Minutes
SPECIAL MEETING
December 18, 2020 | 1:00 PM CDT
New York Room, Radisson Hotel, Bismarck, ND

1. **Call to Order and roll call:** Dr. Evanoff called the meeting to order at 1:04 PM CDT. The ND Board of Dental Examiners convened for the purpose of discussion and consideration of comments submitted by communities of interest and the general public.

Board Members and Administrative Staff Attendance

Greg Evanoff, DDS, President
Alison Fallgatter, DDS, President-Elect
Tim Mehlhoff, CPA, Secretary-Treasurer
Rita Sommers, RDH, MBA, Executive Director
Tara Brandner, Assistant Attorney General
Otto Dohm, DDS
Mike Goebel, DDS
Michael Keim, DDS
Bev Marsh, RDH

2. **Consideration of amendments and public comments**:

Tab #	Comment submitted by	Board Summary of Comments
1	**Rita Sommers, NDBDE Executive Director**	Comments were adopted by the Board. Discussions are noted in side bar.
2	**Dental Assisting National Board (DANB)**	The Board agreed with the majority of suggestions, but did not agree with pg. 1 comment related to: 20-01-02-01(30) or (31). The typo related to the HIPAA acronym was corrected. The Board also did not amend 20-02-01-05(1)(d) as these requirements are addressed within proper sections.
3	**American Association of Orthodontists' (AAO)**	The board preferred to avoid naming membership driven organizations and rather applied educational standards to determine whether or not a specific focus of dental care should be considered a bona fide specialty. Comments came from ND Dental Association requesting inclusion of *The National Commission on Recognition of Dental Specialties and Certifying Boards* or its successor organization. The newest specialty boards recognized in a manner related to educational requirements consistent to criteria used by the NCRDSCB have been included in the proposed rules draft [recent examples – Orofacial Pain and Oral Medicine (3/2020) and Dental Anesthesiology (2019)] Some specific areas of dental practice included as bona fide specialties by other entities do not meet educational guidelines consistent with those used by the NCRDSCB and, therefore have not been included in this proposed change of rules. The NDBDE recognizes that it cannot be the gate keeper to assure the integrity of all boards claiming authority to identify dental specialties. Rather, the NDBDE prefers to avoid bias, conflict of interest and potential antitrust litigation by focusing on advanced educational criteria consistent with that used by the NDRDSCB.
4	**Dr. King**	The Board did not agree that regulating dental records and what must be in the dental record is overreach. The new language is based on review of charting and records during the complaint process and has established that some practitioners may be incompletely recording essential aspects of treatment provided. Dr. King further commented that licensed radiology techs should be allowed to take radiographs. The Board does not license or regulate radiology techs. Furthermore,

		the QDA requirement is minimal which facilitates techs to become qualified to expose x-rays. The tech is under the supervision of the dentist. Regarding outreach from the Board, the Board posts meetings to its website, and invests heavily to maintain this website to properly inform all licensees about matters of interest as required by law. The Board cannot pick how or which members of the public or organizations should be given special notices and be treated differently than the public in general.
5	**American Society of Dentist Anesthesiologists (ASDA)**	The Board agreed with several of the comments. In addition to adding language for clarification to 20-02-01-05, the Board **r**emoved "relative analgesia" throughout rules and replaced with "nitrous oxide inhalation analgesia." The Board addressed ASDA comments that it would be "highly unlikely that the practitioner would be able to meet the requirement - even a trainee in a residency." Dr. Goebel commented that this is not an issue because although the practitioner may not have 20 patients for whom they are personally responsible, the residents observe at least 100 patients in collaboration with other residents. This requirement has previously been in place by way of the anesthesia permit application process and the Board has not experienced pushback from any applicant regarding the 20 intravenous cases requirement.
6	**American Teledentistry Association (ATDA)**	Regarding the ATDA comment "patient of record" (paragraph 4) being a barrier to care: The Board's intent is to regulate those procedures for which dental auxiliary are subject to supervision while performing established diagnostic or treatment related procedures. Whenever a doctor-patient contact is made, some BODE members felt the patient then becomes a patient of record, given the fact that an exchange of health information is likely exchanged and, also most likely, the telehealth event might be billed to insurance, the patient, or both, even if for a consultation. Some BODE members were concerned that the patient could be exploited without a "patient of record" designation or that the patient would be unable to find and follow up with a dentist where the patient is not appropriately considered a "patient of record" (this being a more egregious issue for the patient). Comments refer to scans and digital photos only. Even if a diagnosis is established (diagnoses it is not within the scope of practice for a dental hygienist or dental assistant), a tooth cannot be physically addressed through teledentistry. The Board discussed use of the technology in assisted living or nursing homes or in areas where access to care is limited. The problem is a tooth cannot be restored/repaired through teledentistry. The Board is concerned that once the technology is used, the patient could potentially still have the issue and not have been helped. The patient might be charged for the brief exam and the scan but required treatment not rendered. Despite this observation, once the dentist documents a condition and provides a diagnoses, or a preliminary diagnoses, based on a digital photo, the doctor-patient relationship exists with or without the language. Access to care is a complex issue and the model is not always as useful in dentistry as with medical issues. The board does not view "patient of record" as overreach once a dentist has consulted with, wrote a prescription for, completed a preliminary diagnosis, or made a referral for a patient.
7	**Dr. Fines**	Dr. Fines appears to have misinterpreted the definition of direct supervision as well as an understanding of the anesthesia dental assistant regulations. The board did not reach the same conclusion regarding Advance Cardiac Life Support (ACLS); a dentist permitted to provide moderate sedation is not burdened by the requirement of maintaining ACLS proficiency to enhance patient safety.
8	**Smile Direct Club (SDC)**	SDC opposes the Board's definition of "final impression for digital capture". The Board amended the definition as indicated below. The Board disagrees with the statement that the Board's intent is to regulate digital or photographic scanning of a positive image of the hard and soft tissues in the mouth as a negative "impression." Proposed rules language does not "open the door" to the regulation of all digital photography of the tissues. The Board's intent is to regulate when licensed dental auxiliary, subject to required supervision, can perform procedures necessary for diagnosis of disease or physical abnormality to enable treatment

		planning or those necessary for, or specifically related to clinical treatment procedures. The Board proposes the language "final scan by digital capture." A final scan or a final impression becomes part of a patient record that may be used for diagnosis or treatment purposes by the licensed dentist providing appropriate supervision of auxiliary. SDC asserts that there is "no clinical knowledge required to take a digital photograph of the hard and soft tissues in the mouth". The NDBDE disagrees. In reality, this depends on the intended use of an image. Dental assistants who utilize scanning devices to capture images in preparation for a tooth to receive a crown, for example, must be appropriately and adequately educated regarding dental and oral anatomy and soft tissues to enable acquisition of an image that may include anticipated subgingival margin extensions prepared by the dentist as well as associated interproximal dental or soft tissue anatomy for subsequent review in order to be approved by the supervising dentist prior to submitting the scanned image for manufacture of any permanent or temporary devices or restorations. The BODE does not regulate technology, rather The Board regulates the duties of licensed dental auxiliary.
9	**Dr. Fisher**	Dr. Fisher's first concern regarded the definition of dentistry as found in the ND Century Code and is not in the administrative rules, and therefore was not addressed at this time. Dr. Fisher's second concern was that NDAC 20-02-01-11 should adopt language recognizing the training and experience of individuals who were granted a license in another jurisdiction where administration of Botox and dermal fillers was within the scope of practice. The Board agreed that any such applicant who can show documentation of having previously been permitted to administer Botox in another jurisdiction, has been utilizing the procedure within a preceding specified time frame and has completed the proper training, should be authorized to use the duty in ND without any requirement to retake a qualifying course. For clarification, however, administration of Botox and dermal fillers by dentists who have taken the required training is limited to the practice of dentistry and therefore may only be used as part of a dental treatment plan. Dr. Fisher would like the privilege extended to use in the absence of an established dental treatment plan. The Board has determined that use of Botox and dermal fillers beyond what might be part of an established dental treatment plan is not within the scope of dental practice. Dental scope of practice as found in the NDCC is limited.
10	**Dr. Gray, Oral & Maxillofacial Surgeon**	Dr. Gray did not address specific issues in the draft, rather concerns over the process. The Board noted that the draft of the rules were provided by the Executive Director to Dr. McMahon, Minot Oral & maxillofacial surgeon and President of the ND Society of Oral and Maxillofacial Surgeons, who was appreciative of Administrative Rules efforts and spoke positively about the proposed document. During the process, anesthesia rules language was also reviewed and modifications were considered from an oral and maxillofacial surgeon in Grand Forks. His comments were discussed during meetings as the Board discussed anesthesia and sedation. The drafting of amended rules has been underway with Board review and discussions that began June, 2019. The rules editing process continued during and until September, 2020 when a final draft was adopted by the Board and posted to the NDBDE website. With conclusion of this December 18, 2020 meeting, the Board will have received, considered and debated all additional input including that received between the initiation of the Rules process in September 2019 and the required Public Comment Period.
11	**Dr. Holman**	The Board reviewed Dr. Holman's letter. Dr. Holman inquired about the rules process. The meeting was properly noticed as required by statute. No further comments were made.
12	**ND Dental Association (NDDA)**	The NDDA written comment addressed grammatical errors, and areas that were thought redundant but did offer specific amendments or recommendations for other changes or corrections of the proposed document posted to the Board's web site. The NDDA submitted an Oct 29 letter which appeared a compilation of comments from the ND Dental Association, ND Dental Hygienists Association and the ND Dental Assistants Association with identical comments from the Oct 27

		letter and some additional comments which had previously been addressed concisely and previously throughout the meeting.
13	**ND Dental Assisting Association (NDDAA)**	The NDDAA expressed concern regarding 300 rather than 650 hours of on-the-job training. The Board moved to change the on-the-job hourly requirement to 300 hours in recognition of any applicant successfully completing the Dental Assisting National Board's (DANB) National Entry Level Dental Assistant (NELDA) examination. The Board consensus was that not only is the exchange fair, the three components of the NELDA exam ensure that entry level dental assistants have the basic level of knowledge necessary *for the level of duties they may perform.* The exam includes an additional component not previously required that addresses anatomy, morphology and physiology. The NDBDE accepts the Dental Assisting National Board's (DANB) National Entry Level Dental Assistant (NELDA) pathway as a valid and reasonable pathway for entry level dental assisting that assesses the knowledge required for performing duties that an entry level dental assistant is authorized to provide when coupled with 300 hours of clinical experience. The Board recognizes that entry level dental assistants must spend numerous hours preparing for the exam. In exchange for successful completion of the NELDA examination, it wishes to recognize that 300 hours rather than 650 hours of clinical experience is a reasonable time period to grasp basic dental assisting duties as provided by NDAC 20-03-01-01. The Board considered input from both dental assistants and DANB to arrive at the 300 hour requirement. Regarding NDDAA's question "Will ND's rules language mirror that renewal limitation and goal of becoming DANB certified?" The NDBDE *does not* require DANB renewal of certification to remain registered with the Board as a Qualified Dental Assistant (QDA). NDDAA's requests addressed by the Board also include administration of fluoride varnish and silver diamine fluoride application; nitrous oxide inhalation analgesia; use of slow speed handpiece; and final scan by digital capture under direct or indirect supervision.
14	**Dr. Kemmet**	The Board deferred Dr. Kemmet's 9/2020 letter to the rules process in the event of any language amendments needed. The Board's legal counsel disagreed with the Dr. Kemmet's opinion. No motion. Each state board is permitted their own due diligence in the licensing process.
15	**Mickelle Hultberg, RDH**	The ADEX Dental Hygiene Examination is a clinical examination based on specific performance criteria used to measure clinical competence, judgement and skills. At its January/2018 meeting the Board unanimously moved to accept the ADEX exam and draft rules for the next administrative rules process. At that time the exam was accepted in 41 states. Ms. Hultberg privately contracts at the Minot Air Force Base (not military or military spouse) and requested the Board accept the ADEX examination.
16	**Dr. McMahon, Oral & Maxillofacial Surgeon**	Dr. McMahon reviewed a draft of the admin rules pertaining to sedation and anesthesia and commented favorably.

Board Actions | Motions

Regarding the Creation of a New Section 20-02-01-04.4 Members of the Military and Military Spouses – Licensure Applications: Dr. Dohm moved to delete the section, motion seconded by Dr. Fallgatter. Discussion; Ms Brandner advised should the legislature change or amend the current language in the NDCC, our new rule would be invalid or alternatively, the Board would be required to incur a rules change process to amend the rule. The consensus was that the best practice would be to continue to defer to the current law as seen in the NDCC. Roll call vote (RCV): Dr. Fallgatter, yes; Dr. Keim, yes; Dr. Evanoff, yes; Dr. Dohm, yes; Ms. Marsh, yes; Dr. Goebel, yes; Mr. Mehlhoff, yes. Motion passed 7-0.

Regarding all other modifications to the amendments, Moved by Dr. Fallgatter and seconded by Ms. Marsh to adopt the proposed, newly amended administrative rules. Motion seconded by. RCV: Dr. Fallgatter, yes; Dr. Keim, yes; Dr.

Evanoff, yes; Dr. Dohm, yes; Ms. Marsh, yes; Dr. Goebel, yes; Mr. Mehlhoff, yes. Motion passed 7-0. Dr. Evanoff expressed appreciation and thanks to those who submitted comments to the Board.*

Dr. Evanoff moved to adjourn. Motion seconded by Dr. Fallgatter. RCV: Dr. Fallgatter, yes; Dr. Keim, yes; Dr. Evanoff, yes; Dr. Dohm, yes; Ms. Marsh, yes; Dr. Goebel, yes; Mr. Mehlhoff, yes. Motion passed 7-0. The meeting adjourned at 4:25 PM.

Submitted by

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Rita Sommers, Executive Director, NDBDE Tim Mehlhoff, CPA

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Content utilized in proposed rules changes was developed and established by the NDBDE in consideration of information and input provided from or found within:

- Existing rules or regulations applied in other states
- The American Association of Maxillofacial Surgeons, *9th Addition Office Anesthesia Evaluation Manual*
- American Dental Association, *Guideline for the Use of Sedation and General Anesthesia by Dentists*
- American Dental Association. *Oral Health Topics* https://www.ada.org/en/member-center/oral-health-topics/nitrous-oxide.
- *Pediatric Dentistry, V 40 No 6 Reference Manual, Use of Nitrous Oxide for Pediatric Dental Patients*
- *A Guide to Patient Management Sixth Edition*, Stanley Malamed.
- ND Society of Oral Surgeons, Dr. Michael McMahon, President
- Marcus Tanabe, DDS, Oral & Maxillofacial Surgeon
- Individual oral surgeons, orthodontists, dentists, hygienists, dental assistants
- Professional dental membership organizations, DANB, AAO, ASDA, ATDA, Smile Direct Club®
- NDBDE legal guidance appointed by the ND office of the Attorney General