the Administrative Rules for Dentistry – General Rules Set 2021-40 LR. I have noticed several areas of concern throughout the existing rules and the proposed draft rules. Most notably the areas of dental assisting and dental auxiliaries. I do have concerns regarding the change from DA to UDA. There are also concerns regarding the area of specialty licensing and advertising rules. The current rules were made before the internet and current technology. They are out of sink with today's practice environment and current dental education particularly when it comes to assisting duties and assignment of those duties. With safety in mind, the rules and proposed rules changes do not address the best interests of the public and do not meaningfully protect the public. Most notable are the rules and assigned delegations laid out in Part 4A and Table 1. The rules are also restricting able bodied people from accessing employment that could provide meaningful wages and provide more access to care in the State of Michigan. The current format and content for educating RDAs and RDHs does not provide what is necessary for an orthodontic assistant. Any training in orthodontics has continued to decline since the addition of expanded functions for RDAs. The current schools in which one can become a licensed registered dental assistant are not graduating enough assistants to meet the current needs of our state. Also there is no reason for a person trained as an RDA to be an orthodontic assistant. It is rare to even get an RDA to apply for such a position because it is not their training and there is a difference in wages between an expanded function RDA in a general dental office and an assistant in an orthodontic office. To further restrict the duties of DAs/UDAs or to not take full consideration into the duties that can be safely done under the supervision of an orthodontist or licensed dentist is a detriment to the health, safety, and well-being of the people of the State of Michigan and also the economy in our State. The current rules and proposed rules do not take all of the above issues into consideration and need to be revised to reflect the current state of affairs in dentistry.

Thank you for your time and attention to this matter and I appreciate your consideration of my comments.

Sincerely,
Dr. Heather Gietzen
Grand River Orthodontics
1335 W. Main St, Ste D
Lowell, MI 49331
616-897-0200

Archived: Tuesday, February 21, 2023 8:02:50 AM
From: BPL-BoardSupport
Sent: Mon, 22 Aug 2022 14:50:55
To: Ditschman, Andria (LARA)
Subject: FW: Public Hearing - Administrative Rules for Dentistry
Importance: Normal
Sensitivity: None

From: Brent Accurso <brent.accurso@gmail.com>
Sent: Monday, August 22, 2022 10:50 AM
To: Katie Whitman-Herzer <katie.l.whitman@gmail.com>; BPL-BoardSupport <BPL-BoardSupport@michigan.gov>
Subject: Re: Public Hearing - Administrative Rules for Dentistry

Rule 1811(2)c should be updated from "Oral pathologists" to "Oral & maxillofacial pathologists" for consistency throughout the rules.

Brent Accurso
brent.accurso@gmail.com
734.709.5326

On Mon, Aug 22, 2022 at 10:37 AM Katie Whitman-Herzer <katie.l.whitman@gmail.com> wrote:

> CMDS Members -
>
> LARA is holding a public hearing today on the proposed changes to the Dentistry General Rules set. **If you wish to submit any comments on these proposed rules, you can do so by email through 5:00 p.m. today (8/22/2022) at BPL-BoardSupport@michigan.gov**
>
> Per, Richard Small, "the MDA plans on submitting a request to clarify the anesthesia rules. The current proposal implies any dentist “treating” along with an anesthesiologist, CRNA, etc. should also meet the requirements of Part 6. The state claims its intent was to only require this if the dentist is collaborating in some way with sedation/anesthesia. Bill and I agreed to language that will clarify this which the MDA will propose."
>
> The proposed rules require licensees to meet the requirements that including complying with a minimum English language requirement and an implicit bias training requirement; applicants for endorsement and relicensure will disclose all licenses with other entities, report current discipline or sanctions on a license, and meet the human trafficking training requirement, English language requirement, and implicit bias training; dental professionals will be trained in basic cardiac life support or advanced cardiac life support for healthcare providers with a hands-on component prior to being licensed; limited licensees will be trained in infection control before being licensed; unlicensed assistants will be referred to as an unregistered dental auxiliary (UDA); applicants licensed in Canada, other countries, and other states, who meet certain educational and examination requirements will have a pathway for licensure; dentists from other states may supervise dental therapy program clinical hours; dentists will meet with a patient in-person at least

once in 24 months if duties will be delegated or assigned; a UDA will obtain additional training; the licensure requirements for dental specialists in dental anesthesiology, dental public health, oral and maxillofacial radiology, oral medicine, and orofacial pain will be added to the rules; dentists who administer or collaboratively provide general anesthesia, deep, moderate, or minimal sedation with a physician, anesthesiologist, dentist, or nurse anesthetist will obtain additional training; and dental professionals who use telehealth will meet consent and prescribing requirements

If you wish to submit any comments on these proposed rules, you can do so by email through 5:00 p.m. today (8/22/2022) at BPL-BoardSupport@michigan.gov

Archived: Thursday, March 9, 2023 9:36:15 AM
From: BPL-BoardSupport
Sent: Monday, August 22, 2022 3:59:26 PM
To: Ditschman, Andria (LARA)
Subject: FW: MI Dentistry General Rules Proposed Changes
Response requested: No
Sensitivity: Normal

From: Katherine Beard <Katherine.Beard.566684988@p2a.co>
Sent: Monday, August 22, 2022 3:54 PM
To: BPL-BoardSupport <BPL-BoardSupport@michigan.gov>
Subject: MI Dentistry General Rules Proposed Changes

Dear Departmental Specialist Andria Ditschman,

Attn: Michigan Board of Dentistry

Thank you for the opportunity to provide feedback to the proposed changes to Dentistry General Rules. As a licensed orthodontist and member of the Michigan Association of Orthodontists, I ask that you consider the following changes to Table 1 - Delegated and Assigned Dental Procedures for Allied Dental Personnel to allow dental assistants—or proposed unregistered dental auxiliaries- to perform certain orthodontic tasks under direct supervision:

1. Changing items (h), (i), (j), (k), (l), and new (y) to “D”, Direct Supervision, would allow orthodontically trained Dental Assistants to safely perform these tasks under the direct supervision of their orthodontist.
2. Keep (w) Temporarily cementing and removing temporary crowns and bands, and add “A”, Assignment, to UDAs
3. Changing new item (n) to “A” would allow orthodontic assistants to provide counseling to patients for optimal oral health and diet with multiple orthodontic and orthopedic therapies.
4. Modifying item (v) and deleting “and bands” as that is redundant to item (e).

I understand RDA’s are ideal for a general dental practice with the expanded clinical training and privileges. However, they do not have training in many of the necessary tasks in an orthodontic practice. The current Rules and the Draft rules changes do not address these concerns and specifically prohibit dental assistants, who might be specifically trained in orthodontics, from safely completing tasks.

These changes do not impact the defined privileges for Registered Dental Assistants or Hygienists, but they do allow for UDAs and trained dental assistants to accomplish tasks under the appropriate level of supervision.

These modifications to the current Dentistry General Rules will help address workforce challenges while also enhancing access of patient care to specialty services.

Please reach out to me for more information or any questions.

Thanks to you and your staff for all you do.

Regards,

Katherine Beard
600 Park Ave
Grand Haven, MI 49417