Learning Objectives for Rest Assured Technologies Qualified Dentists

A. Introduction to Dental Sleep Medicine

These learning objectives in paragraph A are available through Rest Assured Technologies introductory lecture, "Solving the Mystery of Dental Sleep Medicine." Dentists may attend the seminar or have an in-office lecture and be awarded 2 CE's. (Rest Assured Technologies is designated as an Approved PACE Program Provider by the Academy of General Dentistry.)

1. The dentist will know what sleep related breathing disorder is.
2. The dentist will know the estimated percent of the adult population that have undiagnosed sleep disordered breathing.
3. The dentist will be able to list some of the medical, lifestyle and public health results of untreated SDB.
4. The dentist will recognize that most patients do not understand the health consequences of sleep apnea.
5. The dentist will appraise that most healthcare professionals are not trained to identify patients with sleep disorders.
6. The dentist will appraise that they are in an ideal position to identify patients with sleep disorders because they see the patient regularly in a controlled environment.
7. The dentist will assess that oral appliances offer a less invasive and effective alternative to CPAP
8. The dentist will identify popular oral appliances for treating SDB
9. The dentist will assess that oral appliances are more comfortable than CPAPs
10. The dentist will assess that oral appliances are more affordable than CPAPs
11. The dentist will recall the red flags in a patient's medical history that are co-morbidities for sleep apnea: high blood pressure, stroke or heart attack, diabetes Type II.
12. The dentist will be able to identify the available sleep questionnaires and recognize the differences and advantages of each
13. The dentist will recall the items of physical examination (BMI, neck circumference, large tongue, crowded throat)
14. The dentist will know that algorithms and/or cloud-based screening tools exist to assist the dentist in diagnosis of SDB
    A. E.g., Dr. Jim Sweeney developed a weighted algorithm that considers each subjective response along with detailed clinical findings from the dentist and provides auto-scoring
15. The dentist will compare written questionnaires with a cloud-based screening tool

16. The dentist will know that services exist that provide a package to the dentist to diagnose and treat SDB, such as

    A. cloud-based screening tool

    B. hands on training for dentist and staff

    C. home sleep testing services

    D. claims processing

    E. credentialing assistance

17. The dentist will observe a sleep screening demonstration and be able to apply the steps

18. The dentist will recognize and summarize the option of setting up a separate entity (dental sleep clinic) for the purposes of enrolling in Medicare as a non-participating provider

19. The dentist will identify the steps in the insurance submittal process

20. The dentist will recognize the usefulness of establishing a relationship with the sleep lab, pulmonologist, sleep physician, and ENT

21. The dentist will list some possible ways to market the new sleep medicine service (e.g., website, social media ads, postcards, radio, Cable TV)

B. Employ Screening Tool

1. The dentist and staff will assess the viable options for their office in bringing patients into the SRBD screening process e.g., medical history, sleep questionnaire, etc)

2. The dentist will recognize the goal of the initial screening is to assess the patient or bed partner's perception of both nocturnal and daytime symptoms (e.g., snoring, witnessed apneas, gasping, sleepiness) as to the likelihood of an SRBD

3. The dentist will appraise the screening tools available, for example

    a. STOP BANG

    b. Epworth Sleepiness Scale

    c. Berlin Sleep Questionnaire

    d. Rest Assured Wellness Tool for the Dental Office

4. The dentist office will assess the options for employing the SRBD screening tool on paper or cloud-based, and

    a. In one sitting with staff, or

    b. In two parts by staff, or

    c. In first part with staff and second with dentist

5. The dentist will know how to apply the chosen screening tool and understand the risk score

C. Physical Examination

1. The dentist will recall the red flags in a patient's medical history that are co-morbidities for sleep apnea: high blood pressure, stroke or heart attack, diabetes Type II, sexual dysfunction, congestive heart failure, cardiac arrhythmia, cancer, dementia, mood disturbances. Obesity, GERD, nocturia, chronic pain.
2. The dentist will perform the physical examination on the patient (BMI, neck circumference, large tongue, crowded throat) for input into the screening tool
3. The dentist and staff will demonstrate how to prepare S.O.A.P. notes to share with the patient's physician

D. Provide Patient Education

1. The dentist and staff will know how to utilize a written form and educate the patient about SRBDs and possible treatments
2. The dentist and staff will explain an overview of the disease process, as well as an understanding of how oral appliances treat SRBDs
3. The dentist will inform the patient undergoing OAT of their SRBD severity including an understanding of the resulting apnea-hypopnea index (AHI), respiratory disturbance index (RDI), or respiratory event index (REI) from objective sleep apnea testing.
4. The dentist will also inform the patient that OAT success may be affected by fragmented sleep, oxygen desaturation, and other coexisting sleep disorders.
5. The dentist will inform the patient of risk modifiers that may mitigate disease severity
6. The dentist and staff will know how to utilize an informed consent form with the patient
7. The dentist and staff will know how to utilize a patient waiver to treatment and when it is appropriate

E. Referral to physician for medical diagnosis

1. The dentist and staff will prepare a physician referral

F. Collaboration with physician on treatment options, to include oral appliance

1. The dentist will recognize the need to develop relationships with sleep and other physicians and the importance of bidirectional referral patterns
2. The dentist will know that a physician must prescribe a sleep test
3. The dentist will know that a physician must diagnose SRBDs
4. The dentist will know how to interpret the results of the sleep test provided by the physician
5. The dentist will recognize that the physician who diagnoses the SRBD, or the treating physician, is responsible for providing a prescription for OAT
6. The dentist will know that he must a have a physician's prescription for OAT before he can initiate OAT

7. The dentist will know that the referring physician should provide a letter of medical necessity and a copy of the sleep study

8. The dentist will recognize the referring physician may refer the patient for OA first-line therapy or when the previous treatment efforts have fallen short of maximum efficacy.

G. Initiate oral appliance treatment plan

1. The dentist will appraise the patient's health history, dental history, dental and skeletal anatomy, and temporomandibular disorder history to develop a treatment plan to utilize an OA

2. The dentist will recognize the need for a letter of medical necessity to be in place before initiation of oral appliance treatment plan

3. The dentist will explain to the patient the potential for side effects prior to initiating treatment and again as needed throughout treatment

4. The dentist will know and explain to the patient the potential for TMJ-related side effects, intraoral tissue-related side effects, occlusal changes, damage to teeth or restorations, and appliance issues

5. The dentist will recognize the need to provide the patient an opportunity to ask questions about the risks of treatment as well as educate the patient as to the risks associated with no treatment

6. The dentist will recognize the need to inform the patient about alternate therapies to OAT, such as PAP therapy, positional therapy, maxillofacial surgery, or otolaryngologic surgery

7. The dentist will recognize that upon agreement to a plan of treatment, the patient should sign the informed consent in front of the qualified dentist or other dental staff.

8. The dentist will understand the need to countersign and date the informed consent document,

9. The dentist will understand the need to keep the informed consent as part of the patient's record of care

H. Selection of oral appliance

1. The dentist will understand that selection of an OA and the initial protrusive position will be at his discretion based on dental history and physical exam

2. The dentist will recall that an effective OA is defined as a custom-fabricated, Food and Drug Administration (FDA)-cleared device that is designed to maintain airway patency during sleep for the management of OSA

3. The dentist will know that custom, adjustable dual-arch OAs have been shown to be highly efficacious for treating primary snoring and mild-moderate OSA and may have significant benefit in more severe disease where other treatment modalities are not effective

4. The dentist will list elements to consider for appliance section such as, craniofacial structures, and oral, dental, and periodontal tissues; the patient's cognitive ability, manual dexterity, visual acuity, range of motion, and nasal patency, as well as number, location, and health of remaining teeth; the clinical tooth height, undercuts, current dental restorative conditions, and anticipated dental restorative needs, along with allergies and or sensitivities

5. The dentist will recognize the patient preferences could include perceived comfort, ease of use and financial considerations

I. Oral appliance fabrication

1. The dentist will employ accurate digital or analog impressions and a protrusive bite record in the fabrication of an OA

2. The dentist will know that although he has discretion as to the initial position of the OA, literature suggests a range of 25% to 75% as a comfortable and yet therapeutic range

J. Oral appliance delivery

1. The dentist will verify the fit and comfort of the OA

2. After successful OAT insertion, the dentist or staff will review the adjustment protocol, homecare instructions, and the warranty specific to the OA selected

3. The dentist will use appropriate provisions to maximize comfort and minimize the development of dental changes including, but not limited to, occlusal irregularities and interdental spacing

4. The dentist will employ appropriate measures to attenuate the possible development of jaw discomfort and muscle fatigue, such as, morning exercises, the use of a morning repositioning device, or associated palliative care

K. Oral appliance calibration within 60 days

1. The dentist will examine the patient to assess the comfort and efficacy of the OA within the first 60 days

2. The dentist will advance the OA setting based on multiple factors including the initial assessment of the patient's range of motion, level of severity, patient comfort, and subjective report of initial response

3. The dentist will recognize the need to determine an appropriate endpoint to the OA advancement process

4. The dentist will perform an OA advancement based on the patient's range of motion and comfort, with consideration of evidence supporting 50% to 75% of the patient's maximum protrusive range

5. The dentist will understand that excessively increasing the patient's protrusive position has not been shown to guarantee improved efficacy and may worsen the patient's sleep-disordered breathing

6. The dentist will know that the use of objective data to verify the therapeutic position of the OA may be appropriate and used within the scope of practice as defined by the dentist's state dental practice act

7. The dentist will know that the American Dental Association's (ADA's) *Policy on Dentistry's Role in Treating Obstructive Sleep Apnea, Similar Disorders* states that unattended cardiorespiratory portable monitors (type 3 or 4) may help define the optimal target position of the mandible

8. The dentist will know that the AASM and AMA have published policies that state that a home sleep apnea test (HT) must be ordered by a physician, even in the instance of determining appliance efficacy

9. The dentist will demonstrate and explain the meaning of the efficacy home sleep test

10. Upon final calibration of the OA, the dentist will understand that he should refer the patient back to the physician and report any notes or findings that may contribute to the physician's assessment

L. Long term follow-up and management

1. The dentist will recognize that patients who utilize OAT should be evaluated by the qualified dentist every 6 months for the first year and at least annually thereafter

2. At the annual recall examination, the dentist will verify OA efficacy and occlusal stability, check the structural integrity of the OA, and ensure that there is maintenance of previously resolved symptoms such as snoring and daytime sleepiness

3. The dentist will inquire about patient comfort and adherence to therapy and screen for possible side effects

4. If side effects are noted, the dentist will document this, as well as any management and manner of resolution

5. If the annual assessment reveals symptoms of worsening OSA or the potential need for additional adjustments to the OA, the dentist will report this and any other relevant subjective or objective findings to the patient's physician

6. The dentist will recognize that OAs should be evaluated by the qualified dentist on a yearly basis for signs of wear, fractures, and bacterial and/ or fungal growth, and should be replaced according to the patient's needs

7. The dentist will recognize that a new OA may require some additional calibration to restore the patient to the previously determined therapeutic position

8. If a new OA is required, the dentist will recognize that the patient's physician should be notified of the delivery of the new OA, who may then decide if an additional objective assessment is required