

PUBLIC PACKET

**OREGON BOARD  
OF  
DENTISTRY**

**BOARD MEETING  
JUNE 26, 2015**



## STANDARD PROTOCOLS FOR GENERAL CONSENT ORDERS

### CIVIL PENALTIES

Licensee shall pay a \$\_\_\_\_ civil penalty in the form of a cashier's, bank, or official check, made payable to the Oregon Board of Dentistry and delivered to the Board offices within 30 days of the effective date of the Order.

**NOTE:** The Board will allow licensed dentists a 30-day payment period for each civil penalty increment of \$2,500

**NOTE:** The Board will allow licensed dental hygienists a 30-day payment period of each civil penalty increment of \$500

### RESTITUTION PAYMENTS

Licensee shall pay \$\_\_\_ in restitution in the form of a cashier's, bank, or official check made payable to patient \_\_\_ and delivered to the Board offices within 30 days of the effective date of the Order.

**NOTE:** The Board will allow licensed dentists a 30-day payment period for each restitution increment of \$2,500

### REIMBURSEMENT PAYMENTS

Licensee shall provide the Board with documentation verifying reimbursement payment made to \_\_\_, the patient's insurance carrier, within 30 days of the effective date of the Order.

**NOTE:** The Board will allow licensed dentists a 30-day payment period for each reimbursement increment of \$2,500

### CONTINUING EDUCATION – BOARD ORDERED

Licensee shall successfully complete \_\_\_ hours of \_\_\_ (OPTIONS: Board pre-approved, hands-on, mentored), continuing education in the area of \_\_\_ within \_\_\_ (OPTIONS: years, months) of the effective date of this Order, unless the Board grants an extension, and advises the Licensee in writing. This ordered continuing education is in addition to the continuing education required for the licensure period \_\_\_ (OPTIONS: April 1, XXX to March 31, XXX OR October 1, XXX to September 30, XXX). As soon as possible after completion of a Board ordered course, Licensee shall submit documentation to the Board verifying completion of the course.

## COMMUNITY SERVICE

Licensee shall provide \_\_\_ hours of Board approved community service within \_\_\_ (OPTIONS: years, months) of the effective date of this Order, unless the Board grants an extension, and advises the Licensee in writing. The community service shall be pro bono, and shall involve the Licensee providing direct dental care to patients. Licensee shall submit documentation verifying completion of the community service within the specified time allowed for the community service.

## FALSE CERTIFICATION OF CONTINUING EDUCATION

Licensee shall be reprimanded, pay a \$\_\_\_ (\$1,000 for dentists OR \$500 for dental hygienists) civil penalty, complete ten hours of community service within 60 days and complete the balance of the \_\_\_ (40 OR 24) hours of continuing education for the licensure period (4/1/-- to 3/31/-- OR 10/1/-- to 9/30/--), within 60 days of the effective date of this Order. As soon as possible following completion of the continuing education the Licensee shall provide the Board with documentation certifying your completion.

## WORKING WITHOUT A CURRENT LICENSE

Licensee shall pay a \$\_\_\_ civil penalty in the form of a cashier's, bank, or official check, made payable to the Oregon Board of Dentistry and delivered to the Board offices within 30 days of the effective date of the Order.

**NOTE:** A licensed dentist, who worked any number of days without a license will be issued a Notice of Proposed Disciplinary Action and offered a Consent Order incorporating a reprimand and a \$5,000 civil penalty.

**NOTE:** A licensed dental hygienist who worked any number of days without a current license, will be issued a Notice of Proposed Disciplinary Action and offered a Consent Order incorporating a reprimand and civil penalty of \$2,500.

## ALLOWING A PERSON TO PERFORM DUTIES FOR WHICH THE PERSON IS NOT LICENSED OR CERTIFIED

Licensee shall pay a \$\_\_\_ civil penalty in the form of a cashier's, bank, or official check, made payable to the Oregon Board of Dentistry and delivered to the Board offices within 30 days of the effective date of the Order, unless the Board grants an extension, and advises the Licensee in writing.

**NOTE:** The Licensee will be charged \$2,000 for the first offense and \$4,000 for the second, and each subsequent offense.

## FAILURE TO CONDUCT WEEKLY BIOLOGICAL TESTING OF STERILIZATION DEVICES

Licensee shall pay a \$ \_\_\_\_ civil penalty in the form of a cashier's, bank, or official check made payable to the Oregon Board of Dentistry and delivered to the Board offices within \_\_\_\_ days of the effective date of the Order, complete \_\_\_\_ hours of Board approved community service within \_\_\_\_\_ (months, year) of the effective date of the Order, and, for a period of one year of the effective date of the Order, submit, by the fifteenth of each month, the results of the previous month's weekly biological monitoring testing of sterilization devices.

**NOTE:** Failure to do biological monitoring testing one to five times within a calendar year will result in a Letter of Concern.

**NOTE:** Failure to do biological monitoring testing six to ten times within a calendar year will result in the issuance of a Notice of Proposed Disciplinary Action and an offer of a Consent Order incorporating a reprimand.

**NOTE:** Failure to do biological monitoring testing 11 to 20 times within a calendar year will result in the issuance of a Notice and an offer of a Consent Order incorporating a reprimand, a \$3,000 civil penalty to be paid within 60 days, 20 hours of Board approved community service to be completed within six months, and monthly submission of spore testing results for a period of one year from the effective date of the Order.

**NOTE:** Failure to do biological monitoring testing more than 20 times within a calendar year will result in the issuance of a Notice and an offer of a Consent Order incorporating a reprimand, a \$6,000 civil penalty to be paid within 90 days, 40 hours of Board approved community service to be completed within one year, and monthly submission of spore testing results for a period of one year from the effective date of the Order.

## STANDARD PROTOCOLS FOR CONSENT ORDERS SPECIFICALLY RELATED TO ALCOHOL ABUSE

### ALCOHOL

Licensee shall, for an indefinite length of time, be subject to the following conditions of this Consent Order:

Licensee shall not apply for relief from these conditions within five years of the effective date of the Order, and then must do so in writing.

Licensee shall not use alcohol, controlled drugs, or mood altering substances at any place or time unless prescribed by a licensed practitioner for a bona fide medical condition and upon prior notice to the Board and care providers, except that prior notice to the Board and care providers shall not be required in the case of a bona fide medical emergency.

Licensee shall undergo an evaluation by a Board approved addictionologist or treatment center within 30 days of the effective date of the Order and make the written evaluation and treatment recommendations available to the Board.

Licensee shall adhere to, participate in, and complete all aspects of any and all residential care programs, continuing care programs and recovery treatment plans recommended by Board approved care providers and arrange for a written copy of all plans, programs, and contracts to be provided to the Board within 30 days of the effective date of this Order.

Licensee shall advise the Board, in writing, of any change or alteration to any residential care programs, continuing care programs, and recovery treatment plans 14 days before the change goes into effect.

Licensee shall instruct all health care providers participating in the residential, continuing care, and recovery programs to respond promptly to any Oregon Board of Dentistry inquiry concerning Licensee's compliance with the treatment plan and to immediately report to the Board, any positive test results or any substantial failure to fully participate in the programs by the Licensee. Licensee shall instruct the foregoing professionals to make written quarterly reports to the Board of Licensee's progress and compliance with the treatment programs.

Licensee shall waive any privilege with respect to any physical, psychiatric, or psychological evaluation or treatment in favor of the Board for the purposes of determining compliance with this Order, or the need to modify this Order, and shall execute any waiver or release upon request of the Board.

Licensee shall submit to a Board approved, random, supervised, urinalysis testing program, at Licensee's expense, with the frequency of the testing to be determined by the Board, but initially at a minimum of 24 random tests per year. Licensee shall arrange for the results of all tests, both positive and negative, to be provided promptly to the Board.

Licensee shall advise the Board, within 72 hours, of any alcohol, illegal or prescription drug, or mind altering substance related relapse, any positive urinalysis test result, or any substantial failure to participate in any recommended recovery program.

Licensee shall personally appear before the Board, or its designated representative(s), at a frequency to be determined by the Board, but initially at a frequency of three times per year.

Licensee shall, within three days, report the arrest for any misdemeanor or felony and, within three days, report the conviction for any misdemeanor or felony.

Licensee shall assure that, at all times, the Board has the most current addresses and telephone numbers for residences and offices.

## STANDARD PROTOCOLS FOR CONSENT ORDERS SPECIFICALLY RELATED TO SUBSTANCE ABUSE

### DRUGS

Licensee shall, for an indefinite length of time, be subject to the following conditions of this Consent Order:

Licensee shall not apply for relief from these conditions within five years of the effective date of the Order and then must do so in writing.

Licensee shall not use controlled drugs or mind altering substances at any place or time unless prescribed by a licensed practitioner for a bona fide medical condition and upon prior notice to the Board and care providers, except that prior notice to the Board and care providers shall not be required in the case of a bona fide medical emergency.

NOTE: It may be appropriate to add "alcohol" to this condition.

Licensee shall undergo an evaluation by a Board approved addictionologist or treatment center within 30 days of the effective date of the Order and make the written evaluation and treatment recommendations available to the Board.

Licensee shall adhere to, participate in, and complete all aspects of any and all residential care programs, continuing care programs and recovery treatment plans recommended by Board approved care providers and arrange for a written copy of all plans, programs, and contracts to be provided to the Board within 30 days of the effective date of the Order.

Licensee shall advise the Board, in writing, of any change or alteration to any residential care programs, continuing care programs, and recovery treatment plans 14 days before the change goes into effect.

Licensee shall instruct all health care providers participating in the residential, continuing care, and recovery programs to respond promptly to any Oregon Board of Dentistry inquiry concerning Licensee's compliance with the treatment plan and to immediately report to the Board, any positive test results or any substantial failure to fully participate in the programs by the Licensee. Licensee shall instruct the foregoing professionals to make written quarterly reports to the Board of Licensee's progress and compliance with the treatment programs.

Licensee shall waive any privilege with respect to any physical, psychiatric, or psychological evaluation or treatment in favor of the Board for the purposes of determining compliance with this Order, or the need to modify this Order and shall execute any waiver or release upon request of the Board.

Licensee shall submit to a Board approved, random, supervised, urinalysis testing program, at Licensee's expense, with the frequency of the testing to be determined by the Board, but initially at a minimum of 24 random tests per year. Licensee shall

arrange for the results of all tests, both positive and negative, to be provided to the Board.

Licensee shall advise the Board, within 72 hours, of any drug related relapse, any positive urinalysis test result, or any substantial failure to participate in any recommended recovery program.

Licensee shall personally appear before the Board, or its designated representative(s), at a frequency to be determined by the Board, but initially at a frequency of three times per year.

IF APPROPRIATE –

Licensee will not order or dispense any controlled substance, nor shall Licensee store any controlled substance in his/her office.

Licensee shall immediately begin using pre-numbered triplicate prescription pads for prescribing controlled substances. Said prescription pads will be provided to the Licensee, at his/her expense, by the Board. Said prescriptions shall be used in their numeric order. Prior to the 15<sup>th</sup> day of each month, Licensee shall submit to the Board office, one copy of each triplicate prescription used during the previous month. The second copy to the triplicate set shall be maintained in the file of the patient for whom the prescription was written. In the event of a telephone prescription, Licensee shall submit two copies of the prescription to the Board monthly. In the event any prescription is not used, Licensee shall mark all three copies void and submit them to the Board monthly.

Licensee shall maintain a dental practice environment in which nitrous oxide is not present or available for any purpose, or establish a Board approved plan to assure that Licensee does not have singular access to nitrous oxide. The Board must approve the proposed plan before implementation.

Licensee shall immediately surrender his/her Drug Enforcement Administration Registration.

## STANDARD PROTOCOLS FOR CONSENT ORDERS SPECIFICALLY RELATED TO SEXUAL VIOLATIONS

### SEX RELATED VIOLATIONS

Licensee shall, for an indefinite length of time, be subject to the following conditions of this Consent Order:

Licensee shall not apply for relief from these conditions within five years of the effective date of the Order, and then must do so in writing.

Licensee shall undergo an assessment by a Board approved evaluator, within 30 days of the effective date of the Order, and make the written evaluation and treatment recommendations available to the Board.

Licensee shall adhere to, participate in, and complete all aspects of any and all residential care programs, continuing care programs and recovery treatment plans recommended by Board approved care providers and arrange for a written copy of all plans, programs, and contracts to be provided to the Board within 30 days of the effective date of the Order.

Licensee shall advise the Board, in writing, of any change or alteration to any residential care programs, continuing care programs, and recovery treatment plans 14 days before the change goes into effect.

Licensee shall instruct all health care providers participating in the residential, continuing care, and recovery programs to respond promptly to any Oregon Board of Dentistry inquiry concerning Licensee's compliance with the treatment plan and to immediately report to the Board, any substantial failure to fully participate in the programs by the Licensee. Licensee shall instruct the foregoing professionals to make written quarterly reports to the Board of Licensee's progress and compliance with the treatment programs.

Licensee shall waive any privilege with respect to any physical, psychiatric, or psychological evaluation or treatment in favor of the Board for the purposes of determining compliance with this Order, or the need to modify this Order, and shall execute any waiver or release upon request of the Board.

Licensee shall submit to a polygraph examination or plethysmograph examination, at Licensee's expense, at the direction of the Board or a counseling provider.

Licensee shall advise the Board, within 72 hours, of any substantial failure to participate in any recommended recovery program.

Licensee shall personally appear before the Board, or its designated representative(s), at a frequency to be determined by the Board, but initially at a frequency of three times per year.

IF APPROPRIATE –

Require Licensee to advise his/her dental staff or his/her employer of the terms of the Consent Order at least on an annual basis. Licensee shall provide the Board with documentation attesting that each dental staff member or employer reviewed the Consent Order. In the case of a Licensee adding a new employee, the Licensee shall advise the individual of the terms of the Consent Order on the first day of employment and shall provide the Board with documentation attesting to that advice.

## STANDARD PROTOCOLS FOR CONSENT ORDERS REQUIRING CLOSE SUPERVISION

### CLOSE SUPERVISION

- a. For a period of at least six months, Licensee shall only practice dentistry in Oregon under the close supervision of a Board approved, Oregon licensed dentist (Supervisor), in order to demonstrate that clinical skills meet the standard of care. Periods of time Licensee does not practice dentistry as a dentist in Oregon, shall not apply to reduction of the (six) month requirement
- b. Licensee will submit the names of any other supervising dentists for Board approval. Licensee will immediately advise the Board of any change in supervising dentists.
- c. Licensee shall only treat patients when another Board approved Supervisor is physically in the office and shall not be solely responsible for emergent care.
- d. The Supervisor will review and co-sign Licensee's treatment plans, treatment notes, and prescription orders.
- e. Licensee will maintain a log of procedures performed by Licensee. The log will include the patient's name, the date of treatment, and a brief description of the procedure. The Supervisor will review and co-sign the log. Prior to the 15<sup>th</sup> of each month, Licensee will submit the log of the previous month's treatments to the Board.
- f. For a period of two weeks, or longer if deemed necessary by the Supervisor, the Supervisor will examine the appropriate stages of dental work performed by Licensee in order to determine clinical competence.
- g. After two weeks, and for each month thereafter for a period of six months, the Supervisor will submit a written report to the Board describing Licensee's level of clinical competence. At the end of six months, the Supervisor, will submit a written report attesting to the level of Licensee's competency to practice dentistry in Oregon.
- h. At the end of the restricted license period, the Board will re-evaluate the status of Licensee's dental license. At that time, the Board may extend the restricted license period, lift the license restrictions, or take other appropriate action.

## STANDARD PROTOCOLS – DEFINITIONS

**Group practice:** On 10/10/08, the Board defined “group practice” as two or more Oregon licensed dentists, one of which may be a respondent, practicing in the same business entity and in the same physical location.

When ordering a licensee to practice only in a group practice, add the caveat, “**Periods of time Licensee is not practicing dentistry as a dentist in Oregon, shall not apply to reduction of the (five year) requirement.**”

## STANDARD PROTOCOLS – PARAGRAPHS

WHEREAS, based on the results of an investigation, the Board has filed a Notice of Proposed Disciplinary Action, dated XXX, and hereby incorporated by reference; and

# APPROVAL OF MINUTES

**OREGON BOARD OF DENTISTRY  
MINUTES  
April 17, 2015**

**MEMBERS PRESENT:** Brandon Schwindt, D.M.D., President  
Alton Harvey Sr., Vice-President  
Todd Beck, D.M.D.  
Yadira Martinez, R.D.H.  
Amy B. Fine, D.M.D.  
Jonna E. Hongo, D.M.D.  
James Morris  
Alicia Riedman, R.D.H.  
Julie Ann Smith, D.D.S., M.D.  
Gary Underhill, D.M.D.

**STAFF PRESENT:** Stephen Prisby, Interim Executive Director  
Paul Kleinstub, D.D.S., M.S., Dental Director/Chief Investigator  
Daryll Ross, Investigator (portion of meeting)  
Harvey Wayson, Investigator (portion of meeting)  
Teresa Haynes, Exam and Licensing Manager (portion of meeting)  
Michelle Lawrence, D.M.D., Consultant (portion of meeting)  
Nadia Roberts, Office Specialist (portion of meeting)

**ALSO PRESENT:** Lori Lindley, Sr. Assistant Attorney General

**VISITORS PRESENT:** Lisa Rowley, R.D.H., Pacific University; Lynn Ironside, R.D.H., ODHA; Heidi Jo Grubbs, R.D.H.; Christina Swartz Bodamer, ODA; Bruce Burton, D.M.D., ODA; R. Owen Combe, D.M.D.; Pamela Lynch, R.D.H.; Kenneth Chung, D.D.S., ODA

**Call to Order:** The meeting was called to order by the President at 7:35 a.m. at the Board office; 1500 SW 1<sup>st</sup> Ave., Suite 770, Portland, Oregon.

**NEW BUSINESS**

**MINUTES**

Mr. Harvey moved and Dr. Beck seconded that the March 11, 2015 Special Teleconference Board meeting minutes be approved as presented. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Smith and Dr. Underhill voting aye.

Dr. Beck moved and Mr. Harvey seconded that the February 27, 2015 Board meeting minutes be approved as amended. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Smith and Dr. Underhill voting aye.

## **ASSOCIATION REPORTS**

### **Oregon Dental Association**

Dr. Bruce Burton reported that the annual Oregon Dental Conference had 6650 attendees and was an outstanding meeting. He thanked Dr. Kleinstub and Mr. Prisby for presenting at the meeting. Next year's ODC will be April 7-9, 2016.

### **Oregon Dental Hygienists' Association**

Ms. Lynn Ironside said Ms. Lisa Rowley had some information for the Board. Ms. Rowley reported that the Expanded Practice Dental Hygiene Conference would be May 1-2 at the Holiday Inn in Springfield. She said that Teresa Haynes, Exam and Licensing Manager, would be a panelist. Also both OBD Dental Hygiene Members (Ms. Martinez and Ms. Riedman) will be on the panel as well.

### **Oregon Dental Assistants Association**

No Report.

## **COMMITTEE AND LIAISON REPORTS**

**WREB Liaison Report** – Dr. Jonna Hongo said upcoming meetings are planned and will have more to report at the next meeting.

**AADB Liaison Report** - Dr. Jonna Hongo said upcoming meetings are planned and will have more to report at the next meeting.

**ADEX Liaison Report** - Dr. Jonna Hongo said upcoming meetings are planned and will have more to report at the next meeting.

**CDCA Report** – Dr. Julie Ann Smith had no report.

### **Committee Meeting Dates**

Communications Committee – Todd Beck, D.M.D., Chair. Met on January 26, 2015.

Rules Oversight Committee - Todd Beck, D.M.D., Chair. Met on March 26, 2015

Anesthesia Committee – Julie Ann Smith, M.D., D.D.S., Chair. Met on April 2, 2015. Dr. Smith anticipated holding another Anesthesia Committee meeting sometime in the summer.

Enforcement & Discipline Committee – meeting scheduled for May 7, 2015. Dr. Smith asked the Board if there were any agenda items to add. Dr. Smith said the agenda already has three items on it. Review discipline for licensees who are late with renewals. Review discipline for licensees who are short their continuing education hours and review discipline for spore testing violations.

## **EXECUTIVE DIRECTOR'S REPORT**

### **OBD Budget Status Report**

Mr. Prisby went over the latest budget report for the 2013 - 2015 Biennium. This report, which is from July 1, 2013 through February 28, 2015, shows revenue of \$2,265,353.53 and expenditures of \$2,041,783.20. The Budget is performing as expected. If Board members have questions on this budget report format, please feel free to ask.

SB 5543 was signed by the Governor on March 30th. This reallocated \$50,000.00 to the current budget to provide funding through June 30th. HB 5014, the OBD's 2015-17 Biennium Budget Bill has not been signed yet. Mr. Prisby stated that he would be attending a work group for the budget bill on April 23<sup>rd</sup> in Salem.

### **Customer Service Survey**

Mr. Prisby reported on the OBD's State Legislatively Mandated Customer Service Survey and attached a report showing results from July 1, 2014 – Feb 28, 2015. The results of the survey show that the OBD continues to receive positive comments from the majority of those that return the surveys. The booklet containing the written comments that are on the survey forms, which staff has reviewed, are available on the table for Board members to review.

### **Proposal to move to online survey**

Mr. Prisby said that he included a proposal for the Board to consider switching to an online survey from the current paper OBD State Legislatively Mandated Customer Service Survey. Dr. Hongo moved and Dr. Fine seconded that the OBD switch to an online survey on July 1, 2015. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Smith and Dr. Underhill voting aye.

### **Board and Staff Speaking Engagements**

Dr. Paul Kleinstub, Dental Director/Chief Investigator and Mr. Prisby made presentations at the ODC on April 8 & 9, 2015.

### **2015 Dental License Renewal**

The dental license renewal period ended March 31. Teresa Haynes, Exam and Licensing Manager did an outstanding job managing this and working hard to help our licensees complete the process. She sent out postcards, email blasts and also called in state licensees directly. As of March 31st only 32 dentists with an Oregon address did not renew, and 62 with an out of state address did not, this is a little lower than renewal periods in the past.

### **Legislative Update**

Mr. Prisby reviewed an attachment of the Oregon Legislative Bills that the OBD is currently tracking that will have a direct impact on the Board or impact on the Board as a state agency.

### **Board Member Appointment & Staff Update**

Mr. Prisby reported that on March 26, 2015 the Oregon Senate confirmed the Governor's appointment of Alicia Riedman, R.D.H. to the open Dental Hygiene seat on the Board for a term starting April 1, 2015 to expire on March 31, 2017. Ms. Riedman attended her new Board member orientation at the OBD on March 27th. The Office Specialist position has been filled with Nadia Roberts accepting the position and her first official day was April 13, 2015. Mr. Prisby introduced Nadia to the board. The recruitment for the next Executive Director for the OBD continues. Everything is on schedule for the Board's Steering Committee to meet on May 21st,

the Interview Committee is scheduled to meet on June 6th and the final interviews will be conducted during the June 26th Board meeting.

#### **2014 Gold Star Certificate**

Mr. Prisby reported that the State Controller's Office has issued the OBD a FY 2014 Gold Star Certificate signifying that the OBD has provided accurate and complete fiscal year end information in a timely manner. He provided a copy of the certificate to the board.

#### **Affirmative Action Report**

Mr. Prisby provided the Board would the most current Affirmative Action Report which has been accepted and approved by the Governor's Affirmative Action Office.

#### **2016 Meeting Dates**

Mr. Prisby asked the Board to approve the 2016 Board calendar. Dr. Fine moved and Dr. Hongo seconded that the OBD approve the 2016 calendar. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Smith and Dr. Underhill voting aye.

#### **Governor's State Employee Food Drive**

Mr. Prisby reviewed the Governor's State Employee Food Drive results and an email from Melanie Bennett recognizing the OBD for its contributions to it.

### **UNFINISHED BUSINESS & RULES**

#### **818-000-0087**

Dr. Hongo moved and Mr. Harvey seconded that this rule increasing the biennial licensure fee, move to a public rulemaking hearing pending passage of the bill. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Smith and Dr. Underhill voting aye.

#### **818-035-0030**

Dr. Beck moved and Dr. Fine seconded implementing a Temporary Rule allowing dental hygienists to prescribe and administer fluoride, fluoride varnish, antimicrobial solutions for mouth rinsing or other non-systemic antimicrobial agents, until a permanent rule can be promulgated. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Smith and Dr. Underhill voting aye.

#### **818-035-0025**

Dr. Hongo moved and Mr. Harvey seconded implementing a Temporary Rule adding the word prescribing back into the rule, until a permanent rule can be promulgated. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Smith and Dr. Underhill voting aye.

The Board will be reviewing many proposed rules at the next board meeting on June 26. A public rulemaking hearing is tentatively scheduled for August 27<sup>th</sup>. The OBD Staff will post the proposed rules on the OBD website once they are approved by the Board to be move forward to a public rulemaking hearing.

## **CORRESPONDENCE**

### **The Board received a letter from Laleh Hedayat, DDS**

The letter was regarding the hours necessary for path to licensure.

### **The Board received a letter from Lant Haymore DMD and Owen Combe DMD**

The letter was regarding anesthesia. The Board decided to take this letter to the Anesthesia meeting.

## **OTHER BUSINESS**

### **Election of Officers**

Dr. Hongo moved and Dr. Beck seconded that Alton Harvey Sr. become the next president of the OBD. The motion passed with Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Smith, Dr. Schwindt and Dr. Underhill voting aye.

Dr. Beck moved and Dr. Fine seconded that Dr. Julie Ann Smith become the next vice-president of the OBD. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

### **Committee Appointments**

Ms. Martinez moved and Dr. Hongo seconded that Laurel M. Mavuwa, R.D.H. be approved to become a WREB Restorative Examiner. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Smith and Dr. Underhill voting aye.

Ms. Martinez moved and Dr. Hongo seconded that Lizette Nguyen, R.D.H. be approved to become a WREB Restorative Examiner. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Smith and Dr. Underhill voting aye.

CODA invited the Board to join the evaluation team at Umpqua Community College- Dental Assisting Program. Dr. Fine volunteered to be a part of the committee.

### **Articles and News of Interest (no action necessary)**

No articles.

**EXECUTIVE SESSION:** The Board entered into Executive Session pursuant to ORS 192.606 (1)(f), (h) and (k); ORS 676.165; ORS 676.175 (1), and ORS 679.320 to review records exempt from public disclosure, to review confidential investigatory materials and investigatory information, and to consult with counsel.

## **PERSONAL APPEARANCES AND COMPLIANCE ISSUES**

Licensee appeared pursuant to their Consent Order in case number **2005-0117**.

## **LICENSING ISSUES**

**OPEN SESSION:** The Board returned to Open Session.

**2005-0117**

Mr. Morris moved and Mr. Harvey seconded that the Board move to grant Licensee's release from the terms of their Consent Order. The motion passed with Mr. Harvey, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Smith and Dr. Underhill voting aye. Dr. Beck and Dr. Schwindt recused themselves.

**EXECUTIVE SESSION:** The Board entered into Executive Session pursuant to ORS 192.606 (1)(f), (h) and (k); ORS 676.165; ORS 676.175 (1), and ORS 679.320 to review records exempt from public disclosure, to review confidential investigatory materials and investigatory information, and to consult with counsel.

**LICENSING ISSUES**

**CONSENT AGENDA**

**2015-0152, 2015-0164, 2015-0163, 2015-0166, 2015-0149 and 2015-0148** Dr. Smith moved and Mr. Harvey seconded that the above referenced cases be closed with No Further Action per the staff recommendations. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Smith and Dr. Underhill voting aye. Dr. Beck recused himself on case 2015-0164.

**COMPLETED CASES**

**2014-0137, 2015-0110, 2014-0102, 2014-0109, 2014-0134 , 2015-0083, 2014-0126, 2014-0060 and 2014-0078.** Dr. Smith moved and Dr. Underhill seconded that the above referenced cases be closed with a finding of No Violation of the Dental Practice Act or No Further Action per the Board recommendations. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Smith and Dr. Underhill voting aye. Dr. Hongo recused herself on cases 2014-0137 and 2014-0134. Dr. Smith recused herself on case 2014-0134.

**2014-0118 Bui, Phong T. D.M.D.**

Mr. Morris moved and Dr Hongo seconded that the Board issue a Notice of Proposed Disciplinary Action and offer the Licensee a Consent Order in which the Licensee would agree to be reprimanded, to comply with all of the provisions of the Agreed Order in the Licensee's disciplinary action in the State of Washington, Department of Health, Dental Quality Assurance Commission in Case Numbers M2011-1098 and M2011-1099; to surrender the Licensee's Oregon Moderate Sedation permit; to not reapply for a permit to administer any level of sedation for a period of three years from the effective date of this order; and if a permit to administer any level of sedation is later granted by the Board, the Licensee shall only be allowed to work in a group practice; and complete a Board approved Ethics CE course of 16 hours within 12 months of the effective date of the Order. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Smith and Dr. Underhill voting aye.

**2015-0119 Campbell, Alysse T.M., R.D.H.**

Ms. Martinez moved and Dr. Beck seconded that the Board issue a Notice of Proposed

Disciplinary Action and offer a Consent Order incorporating a reprimand and require the Licensee to successfully complete 8 hours of Board approved continuing education, within 6 months of the effective date of this Order, unless the Board grants an extension, and advises the Licensee in writing. This ordered continuing education is in addition to the continuing education required for the licensure period October 1, 2014 to September 30, 2016. As soon as possible after completion of a Board ordered course, Licensee shall submit documentation to the Board verifying completion of the course. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Smith and Dr. Underhill voting aye.

**2014-0080 Clark, Curtis M., D.M.D.**

Ms. Riedman moved and Mr. Morris seconded that the Board move to issue a Notice of Proposed Disciplinary Action and offer the Licensee a Consent Order in which the Licensee would agree to be reprimanded and pay a civil penalty of \$1000.00. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Smith and Dr. Underhill voting aye

**2015-0116 Dacey, Tanya M., R.D.H.**

Dr. Underhill moved and Dr. Smith seconded that the Board issue a Notice of Proposed Disciplinary Action and offer a Consent Order incorporating a reprimand and require the Licensee to successfully complete 8.5 hours of Board approved continuing education, within 6 months of the effective date of this Order, unless the Board grants an extension, and advises the Licensee in writing. This ordered continuing education is in addition to the continuing education required for the licensure period October 1, 2014 to September 30, 2016. As soon as possible after completion of a Board ordered course, Licensee shall submit documentation to the Board verifying completion of the course. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Smith and Dr. Underhill voting aye.

**2015-0056 Haymore, Thomas L., D.M.D.**

Dr. Hongo moved and Mr. Morris seconded that the Board issue a Notice of Proposed Disciplinary Action and offer the Licensee a Consent Order in which the Licensee would agree to be reprimanded, to surrender the Licensee's minimal sedation permit, and to pay a \$5,000.00 civil penalty. The motion passed with Mr. Harvey, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye. Dr. Smith, Dr. Schwindt and Dr. Beck recused themselves.

**2015-0181 Kaufman, Francis E., D.D.S.**

Dr. Fine moved and Dr. Hongo seconded that the Board issue a Notice of Proposed License Suspension. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Smith and Dr. Underhill voting aye.

**2015-0142**

Mr. Harvey moved and Dr. Hongo seconded. **RESPONDENT #1**, the Board close the matter with a Letter of Concern reminding the Licensee that it is the Licensee's responsibility to conspicuously display their current license in every office where they practice in plain sight of the Licensee's patients; with regard to **RESPONDENT #2**, the Board close the matter with a finding of no violation of the Dental Practice Act. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Smith and Dr. Underhill voting aye.

**2014-0036**

Mr. Morris moved and Dr. Hongo seconded that the Board close the matter with a Letter of Concern reminding the Licensee that it is the Licensee's responsibility that heat sterilization devices are to be tested on a weekly basis per OAR 818-012-0040(4). The motion passed with Mr. Harvey, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Smith and Dr. Underhill voting aye. Dr. Beck recused himself.

**2014-0089 Robert Boyd Millard, Jr., D.D.S.**

Ms. Martinez moved and Dr. Hongo seconded that the Board issue a Notice of Proposed Disciplinary Action and offer the Licensee a Consent Order in which the Licensee would agree to be reprimanded and complete at least three hours of Board approved continuing education in record keeping. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Smith and Dr. Underhill voting aye.

**2014-0025**

Ms. Riedman moved and Dr. Hongo seconded that the Board issue a Letter of Concern suggesting the use of more complete documentation when entering clinical notes into a patient chart and a reminder that all sterilizing devices must be spore tested weekly. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Smith and Dr. Underhill voting aye.

**2014-0207 Ross, Jeffrey O., D.M.D.**

Dr. Underhill moved and Dr. Hongo seconded that the Board merge the issues in this case with case 2014-0096, issue a Notice of Proposed Disciplinary Action, and offer the Licensee a Consent Order in which the Licensee would agree to be reprimanded and pay a \$1,000.00 civil penalty. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Smith and Dr. Underhill voting aye.

**2014-0096 Ross, Jeffrey O., D.M.D.**

Dr. Underhill moved and Dr. Hongo seconded that the Board merge the issue in this case with case 2014-0207, issue a Notice of Proposed Disciplinary Action, and offer the Licensee a Consent Order in which the Licensee would agree to be reprimanded and pay a \$1,000.00 civil penalty. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Smith and Dr. Underhill voting aye.

**2014-0065**

Dr. Fine moved and Dr. Hongo seconded that the Board move to close the case with a **STRONGLY** worded Letter of Concern addressing the issue of ensuring that when continuing education is taken, that all certificates that support the continuing education log are maintained as proof for two licensure cycles. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Smith and Dr. Underhill voting aye.

**2014-0188**

Dr. Hongo moved and Dr. Smith seconded that the Board close the matter with a Letter of Concern reminding the Licensee that regardless of distractions in the Licensee's personal life, the Licensee has a responsibility to make certain that all aspects of re-licensure are met in a timely manner. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Smith and Dr. Underhill voting aye.

**2014-0120**

Mr. Harvey moved and Dr. Smith seconded that the Board close the case with a Letter of Concern addressing the issues of ensuring that a complete dental diagnosis is documented in the patient record for all teeth when treatment is subsequently provided, and testing of heat sterilizers is done on a weekly basis. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Smith and Dr. Underhill voting aye.

**PREVIOUS CASES REQUIRING BOARD ACTION**

**2010-0133 Gilbert, Delon K., D.D.S.**

Dr. Beck moved and Dr. Hongo seconded that the Board offer Licensee an Amended Consent Order incorporating a requirement that, within 30 days of a WPHP approved evaluation, Licensee will arrange for the Board to receive a copy of the evaluation and all diagnoses, treatment recommendations, and treatment plans; Licensee shall sign releases in favor of the Board with any evaluator and WPHP. All terms of Licensee's Consent Order remain in full effect. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Smith and Dr. Underhill voting aye.

**2009-0230**

Ms. Martinez moved and Dr. Hongo seconded that the Board grant Licensee's request and relieve him of the terms of his Voluntary Diversion Agreement and his contracts with HPSP. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Smith and Dr. Underhill voting aye.

**2010-0100**

Ms. Riedman moved and Dr. Hongo seconded that the Board grant Licensee's request and relieve him of the terms of his contracts with HPSP. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Smith and Dr. Underhill voting aye.

**2010-0164**

Dr. Underhill moved and Dr. Fine seconded that the Board grant Licensee's request and relieve him of the conditions of his Agreement to Enter the Health Professionals' Service Program with the Board and his contracts with HPSP. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Smith and Dr. Underhill voting aye.

**2012-0092**

Dr. Fine moved and Dr. Beck seconded that the Board grant Licensee's request and release her from the terms of her Agreement to Enter the Health Professionals' Services Program and her HPSP contracts. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Smith and Dr. Underhill voting aye.

**2013-0116**

Dr. Hongo moved and Dr. Smith seconded that the Board share the Board's investigative file to the Gresham Police Department. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Smith and Dr. Underhill voting aye.

**LICENSURE AND EXAMINATION**

**Ratification of Licenses Issued**

As authorized by the Board, licenses to practice dentistry and dental hygiene were issued to applicants who fulfilled all routine licensure requirements. It is recommended the Board ratify issuance of the following licenses. Complete application files will be available for review during the Board meeting.

**DENTAL HYGIENE**

H6910	TERI LYNN PARDUE, R.D.H.	2/18/2015
H6911	ALICIA LAVON CARTER, R.D.H.	2/18/2015
H6912	SUSAN J HOFBAUER, R.D.H.	2/19/2015
H6913	SHILO DEVON HARDIN, R.D.H.	2/19/2015
H6914	SHANTELL E DENDAUW, R.D.H.	3/5/2015
H6915	PRIYANKA HANDA, R.D.H.	3/5/2015
H6916	ANGELA K BARRETT, R.D.H.	3/5/2015
H6917	BREANNA MARIE MONROE, R.D.H.	3/5/2015
H6918	ELOISA CRYSTAL CRUZ, R.D.H.	3/5/2015
H6919	KAREN L BOTEILHO, R.D.H.	3/5/2015
H6920	NATASHA M CRISMAN, R.D.H.	3/5/2015
H6921	BROOKLYN A EDWARDS, R.D.H.	3/5/2015
H6922	ELLEN R EDWARDS, R.D.H.	3/19/2015
H6923	CLAUDIA SANDIVEL PEREZ, R.D.H.	3/19/2015
H6924	ARIELLE K BARRY, R.D.H.	3/19/2015
H6925	KAYLEE M HANSEN, R.D.H.	3/19/2015
H6926	KEIRA SEAN BOOTH, R.D.H.	3/19/2015
H6927	DANIEL A COSOVAN, R.D.H.	3/19/2015
H6928	ALESHA CHOI REYES, R.D.H.	3/27/2015
H6929	CRYSTAL DEE PETERSEN, R.D.H.	3/27/2015
H6930	HEATHER L CROOK, R.D.H.	3/27/2015
H6931	AMANDA P CALDCLEUGH, R.D.H.	3/27/2015

**DENTISTS**

D10190	DARBY J LEFLER, D.M.D.	2/19/2015
D10191	AZMA AHMED, D.D.S.	3/5/2015
D10192	ROBERT KIRK MC BRIDE, D.D.S.	3/5/2015
D10193	DENNIS H GILLESPIE, D.D.S.	3/5/2015
D10194	SCOTT S BECKER, D.D.S.	3/5/2015
D10195	CORBIN K POPP, D.M.D.	3/19/2015
D10196	CHARLES CHI HAO LEUNG, D.D.S.	3/19/2015
D10197	KIMBERLY LEEDS HEETER, D.D.S.	3/19/2015
D10198	ASHLEY H PALLADINO, D.M.D.	3/19/2015
D10199	PATTY LYNN MARTIN, D.D.S.	3/27/2015
D10200	SAMUEL C PAGE, D.M.D.	3/27/2015
D10201	ALISTAIR LEON KOK, D.D.S.	3/27/2015
D10202	FRANK JAMES FOREMAN, D.D.S.	3/27/2015

Dr. Beck moved and Dr. Hongo seconded, that the licenses issued be ratified as published. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Smith and Dr. Underhill voting aye.

**Extension to obtain Continuing Education – Robert W. Smith, D.M.D.**

Mr. Harvey moved and Dr. Hongo seconded that the Board grant a 60 day extension for Dr. Smith to complete his required CE. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Smith and Dr. Underhill voting aye.

**Announcement**

No announcements

**ADJOURNMENT**

The meeting was adjourned at 1:15 p.m. President Schwindt stated that the next Board meeting would take place June 26, 2015.

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Alton Harvey, Sr.  
President

# ASSOCIATION REPORTS

**Nothing to report under this tab**

# COMMITTEE REPORTS

AADB MID YEAR MEETING  
HONGO  
CHICAGO  
April 26, 2015

RESPECTFULLY SUBMITTED BY DR. JONNA

46 states belong to AADB

## **Board Recognition of Dental Specialties and Courts vs Boards**

Craig Busey, ADA General Counsel (speaker)

Current status of FTC ruling - North Carolina case - state action exemption - back in the 1940's - Parker v Brown - an agricultural case - Supreme Court basically ignored this case - state agency vs non state agency - FTC and Supreme Court discounted the evidence of protecting the public and focused on competition. Now the focus is on licensure. Confusion lies in whether the dental board is a state agency? Active supervision of someone in the state must be illustrated in order for the board to be a state agency. Who exactly is this? Any antitrust or competition action needs to be reviewed by someone who has a veto power over action. AG office? Public Health Dept.?

Specialty recognition - several groups who claim recognition as a specialty that has not been recognized by ADA - or have been denied. Four organizations have formed a board of specialties that are trying to sue for recognition and the ability to advertise - even though they have not been recognized by the ADA. Can we advertise as a specialist if we are not recognized by the ADA? That is their focus. Two cases - Florida and CA - yes you can. Advertising restrictions should be imposed to protect the public. Courts in FL and CA said that these specialties could advertise. Advertising is commercial speech.

## **SESSION I - Impairment Issues for Regulation**

### **How Has Medicine Addressed Impairment**

David Johnson - Federation of State Medical Boards

### **State Dental Boards and Impaired Practitioners**

Wade Winker

19-22% of profession has a substance abuse problem. Diversion programs discussed and speaker featured diversion programs in Maryland, Tennessee, North Carolina, Oklahoma, and Michigan. Basically the message is that we need to be committed to helping the licensee not punishing.

## **ADA Ethics Program**

Thomas Raimann

First code of ethics appeared in 1866. How to handle the conflict between the patient's right to know about their provider and the practitioner's right to maintain privacy?

## **SESSION II - Impairment Issues for Regulation**

### **ADA Dentist Health and Well-Being Outreach**

James Willey

## **Best Practices for Prescribing and Dispensing**

Demetra Ashley, DEA

How do you lose your registration? Falsification of application, felony conviction, not locking drugs up, not keeping records. US produces 100% of Oxycodone and uses 99% of it. Slide presentation available.

## **Future of Controlled Substances**

Carmen Catizone

29 states in the current PMP system - hoping for 35 by the end of 2015. PMP tool. PMP could become mandated if we don't use the PMP. If we can't control the abused controlled substances then there will be more rescheduling (ie vicodin)

*NOTE: ALL PRESENTATIONS WILL BE ON AADB WEBSITE*

## **AADB Update**

James Tarrant

## **Panel on Current Trends and Difficult Cases**

Mo Miskell

FTC, Have to report to the FTC WRT teeth whitening until 2031. Essentially, the decision impacts the wording of Cease and Desist Letters. The letters must now use language dictated by the FTC to ensure that recipients know they have additional rights. This is something the NC Board did long before being sued by the FTC. The NC/FTC process took 8 years.

## **National Dental Examiners' Advisory Forum**

### **INBDE - Integrated National Board Dental Examination**

**In 2009, the JDNCE appointed a committee for an Integrated Exam. The process is still in active, forward progress.**

**Enforcement and Discipline Committee Meeting  
Minutes  
May 7, 2015**

MEMBERS PRESENT: Committee Members:  
Julie Ann Smith, D.D.S., M.D., Chair  
Todd Beck, D.M.D.  
Amy B. Fine, D.M.D. via Telephone  
Alicia Riedman, R.D.H., E.P.P.  
Jason Bajuscak, D.M.D. - ODA Rep.  
Lynn Ironside, R.D.H. - ODHA Rep.  
Mary Harrison, CDA, EFDA, EFODA, FADAA - ODAA Rep.

STAFF PRESENT: Stephen Prisby, Interim Executive Director  
Paul Kleinstub, D.D.S., M.S., Dental Director/Chief Investigator  
Harvey Wayson, Investigator  
Nadia Roberts, Office Specialist

ALSO PRESENT: Lori Lindley, Sr. Assistant Attorney General

VISITORS PRESENT: Alton Harvey, Sr., Board Member; Jonna Hongo, D.M.D., Board Member

**Call to Order:** The meeting was called to order by the Chair at 6:00 p.m. at the Board office; 1500 SW 1<sup>st</sup> Ave., Suite 770, Portland, Oregon.

**MINUTES**

Dr. Beck moved and Ms. Ironside seconded that the minutes of the June 30, 2004 Enforcement and Discipline Committee meeting be approved as presented. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Ms. Riedman, Dr. Bajuscak, Ms. Ironside and Ms. Harrison voting aye.

General discussion on standard protocols for general consent orders, discipline for licensees, and unprofessional conduct.

**FALSE CERTIFICATION OF CONTINUING EDUCATION**

Ms. Ironside moved and Ms. Harrison seconded that the Committee recommend to the Board to update the protocols regarding False Certification of Continuing Education, increasing the potential fine to \$2,000.00 for dentists and \$1,000.00 for dental hygienists. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Ms. Riedman, Ms. Ironside, Ms. Harrison and Dr. Bajuscak voting aye.

Meeting adjourned at 7:21 p.m.

**EXECUTIVE  
DIRECTORS  
REPORT**

## **EXECUTIVE DIRECTOR'S REPORT**

### **June 26, 2015**

#### **Board Member Reappointment & Staff Updates**

Governor Brown reappointed and the Senate confirmed Board Member Julie Ann Smith MD, DDS for another term that will expire on May 9, 2019. Dr. Bill Herzog is no longer with the OBD. I am pleased to introduce our new Dental Consultant/Investigator, Dr. Daniel Blickenstaff. I am working with DAS-HR to finalize our job posting for a new full time Dental Investigator. Our 2015-17 Budget was approved by the Governor, and this included a biennial fee increase of \$75/Licensee to help pay for the additional Dental Investigator.

#### **OBD COMMITTEES May 2015 - April 2016**

OBD President Alton Harvey, Sr. has finalized the Committee appointments. I want to thank the ODA, ODHA and ODAA for their feedback and cooperation in choosing their representatives.

#### **Attachment #1 No Action Required**

#### **OBD Budget Status Report**

Attached is the latest budget report for the 2013 - 2015 Biennium. This report, which is from July 1, 2013 through May 31, 2015, shows revenue of \$2,636,410.72 and expenditures of \$2,534,601.61. We are at the end of the 2013-15 Biennium budget on June 30<sup>th</sup>. If Board members have questions on this budget report format, please feel free to ask me.

#### **Attachment #2 No Action Required**

#### **Proposal to recoup costs**

Attached is a memo outlining a proposal for recouping costs when cases are referred to hearing. The average cost to the OBD for referring a case to hearing and through the pre-hearing conference process can average \$400 per case.

#### **Attachment #3 ACTION REQUESTED**

#### **Customer Service Survey**

Attached is a chart which shows the OBD State Legislatively Mandated Customer Service Survey Results from July 1, 2013 – May 31, 2015.

The results of the survey show that the OBD continues to receive positive comments from the majority of those that return the surveys. The booklet containing the written comments that are on the survey forms, which staff has reviewed, are available on the table for Board members to review. **Attachment #4 No Action Required**

#### **Board and Staff Speaking Engagements**

Teresa Haynes, Exam and Licensing Manager made a License Application Presentation to the graduating Dental Hygiene Students at Portland Community College in Portland on Thursday, April 30, 2015.

Teresa Haynes, Exam and Licensing Manager made a presentation at the ODHA Annual EPP Conference – and joined a panel with Board members Yadira Martinez and Alicia Riedman, in Springfield on Friday, May 1, 2015.

Teresa Haynes, Exam and Licensing Manager made a License Application Presentation to the graduating Dental Hygiene Students at Lane Community College in Portland on Monday, May 11, 2015

Teresa Haynes, Exam and Licensing Manager made a License Application Presentation to the graduating Dental Students at the OHSU Dental School in Portland on Friday, May 29, 2015.

Teresa Haynes, Exam and Licensing Manager made a License Application Presentation to the graduating Dental Hygiene Students at Mt. Hood Community College in Gresham on Monday, June 1, 2015.

Teresa Haynes, Exam and Licensing Manager made a License Application Presentation to the graduating Dental Hygiene Students at Pacific University in Forest Grove on Tuesday, June 2, 2015

Dr. Paul Kleinstub, Dental Director/Chief Investigator made a presentation to the dentists and staff members of Dental Care Today and Gentech Dentistry in Portland on Wednesday, April 22, 2015.

### **AADB/AADA Annual Meeting**

The Board needs to authorize the attendance of the OBD's Executive Director (whether me or someone else) at the American Association of Dental Administrators (AADA) Meeting to be held November 2 - 3, 2015 to be held in conjunction with the American Association of Dental Boards (AADB) Meeting to be held, Nov 3 - 4, 2015, in Washington D.C. Senior Assistant Attorney General Lori Lindley will be attending the Board Attorneys' Roundtable Meeting that is held in conjunction with the AADB Meeting and Amy Fine, D.M.D.(or an alternate) and Yadira Martinez, R.D.H., who are the Dental and Dental Hygiene Liaisons, will be authorized by me to attend the AADB meeting.

### **ACTION REQUESTED**

### **Legislative Update**

Attached please find a list of the Oregon Legislative Bills that the OBD is currently tracking that will have a direct impact in the Board or impact on the Board as a state agency. This list also shows those Bills that have been passed and signed into law by the Governor.

### **Attachment #5 No Action Required**

### **Switching to laser embossed seals**

Teresa Haynes suggested switching to laser embossed state seals, from the hand-pressed seals we have been using. Pressing the seals on by hand is a time intensive process, and physically it hurts the hand/wrist from the pressure and repetitive nature of it. The laser embossed seals will save staff time and money as the manual press will need to be replaced.

### **Newsletter**

It is time to consider another newsletter and articles are welcome from the Board Members.

**Oregon Board of Dentistry  
Committee and Liaison Assignments  
May 2015 - April 2016**

**STANDING COMMITTEES**

**Communications**

Purpose: To enhance communications to all constituencies

*Committee:*

Todd Beck, D.M.D., Chair	Barry Taylor, D.M.D., ODA Rep.
Yadira Martinez, R.D.H., E.P.P.	Gail Aamondt, R.D.H., M.S., ODHA Rep.
Alton Harvey, Sr.	Linda Kihs, CDA, EFDA, OMSA, MADAA, ODAA Rep.

*Subcommittees:*

- Newsletter – Amy B. Fine, D.M.D., Editor

**Dental Hygiene**

Purpose: To review issues related to Dental Hygiene

*Committee:*

Yadira Martinez, R.D.H., E.P.P., Chair	David J. Dowsett, D.M.D., ODA Rep.
Amy B. Fine, D.M.D.	Kristen L. Simmons, R.D.H., B.S., ODHA Rep.
Alicia Riedman, R.D.H., E.P.P.	Mary Harrison, CDA, EFDA, EFODA, FADAA, ODAA Rep.

**Enforcement and Discipline**

Purpose: To improve the discipline process

*Committee:*

Julie Ann Smith, M.D., D.D.S., Chair	Jason Bajuscak, D.M.D., ODA Rep.
Alicia Riedman, R.D.H., E.P.P.	Lynn Ironside, R.D.H., ODHA Rep.
Todd Beck, D.M.D.	Mary Harrison, CDA, EFDA, EFODA, FADAA, ODAA Rep.
James Morris	

*Subcommittees:*

Evaluators

- Julie Ann Smith, M.D., D.D.S., Senior Evaluator
- Todd Beck, D.M.D., Evaluator

**Licensing, Standards and Competency**

Purpose: To improve licensing programs and assure competency of licensees and applicants

*Committee:*

Amy B. Fine, D.M.D., Chair	Daren L. Goin, D.M.D., ODA Rep.
Gary Underhill, D.M.D.	Lisa J. Rowley, R.D.H., M.S., ODHA Rep.
Yadira Martinez, R.D.H., E.P.P.	Mary Harrison, CDA, EFDA, EFODA, FADAA, ODAA Rep.

**Rules Oversight**

Purpose: To review and refine OBD rules

*Committee:*

Brandon Schwindt, D.M.D., Chair	Bruce Burton, D.M.D., ODA Rep.
Jonna Hongo D.M.D.	Lynn Ironside, R.D.H., ODHA Rep.
Alicia Riedman, R.D.H., E.P.P.	Bonnie Marshall, CDA, EFDA, EFODA, MADAA, ODAA Rep.

## **LIAISONS**

American Assoc. of Dental Administrators (AADA) — Stephen Prisby, Interim Executive Director

American Assoc. of Dental Boards (AADB)

- Administrator Liaison – Stephen Prisby, Interim Executive Director
- Board Attorneys' Roundtable – Lori Lindley, SAAG - Board Counsel
- Dental Liaison – Amy B. Fine, D.M.D.
- Hygiene Liaison – Yadira Martinez, R.D.H., E.P.P.

American Board of Dental Examiners (ADEX)

- House of Representatives – Jonna Hongo, D.M.D.
- Dental Exam Committee – Jonna Hongo, D.M.D.

Commission on Dental Competency Assessments (CDCA)

- Amy Fine, D.M.D.
- Gary Underhill, D.M.D.
- Yadira Martinez, R.D.H., E.P.P.

Oregon Dental Association – Alton Harvey, Sr.

Oregon Dental Hygienists' Association Yadira Martinez, R.D.H., E.P.P.

Oregon Dental Assistants Association – Alton Harvey, Sr.

Western Regional Exam Board (WREB)

- Dental Exam Review Committee – Jonna Hongo, D.M.D
- Hygiene Exam Review Committee – Yadira Martinez, R.D.H., E.P.P.

## **OTHER**

### **Administrative Workgroup**

Purpose: To update Board and agency policies and guidelines. Consult with Executive Director on administrative issues. Conduct evaluation of Executive Director.

*Committee:*

Alton Harvey, Sr., Chair  
Jonna Hongo, D.M.D.  
Yadira Martinez, R.D.H., E.P.P.

*Subcommittee:*

Budget/Legislative – *(President, Vice President, Immediate Past President)*

- Alton Harvey, Sr.
- Julie Ann Smith, D.D.S, M.D.
- Brandon Schwindt, D.M.D.

### **Anesthesia**

Purpose: To review and make recommendations on the Board's rules regulating the administration of sedation in dental offices.

*Committee:*

Julie Ann Smith, D.D.S, M.D., Chair  
Brandon Schwindt, D.M.D.  
Rodney Nichols, D.M.D.  
Daniel Rawley, D.D.S.  
Mark Mutschler, D.D.S.  
Jay Wylam, D.M.D.  
Normund Auzins, D.M.D.  
Eric Downey, D.D.S.  
Ryan Allred, D.M.D.

\*Not Selected by the OBD

Appn Year        2015  
**BOARD OF DENTISTRY**  
**Fund 3400 BOARD OF DENTISTRY**  
**For the Month of MAY 2015**

**REVENUES**

Budget Obj	Budget Obj Title	<u>Prior Month</u>	<u>Current Month</u>	<u>Bien to Date</u>	<u>Financial Plan</u>	<u>Unoblig</u>
0975	OTHER REVENUE	42,754.18	1,166.00	43,920.18	24,447.00	-19,473.18
0205	OTHER BUSINESS LICENSES	2,415,347.00	43,196.00	2,458,543.00	2,376,611.00	-81,932.00
0605	INTEREST AND INVESTMENTS	7,098.15	291.39	7,389.54	7,890.00	500.46
0505	FINES AND FORFEITS	99,500.00	1,000.00	100,500.00	136,085.00	35,585.00
0210	OTHER NONBUSINESS LICENSES AND FEES	8,650.00	300.00	8,950.00	15,772.00	6,822.00
0410	CHARGES FOR SERVICES	17,097.50	10.50	17,108.00	0.00	-17,108.00
		<b>2,590,446.83</b>	<b>45,963.89</b>	<b>2,636,410.72</b>	<b>2,560,805.00</b>	<b>-75,605.72</b>

**TRANSFER OUT**

Budget Obj	Budget Obj Title	<u>Prior Month</u>	<u>Current Month</u>	<u>Bien to Date</u>	<u>Financial Plan</u>	<u>Unoblig</u>
2443	TRANSFER OUT TO OREGON HEALTH AUTHORITY	127,550.00	0.00	127,550.00	215,500.00	87,950.00
		<b>127,550.00</b>	<b>0.00</b>	<b>127,550.00</b>	<b>215,500.00</b>	<b>87,950.00</b>

**PERSONAL SERVICES**

Budget Obj	Budget Obj Title	<u>Prior Month</u>	<u>Current Month</u>	<u>Bien to Date</u>	<u>Financial Plan</u>	<u>Unoblig</u>
3110	CLASS/UNCLASS SALARY & PER DIEM	819,605.84	28,136.04	847,741.88	940,701.00	92,959.12
3230	SOCIAL SECURITY TAX	62,870.49	2,274.18	65,144.67	73,795.00	8,650.33
3250	WORKERS' COMPENSATION ASSESSMENT	433.64	15.30	448.94	434.00	-14.94
3210	ERB ASSESSMENT	176.55	8.25	184.80	212.00	27.20
3260	MASS TRANSIT	4,599.01	173.42	4,772.43	5,414.00	641.57
3170	OVERTIME PAYMENTS	9,058.70	51.83	9,110.53	13,384.00	4,273.47
3180	SHIFT DIFFERENTIAL	141.38	0.00	141.38	114.00	-27.38
3190	ALL OTHER DIFFERENTIAL	5,874.00	2,136.00	8,010.00	0.00	-8,010.00
3220	PUBLIC EMPLOYES' RETIREMENT SYSTEM	118,984.95	4,131.07	123,116.02	133,173.00	10,056.98
3221	PENSION BOND CONTRIBUTION	50,876.26	1,787.69	52,663.95	52,001.00	-662.95
3270	FLEXIBLE BENEFITS	182,058.43	7,438.00	189,496.43	209,350.00	19,853.57
3160	TEMPORARY APPOINTMENTS	0.00	0.00	0.00	15,434.00	15,434.00
		<b>1,254,679.25</b>	<b>46,151.78</b>	<b>1,300,831.03</b>	<b>1,444,012.00</b>	<b>143,180.97</b>

**SERVICES and SUPPLIES**

Budget Obj	Budget Obj Title	<u>Prior Month</u>	<u>Current Month</u>	<u>Bien to Date</u>	<u>Financial Plan</u>	<u>Unoblig</u>
4225	STATE GOVERNMENT SERVICE CHARGES	73,014.88	5,693.06	78,707.94	75,916.00	-2,791.94
4650	OTHER SERVICES AND SUPPLIES	54,873.64	1,677.16	56,550.80	55,077.00	-1,473.80
4325	ATTORNEY GENERAL LEGAL FEES	173,353.00	16,817.80	190,170.80	176,916.00	-13,254.80
4200	TELECOMM/TECH SVC AND SUPPLIES	25,161.61	1,179.47	26,341.08	26,077.00	-264.08

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
4715	IT EXPENDABLE PROPERTY	6,780.42	0.00	6,780.42	6,411.00	-369.42
4315	IT PROFESSIONAL SERVICES	19,045.00	0.00	19,045.00	22,503.00	3,458.00
4300	PROFESSIONAL SERVICES	168,365.42	8,533.80	176,899.22	104,922.00	-71,977.22
4575	AGENCY PROGRAM RELATED SVCS & SUPP	91,142.53	1,560.98	92,703.51	104,286.00	11,582.49
4100	INSTATE TRAVEL	48,523.93	573.28	49,097.21	55,994.00	6,896.79
4700	EXPENDABLE PROPERTY \$250-\$5000	2,980.66	0.00	2,980.66	3,182.00	201.34
4425	FACILITIES RENT & TAXES	151,769.64	5,574.92	157,344.56	164,950.00	7,605.44
4475	FACILITIES MAINTENANCE	5,314.95	0.00	5,314.95	3,977.00	-1,337.95
4150	EMPLOYEE TRAINING	7,170.00	0.00	7,170.00	8,877.00	1,707.00
4125	OUT-OF-STATE TRAVEL	33,211.49	2,911.99	36,123.48	48,487.00	12,363.52
4375	EMPLOYEE RECRUITMENT AND DEVELOPMENT	0.00	1,845.00	1,845.00	0.00	-1,845.00
4400	DUES AND SUBSCRIPTIONS	11,520.80	0.00	11,520.80	10,888.00	-632.80
4250	DATA PROCESSING	4,078.11	75.74	4,153.85	4,702.00	548.15
4275	PUBLICITY & PUBLICATIONS	23,160.45	0.00	23,160.45	22,866.00	-294.45
4175	OFFICE EXPENSES	79,231.83	894.02	80,125.85	86,657.00	6,531.15
		<b>978,698.36</b>	<b>47,337.22</b>	<b>1,026,035.58</b>	<b>982,688.00</b>	<b>-43,347.58</b>

## SPECIAL PAYMENTS

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
6443	DIST TO OREGON HEALTH AUTHORITY	207,735.00	0.00	207,735.00	230,216.00	22,481.00
		<b>207,735.00</b>	<b>0.00</b>	<b>207,735.00</b>	<b>230,216.00</b>	<b>22,481.00</b>

		3400		
		Monthly Activity	Biennium Activity	Financial Plan
REVENUES	REVENUE	45,963.89	2,636,410.72	2,560,805.00
	Total	45,963.89	2,636,410.72	2,560,805.00
EXPENDITURES	PERSONAL SERVICES	46,151.78	1,300,831.03	1,444,012.00
	SERVICES AND SUPPLIES	47,337.22	1,026,035.58	982,688.00
	SPECIAL PAYMENTS	0	207,735	230,216.00
	Total	93,489	2,534,601.61	2,656,916.00
TRANSFER OUT	TRANSFER OUT	0	127,550	215,500.00
	Total	0	127,550	215,500.00

# Memorandum

**DATE:** JUNE 12, 2015

**TO:** ALTON HARVEY SR., PRESIDENT  
MEMBERS, OREGON BOARD OF DENTISTRY

**FROM:** STEPHEN PRISBY  
INTERIM EXECUTIVE DIRECTOR

**SUBJECT:** RECOVERING COSTS OF REFERRALS TO HEARINGS

The cost to the Board for referring a case to hearing and through the pre-hearing conference process can average \$400 per case. This can be expensive when licensees and/or their attorneys delay seeking a resolution to a case until after it has been referred to hearing.

The referral to hearing involves forwarding documents to the Office of Administrative Hearings. That office establishes a file, assigns the case to a judge, and schedules a pre-hearing conference. Typically, the pre-hearing conference is a telephonic meeting with the judge, the Board's counsel, the investigator, and the licensee and/or licensee's attorney. The purpose of the Pre-Hearing conference is to set a hearing date, and establish the various administrative dates for exchange of evidence and witness lists, etc.

After the Board votes to issue a Notice of Proposed Disciplinary Action, staff prepares the document and lists the allegations. Following review and approval of the draft document by the Board's counsel, staff mails the document to the licensee by certified mail with a return receipt requested. The accompanying cover letter advises the licensee of his/her right to request a hearing within 21 days to contest the Board's action.

Staff tracks the cases noting when the licensees receive the Notices and when the 21 days elapse. In the vast majority of cases, the licensee requests a hearing. If a licensee fails to request a hearing within 21 days, the Board considers a default order at its next meeting.

Additionally, the accompanying cover letter requests the licensee, if he/she wishes, to return the proffered Consent Order or submit an alternative resolution within 30 days of the receipt of the Notice.

A number of licensees and/or their attorneys have adopted a tactic whereby they stonewall the process and do not engage with staff or Board's counsel in efforts to find a resolution. It is believed by some that with a stall of sufficient time, the Board will lose interest and change its position to one more favorable for the licensee.

Another tactic used by some licensees and/or their attorneys is to stall until after the pre-hearing conference to negotiate a resolution for Board approval. By this time, the Board has incurred costs.

Board's staff is exploring how to lighten the financial burden and seeking Board approval and support for the following process.

On or about the date the 30-day timeline for presentation of an alternative resolution expires, staff will send the following letter to the licensee –

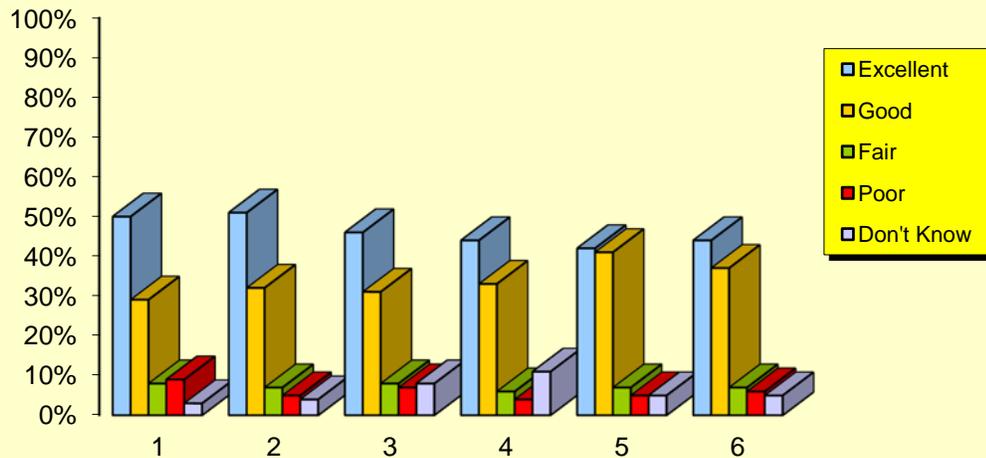
On or before (*DATE*), the Oregon Board of Dentistry served you with a Notice of Proposed Disciplinary Action. On (*DATE*) you requested a hearing. The Board has no record that you submitted an alternative resolution within the 30-day timeline ending (*DATE*).

The Board will refer this matter to the Office of Administrative Hearings (OAH) on (*DATE*) in the absence of any action on your part. Pursuant to ORS 679.140(5), the Board is authorized to recover costs of a disciplinary proceeding including the costs of referring the case. The Board will require that you reimburse it for the OAH referral and pre-hearing costs of approximately \$400, regardless of whether the final resolution is disciplinary or not.

Ten days from the date of the letter to referral date seems appropriate.

It is unreasonable for licensees not involved in the disciplinary process to pay for the referral of cases to hearing due to the delay tactics of some licensees.

## Oregon Board of Dentistry Customer Service Survey July 1, 2014 - May 31, 2015



1 How do you rate the timeliness of the services provided by the OBD?

E= 50% G= 29% F= 8% P= 9% DK= 3%

2 How do you rate the ability of the OBD to provide services correctly the first time?

E= 51% G= 32% F= 7% P= 5% DK= 4%

3 How do you rate the helpfulness of the OBD?

E= 46% G= 31% F= 8% P= 7% DK= 8%

4 How do you rate the knowledge and expertise of the OBD?

E= 44% G= 33% F= 6% P= 4% DK= 11%

5 How do you rate the availability of information at the OBD?

E= 42% G= 41% F= 7% P= 5% DK= 5%

6 How do you rate the overall quality of services provided by the OBD?

E= 44% G= 37% F= 7% P= 6% DK= 5%

## Search Bill

State	Session	Bill	Current Version	Date
OR	2015 Regular Session	HB 2024	B-Engrossed	06/09/2015
<i>Relating To:</i> Relating to basic preventive dental services; declaring an emergency. <i>Summary:</i> Directs Oregon Health Authority, in consultation with coordinated care organizations and dental care organizations, to adopt rules and procedures for training and certifying certain health workers to provide oral disease prevention services.				
OR	2015 Regular Session	HB 2238	Introduced	01/11/2015
<i>Relating To:</i> Relating to the Oregon transparency website. <i>Summary:</i> Directs state agencies to make available on Oregon transparency website copies of reports agency is required by law to produce.				
OR	2015 Regular Session	HB 2295	Introduced	01/11/2015
<i>Relating To:</i> Relating to anesthesiologist assistants; declaring an emergency. <i>Summary:</i> Provides for licensing and regulation of anesthesiologist assistants.				
OR	2015 Regular Session	HB 2476	Enrolled	04/08/2015
<i>Relating To:</i> Relating to administrative rules; and declaring an emergency. <i>Summary:</i> Authorizes Oregon Department of Administrative Services to adopt by rule uniform policies or procedures.				
OR	2015 Regular Session	HB 2570	Introduced	01/11/2015
<i>Relating To:</i> Relating to ambulatory surgical centers; declaring an emergency. <i>Summary:</i> Creates new category of ambulatory surgical centers for licensing purposes.				
OR	2015 Regular Session	HB 2611	Enrolled	06/10/2015
<i>Relating To:</i> Relating to university shared services; and declaring an emergency. <i>Summary:</i> Requires universities with institutional governing boards to continue to participate in shared services relating to listed employee benefits and to collective bargaining until July 1, 2019.				
OR	2015 Regular Session	HB 2683	Introduced	01/11/2015
<i>Relating To:</i> Relating to dentistry; declaring an emergency. <i>Summary:</i> Requires Oregon Board of Dentistry, upon request of individual who has been disciplined by board, to remove from its website and other publicly accessible print and electronic publications information related to disciplining individual if individual meets certain criteria.				

State	Session	Bill	Current Version	Date
OR	2015 Regular Session	HB 2754	Introduced	01/11/2015
<i>Relating To:</i> Relating to immunity for persons who seek medical assistance.				
<i>Summary:</i> Exempts person from arrest and prosecution for certain offenses and finding of violation of terms of release or supervision if person contacts emergency medical services or law enforcement agency to obtain necessary medical assistance for other person due to drug-related overdose.				
OR	2015 Regular Session	HB 2972	B-Engrossed	06/09/2015
<i>Relating To:</i> Relating to dental screenings of students; declaring an emergency.				
<i>Summary:</i> Requires public school students seven years of age or younger who are beginning educational program to have dental screening.				
OR	2015 Regular Session	HB 3023	Introduced	02/13/2015
<i>Relating To:</i> Relating to referrals to dental specialists; declaring an emergency.				
<i>Summary:</i> Requires that referrals to dental specialists, of medical assistance recipients who are pregnant, occur within 60 days.				
OR	2015 Regular Session	HB 3139	Enrolled	05/13/2015
<i>Relating To:</i> Relating to mobile medical clinics.				
<i>Summary:</i> Prohibits local government from preventing mobile medical clinic from locating to private property for not more than 180 days.				
OR	2015 Regular Session	HB 3326	Introduced	02/26/2015
<i>Relating To:</i> Relating to in-office sedation services; declaring an emergency.				
<i>Summary:</i> Directs Oregon Board of Dentistry, Oregon Medical Board and Oregon State Board of Nursing to adopt rules regulating use of in-office sedation services.				
OR	2015 Regular Session	HB 5014	Enrolled	05/20/2015
<i>Relating To:</i> Relating to the financial administration of the Oregon Board of Dentistry; and declaring an emergency.				
<i>Summary:</i> Limits biennial expenditures from fees, moneys or other revenues, including Miscellaneous Receipts, but excluding lottery funds and federal funds, collected or received by Oregon Board of Dentistry.				
OR	2015 Regular Session	SB 55	A-Engrossed	05/18/2015
<i>Relating To:</i> Relating to debt collection; declaring an emergency.				
<i>Summary:</i> Authorizes state agencies that request persons to voluntarily supply Social Security numbers on documents relating to any monetary obligation or transaction to include on documents notice that Social Security numbers may be used for state agency debt collection activities.				
OR	2015 Regular Session	SB 230	Enrolled	06/03/2015
<i>Relating To:</i> Relating to health care workforce information; and declaring an emergency.				
<i>Summary:</i> Makes law requiring certain health care workers to submit demographic, education and other information to health care worker regulatory boards apply to all health care workers.				

State	Session	Bill	Current Version	Date
OR	2015 Regular Session	SB 279	Introduced	01/11/2015
<i>Relating To:</i> Relating to operations of state agencies that regulate the practice of medicine; declaring an emergency.				
<i>Summary:</i> Designates Oregon Medical Board as semi-independent state agency.				
OR	2015 Regular Session	SB 289	Introduced	01/11/2015
<i>Relating To:</i> Relating to monitoring the efficacy of state government entities.				
<i>Summary:</i> Establishes legislative policy of conducting periodic review of state boards, commissions and other small entities within executive branch of state government to enhance budget and government efficiency, minimize duplication of effort and enhance efforts of such entities in meeting current needs of Oregonians.				
OR	2015 Regular Session	SB 294	A-Engrossed	05/06/2015
<i>Relating To:</i> Relating to executive session provisions of public meeting law.				
<i>Summary:</i> Grants Oregon Government Ethics Commission administrative rulemaking authority to assist in commission's enforcement of executive session provisions of public meeting laws.				
OR	2015 Regular Session	SB 301	Enrolled	05/29/2015
<i>Relating To:</i> Relating to expanded practice dental hygienists; and declaring an emergency.				
<i>Summary:</i> Specifies which services to be performed by expanded practice dental hygienist must be included in agreement between expanded practice dental hygienist and dentist.				
OR	2015 Regular Session	SB 302	Enrolled	03/16/2015
<i>Relating To:</i> Relating to prescription drugs used for purposes related to dentistry; and declaring an emergency.				
<i>Summary:</i> Clarifies that practice of dentistry includes prescribing, dispensing and administering prescription drugs for purposes related to dentistry.				
OR	2015 Regular Session	SB 474	Enrolled	06/03/2015
<i>Relating To:</i> Relating to dental business entities for children with special needs; and declaring an emergency.				
<i>Summary:</i> Allows certain nonprofit charitable corporations to own and operate dental clinics that serve children with special needs.				
OR	2015 Regular Session	SB 606	A-Engrossed	04/07/2015
<i>Relating To:</i> Relating to dental pilot project; declaring an emergency.				
<i>Summary:</i> Extends dental pilot project by seven years.				
OR	2015 Regular Session	SB 626	A-Engrossed	03/24/2015
<i>Relating To:</i> Relating to prescription drugs; declaring an emergency.				
<i>Summary:</i> Shortens timeframe within which pharmacies must electronically report to Oregon Health Authority information under prescription monitoring program.				

State	Session	Bill	Current Version	Date
OR	2015 Regular Session	SB 662	Enrolled	08/03/2015
<i>Relating To:</i> Relating to dental instructor licensing.				
<i>Summary:</i> Requires that dental instructor's license issued to specialist be restricted to specialty for which applicant completed advanced dental education program.				
OR	2015 Regular Session	SB 672	Enrolled	06/03/2015
<i>Relating To:</i> Relating to state dental director; and declaring an emergency.				
<i>Summary:</i> Directs Oregon Health Authority to appoint state dental director to oversee programs operated by authority that increase access to oral health services.				
OR	2015 Regular Session	SB 673	Introduced	02/18/2015
<i>Relating To:</i> Relating to administration of immunizations by dentists.				
<i>Summary:</i> Permits licensed dentists to administer certain immunizations.				
OR	2015 Regular Session	SB 692	A-Engrossed	04/27/2015
<i>Relating To:</i> Relating to dental pilot projects; declaring an emergency.				
<i>Summary:</i> Provides that providers of dental services to certain patients in dental pilot project approved by Oregon Health Authority are eligible for reimbursement.				
OR	2015 Regular Session	SB 904	Introduced	03/02/2015
<i>Relating To:</i> Relating to the Joint Legislative Committee on Privacy and Civil Liberties Oversight.				
<i>Summary:</i> Establishes Joint Legislative Committee on Privacy and Civil Liberties Oversight.				
OR	2015 Regular Session	SB 5543	Enrolled	03/23/2015
<i>Relating To:</i> Relating to state financial administration; and declaring an emergency.				
<i>Summary:</i> Increases and decreases certain biennial appropriations made from General Fund to specified state agencies and Emergency Board.				

## B-Engrossed House Bill 2024

Ordered by the Senate June 9  
Including House Amendments dated April 16 and Senate Amendments  
dated June 9

Sponsored by Representatives KENY-GUYER, GALLEGOS; Representatives NOSSE, PILUSO, VEGA PEDERSON,  
Senator STEINER HAYWARD

### SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure.

*[Directs Oregon Health Authority, in consultation with coordinated care organizations and dental care organizations in this state, to certify certain health workers to provide early childhood basic preventive dental services. Requires authority to reimburse certified health workers for services provided to medical assistance recipients. Defines "dental home."]*

**Directs Oregon Health Authority, in consultation with coordinated care organizations and dental care organizations, to adopt rules and procedures for training and certifying certain health workers to provide oral disease prevention services. Defines "dental provider."**  
Declares emergency, effective on passage.

### A BILL FOR AN ACT

1  
2 Relating to basic preventive dental services; and declaring an emergency.

3 **Be It Enacted by the People of the State of Oregon:**

4 **SECTION 1. (1) As used in this section:**

5 (a) "Dental provider" means a licensed dentist, dental hygienist or other dental practi-  
6 tioner or a dental care team or clinic that provides the following core services:

7 (A) Comprehensive dental care;

8 (B) Basic preventive dental services;

9 (C) Referral to dental specialists; and

10 (D) Family centered dental care.

11 (b) "Health worker" means "traditional health worker" as defined by the Oregon Health  
12 Authority by rule.

13 (2) The Oregon Health Authority, in consultation with coordinated care organizations and  
14 dental care organizations in this state, shall adopt rules and procedures for the training and  
15 certification of health workers to provide oral disease prevention services and for the re-  
16 imbursement of oral disease prevention services provided by certified health workers.

17 (3) The rules adopted under subsection (2) of this section must prescribe the training  
18 required for certification, including instruction on:

19 (a) The performance of dental risk assessments; and

20 (b) The provision of oral disease prevention services.

21 (4) The authority shall adopt rules requiring that a certified health worker:

22 (a) Refer patients to dental providers; and

23 (b) Recommend to patients, or to the parent or legal guardian of a patient, that the pa-

NOTE: Matter in boldfaced type in an amended section is new; matter [italic and bracketed] is existing law to be omitted.  
New sections are in boldfaced type.

LC 3393

1   tient visit a dental provider at least once annually.

2       **SECTION 2.** (1) Section 1 of this 2015 Act becomes operative on July 1, 2016.

3       (2) The Oregon Health Authority may take any action before the operative date specified  
4   in subsection (1) of this section that is necessary to enable the authority to exercise, on or  
5   after the operative date specified in subsection (1) of this section, all of the duties, functions  
6   and powers conferred on the authority by section 1 of this 2015 Act.

7       **SECTION 3.** Section 1 of this 2015 Act applies to services provided on or after the oper-  
8   ative date specified in section 2 of this 2015 Act.

9       **SECTION 4.** This 2015 Act being necessary for the immediate preservation of the public  
10   peace, health and safety, an emergency is declared to exist, and this 2015 Act takes effect  
11   on its passage.

12

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**B-Engrossed**  
**House Bill 2972**

Ordered by the Senate June 9  
Including House Amendments dated April 16 and Senate Amendments  
dated June 9

Sponsored by Representatives HAYDEN, KENY-GUYER, PARRISH; Representatives BUEHLER, LIVELY, PILUSO

**SUMMARY**

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure.

Requires public school students seven years of age or younger who are beginning educational program to have dental screening.

Declares emergency, effective on passage.

**A BILL FOR AN ACT**

1  
2 Relating to dental screenings of students; creating new provisions; amending ORS 326.580 and  
3 680.020; and declaring an emergency.

4 **Be It Enacted by the People of the State of Oregon:**

5 **SECTION 1. (1) As used in this section:**

6 (a) "Dental screening" means a dental screening test to identify potential dental health  
7 problems that is conducted by:

8 (A) A dentist licensed under ORS chapter 679;

9 (B) A dental hygienist licensed under ORS 680.010 to 680.205;

10 (C) A health care practitioner who is acting in accordance with rules adopted by the  
11 State Board of Education; or

12 (D) A person who:

13 (i) Is one of the following:

14 (I) An employee of an education provider; or

15 (II) Trained in accordance with guidelines established by the dental director appointed  
16 by the Oregon Health Authority; and

17 (ii) Is acting in accordance with rules adopted by the State Board of Education in col-  
18 laboration with the dental director appointed by the Oregon Health Authority.

19 (b) "Education provider" means:

20 (A) An entity that offers a program that is recognized as an Oregon prekindergarten  
21 program under ORS 329.170 to 329.200.

22 (B) A school district board.

23 (2)(a) Except as provided in subsection (3) of this section, each education provider shall  
24 require a student who is seven years of age or younger and who is beginning an educational  
25 program with the education provider for the first time to submit certification that the stu-  
26 dent received a dental screening within the previous 12 months.

27 (b) The certification required by this subsection:

**NOTE:** Matter in boldfaced type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted.  
New sections are in boldfaced type.

LC 2629

1 (A) Must be provided no later than 120 days after the student begins the educational  
2 program.

3 (B) May be provided by a person identified in subsection (1)(a) of this section who con-  
4 ducts the dental screening at a location not associated with the education provider or who  
5 conducts regular dental screenings of the student.

6 (3) A student is not required to submit certification as required under subsection (2) of  
7 this section if the student provides a statement from the parent or guardian of the student  
8 that:

9 (a) The student submitted certification to a prior education provider;

10 (b) The dental screening is contrary to the religious beliefs of the student or the parent  
11 or guardian of the student; or

12 (c) The dental screening is a burden, as defined by the State Board of Education by rule,  
13 for the student or the parent or guardian of the student.

14 (4) Each education provider shall:

15 (a) File in the student's dental health record any certifications and any results of a  
16 dental screening known by the education provider.

17 (b) Provide the parent or guardian of each student with information about:

18 (A) The dental screenings;

19 (B) Further examinations or necessary treatments; and

20 (C) Preventive care, including fluoride varnish, sealants and daily brushing and flossing.

21 (5) The dental director appointed by the Oregon Health Authority shall develop stand-  
22 ardized information described in subsection (4)(b) of this section for distribution by education  
23 providers.

24 (6)(a) No later than October 1 each year, each school district shall submit to the De-  
25 partment of Education a report that identifies the percentage of students who failed to sub-  
26 mit the certification required under this section for the previous school year.

27 (b) No later than December 1 each year, the department shall summarize the reports  
28 received under paragraph (a) of this subsection and submit the summary to the interim  
29 legislative committees on education and to the dental director appointed by the Oregon  
30 Health Authority.

31 (7) The State Board of Education, in consultation with the Oregon Health Policy Board  
32 and the Oregon Board of Dentistry, shall adopt by rule any standards for the implementation  
33 of this section.

34 **SECTION 2.** (1) Section 1 of this 2015 Act becomes operative on July 1, 2016.

35 (2) Section 1 of this 2015 Act first applies to the 2016-2017 school year.

36 (3) For the purpose of section 1 (6) of this 2015 Act:

37 (a) The first report required under section 1 (6)(a) of this 2015 Act must be submitted to  
38 the Department of Education no later than October 1, 2017.

39 (b) The first report required under section 1 (6)(b) of this 2015 Act must be submitted to  
40 the interim legislative committees on education and to the dental director appointed by the  
41 Oregon Health Authority no later than December 1, 2017.

42 **SECTION 3.** The State Board of Education, in consultation with the Oregon Health Policy  
43 Board and the Oregon Board of Dentistry, may adopt rules or take any action before the  
44 operative date specified in section 2 of this 2015 Act that is necessary to enable the board  
45 to exercise, on or after the operative date specified in section 2 of this 2015 Act, all the du-

1 **ties, functions and powers conferred on the board by section 1 of this 2015 Act.**

2 **SECTION 4.** ORS 326.580 is amended to read:

3 326.580. (1) As used in this section, "educational institution" means:

4 (a) An "educational institution" as defined in ORS 326.575.

5 (b) A state agency.

6 (c) A local correctional facility.

7 (2) The State Board of Education may adopt by rule standards for the content and format of an  
8 Oregon electronic student record. An Oregon electronic student record may be used to transfer  
9 student record information from one educational institution to another.

10 (3) The board may define the Oregon electronic student record to constitute a full and complete  
11 copy of the official student permanent record, student education record, student vision health  
12 record, **student dental health record** and certificate of immunization status that are required by  
13 state and federal law.

14 (4) The standards established by the board shall include procedures and criteria for participation  
15 in the Oregon electronic student record program by educational institutions. An educational insti-  
16 tution may apply to the Department of Education for a certificate of participation in the Oregon  
17 electronic student record program.

18 (5) An educational institution that is approved for participation in the Oregon electronic student  
19 record program by the Department of Education:

20 (a) Shall not be required to forward by mail or other means physical items such as original  
21 documents or photocopies to a receiving educational institution that also is approved for partic-  
22 ipation in the program. This paragraph does not apply to special education records that are specif-  
23 ically required by federal law to be physically transferred.

24 (b) May elect to designate the Oregon electronic student record as the official student record.

25 (c) Shall retain the official student record in compliance with state and federal law.

26 **SECTION 5.** ORS 680.020 is amended to read:

27 680.020. (1) It is unlawful for any person not otherwise authorized by law to practice dental  
28 hygiene or purport to be a dental hygienist without a valid license to practice dental hygiene issued  
29 by the Oregon Board of Dentistry.

30 (2) The requirements of this section do not apply to:

31 (a) Dental hygienists licensed in another state making a clinical presentation sponsored by a  
32 bona fide dental or dental hygiene society or association or an accredited dental or dental hygiene  
33 education program approved by the board.

34 (b) Bona fide students of dental hygiene who engage in clinical studies during the period of their  
35 enrollment and as a part of the course of study in an Oregon dental hygiene education program. The  
36 program must be accredited by the Commission on Dental Accreditation of the American Dental  
37 Association, or its successor agency, if any, and approved by the board. The clinical study may be  
38 conducted on the premises of the program or in a clinical setting located off the premises. The fa-  
39 cility, the instructional staff, and the course of study at the off-premises location must meet mini-  
40 mum requirements prescribed by the rules of the board, and the clinical study at the off-premises  
41 location must be performed under the direct supervision of a member of the faculty.

42 (c) Bona fide students of dental hygiene who engage in community-based or clinical studies as  
43 an elective or required rotation in a clinical setting located in Oregon during the period of their  
44 enrollment and as a part of the course of study in a dental hygiene education program located out-  
45 side of Oregon. The program must be accredited by the Commission on Dental Accreditation of the

1 American Dental Association or its successor agency. The community-based or clinical studies must:

2 (A) Meet minimum requirements prescribed by the rules of the board; and

3 (B) Be performed under the direct supervision of a member of the faculty of the Oregon Health  
4 and Science University School of Dentistry or another Oregon institution with an accredited dental  
5 hygiene education program approved by the board.

6 (d) Students of dental hygiene or graduates of dental hygiene programs who engage in clinical  
7 studies as part of a course of study or continuing education course offered by an institution with a  
8 dental or dental hygiene program. The program must be accredited by the Commission on Dental  
9 Accreditation of the American Dental Association or its successor agency.

10 (e) Candidates who are preparing for licensure examination to practice dental hygiene and  
11 whose application has been accepted by the board or its agent, if such clinical preparation is con-  
12 ducted in a clinic located on premises approved for that purpose by the board and if the procedures  
13 are limited to examination-only.

14 (f) Dental hygienists practicing in the discharge of official duties as employees of the United  
15 States Government and any of its agencies.

16 (g) Instructors of dental hygiene, whether full- or part-time, while exclusively engaged in teach-  
17 ing activities and while employed in accredited dental hygiene educational programs.

18 (h) Dental hygienists employed by public health agencies who are not engaged in direct delivery  
19 of clinical dental hygiene services to patients.

20 (i) Counselors and health assistants who have been trained in the application of fluoride  
21 varnishes to the teeth of children and who apply fluoride varnishes only to the teeth of children  
22 enrolled in or receiving services from the Women, Infants and Children Program, the Oregon  
23 prekindergarten program or a federal Head Start grant program.

24 **(j) Persons acting in accordance with rules adopted by the State Board of Education un-  
25 der section 1 of this 2015 Act to provide dental screenings to students.**

26 [(j)] **(k) Dental hygienists licensed in another state and in good standing, while practicing dental  
27 hygiene without compensation for no more than five consecutive days in any 12-month period, pro-  
28 vided the dental hygienist submits an application to the [board] Oregon Board of Dentistry at least  
29 10 days before practicing dental hygiene under this paragraph and the application is approved by  
30 the board.**

31 **SECTION 6. This 2015 Act being necessary for the immediate preservation of the public  
32 peace, health and safety, an emergency is declared to exist, and this 2015 Act takes effect  
33 on its passage.**

34

# House Bill 3326

Sponsored by Representative HAYDEN

## SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure as introduced.

Directs Oregon Board of Dentistry, Oregon Medical Board and Oregon State Board of Nursing to adopt rules regulating use of in-office sedation services.  
Declares emergency, effective on passage.

### A BILL FOR AN ACT

1 Relating to in-office sedation services; and declaring an emergency.

2 **Be It Enacted by the People of the State of Oregon:**

3 **SECTION 1. (1) The Oregon Board of Dentistry, the Oregon Medical Board and the**  
4 **Oregon State Board of Nursing shall, in consultation with each other, adopt rules regarding**  
5 **the use of in-office sedation services by licensed professionals regulated by the boards for**  
6 **dental and surgical procedures.**

7  
8 **(2) The rules adopted by the boards must permit licensed professionals regulated by the**  
9 **boards to administer in-office sedation services only to patients classified as physical status**  
10 **1 and physical status 2 by the American Society of Anesthesiologists.**

11 **(3) The rules adopted by the Oregon Board of Dentistry and the Oregon Medical Board**  
12 **must permit only a dentist as defined in ORS 679.010 or a physician as defined in ORS 677.010**  
13 **who has admitting privileges at a health care facility in this state to administer in-office**  
14 **sedation services to patients classified as physical status 3 by the American Society of**  
15 **Anesthesiologists.**

16 **SECTION 2. (1) Section 1 of this 2015 Act becomes operative on January 1, 2016.**

17 **(2) The Oregon Board of Dentistry, the Oregon Medical Board and the Oregon State**  
18 **Board of Nursing may take any action before the operative date specified in subsection (1)**  
19 **of this section that is necessary to enable the boards to exercise, on or after the operative**  
20 **date specified in subsection (1) of this section, all of the duties, functions and powers con-**  
21 **ferred on the boards by section 1 of this 2015 Act.**

22 **SECTION 3. This 2015 Act being necessary for the immediate preservation of the public**  
23 **peace, health and safety, an emergency is declared to exist, and this 2015 Act takes effect**  
24 **on its passage.**

25

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**NOTE:** Matter in boldfaced type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted.  
New sections are in boldfaced type.

LC 3414

**Enrolled**  
**House Bill 5014**

Introduced and printed pursuant to House Rule 12.00. Pre-session filed (at the request of Oregon Department of Administrative Services).

CHAPTER .....

**AN ACT**

Relating to the financial administration of the Oregon Board of Dentistry; and declaring an emergency.

**Be It Enacted by the People of the State of Oregon:**

**SECTION 1.** Notwithstanding any other law limiting expenditures, the amount of \$3,010,692 is established for the biennium beginning July 1, 2015, as the maximum limit for payment of expenses from fees, moneys or other revenues, including Miscellaneous Receipts, but excluding lottery funds and federal funds, collected or received by the Oregon Board of Dentistry.

**SECTION 2.** This 2015 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2015 Act takes effect July 1, 2015.

Passed by House May 7, 2015

.....  
Timothy G. Sekerak, Chief Clerk of House

.....  
Tina Kotek, Speaker of House

Passed by Senate May 19, 2015

.....  
Peter Courtney, President of Senate

Received by Governor:

.....M.,....., 2015

Approved:

.....M.,....., 2015

.....  
Kate Brown, Governor

Filed in Office of Secretary of State:

.....M.,....., 2015

.....  
Jeanne P. Atkins, Secretary of State

**Enrolled**  
**Senate Bill 301**

Sponsored by Senators GIROD, MONNES ANDERSON; Senator STEINER HAYWARD (Pre-session filed.)

CHAPTER .....

AN ACT

Relating to expanded practice dental hygienists; creating new provisions; amending ORS 679.010 and 680.205; and declaring an emergency.

**Be It Enacted by the People of the State of Oregon:**

**SECTION 1.** ORS 679.010 is amended to read:

679.010. As used in this chapter and ORS 680.010 to 680.205, unless the context requires otherwise:

(1) "Dental assistant" means a person who, under the supervision of a dentist, renders assistance to a dentist, dental hygienist, dental technician or another dental assistant or renders assistance under the supervision of a dental hygienist providing dental hygiene.

(2) "Dental hygiene" means that portion of dentistry that includes the rendering of educational, preventive and therapeutic dental services and diagnosis and treatment planning for such services. "Dental hygiene" includes, but is not limited to, **prediagnostic risk assessment**, scaling, root planing, curettage, the application of sealants and fluoride and any related intraoral or extraoral procedure required in the performance of such services.

(3) "Dental hygienist" means a person who, under the supervision of a dentist, practices dental hygiene.

(4) "Dental technician" means that person who, at the authorization of a dentist, makes, provides, repairs or alters oral prosthetic appliances and other artificial materials and devices which are returned to a dentist and inserted into the human oral cavity or which come in contact with its adjacent structures and tissues.

(5) "Dentist" means a person who may perform any intraoral or extraoral procedure required in the practice of dentistry.

(6) "Dentist of record" means a dentist that either authorizes treatment for, supervises treatment of or provides treatment for a patient in a dental office or clinic owned or operated by an institution as described in ORS 679.020 (3).

(7) "Dentistry" means the healing art which is concerned with the examination, diagnosis, treatment planning, treatment, care and prevention of conditions within the human oral cavity and maxillofacial region and conditions of adjacent or related tissues and structures. The practice of dentistry includes but is not limited to the cutting, altering, repairing, removing, replacing or repositioning of hard or soft tissues and other acts or procedures as determined by the Oregon Board of Dentistry and included in the curricula of dental schools accredited by the Commission on Dental Accreditation of the American Dental Association, post-graduate training programs or continuing education courses.

(8) "Direct supervision" means supervision requiring that a dentist diagnose the condition to be treated, that a dentist authorize the procedure to be performed, and that a dentist remain in the dental treatment room while the procedures are performed.

(9) "Expanded practice dental hygienist" means a dental hygienist who performs dental hygiene services in accordance with ORS 680.205 as authorized by an expanded practice dental hygienist permit issued by the board under ORS 680.200.

(10) "General supervision" means supervision requiring that a dentist authorize the procedures by standing orders, practice agreements or collaboration agreements, but not requiring that a dentist be present when the authorized procedures are performed. The authorized procedures may also be performed at a place other than the usual place of practice of the dentist.

(11) "Indirect supervision" means supervision requiring that a dentist authorize the procedures and that a dentist be on the premises while the procedures are performed.

**SECTION 2.** ORS 680.205 is amended to read:

680.205. (1) An expanded practice dental hygienist may render all services within the scope of practice of dental hygiene, as defined in ORS 679.010, without the supervision of a dentist and as authorized by the expanded practice dental hygienist permit to:

(a) Patients or residents of the following facilities or programs who, due to age, infirmity or disability, are unable to receive regular dental hygiene treatment:

(A) Nursing homes as defined in ORS 678.710;

(B) Adult foster homes as defined in ORS 443.705;

(C) Residential care facilities as defined in ORS 443.400;

(D) Adult congregate living facilities as defined in ORS 441.525;

(E) Mental health residential programs administered by the Oregon Health Authority;

(F) Facilities for persons with mental illness, as those terms are defined in ORS 426.005;

(G) Facilities for persons with developmental disabilities, as those terms are defined in ORS 427.005;

(H) Local correctional facilities and juvenile detention facilities as those terms are defined in ORS 169.005, regional correctional facilities as defined in ORS 169.620, youth correction facilities as defined in ORS 420.005, youth care centers as defined in ORS 420.855, and Department of Corrections institutions as defined in ORS 421.005; or

(I) Public and nonprofit community health clinics.

(b) Adults who are homebound.

(c) Students or enrollees of nursery schools and day care programs and their siblings under 18 years of age, Job Corps and similar employment training facilities, primary and secondary schools, including private schools and public charter schools, and persons entitled to benefits under the Women, Infants and Children Program.

(d) Patients in hospitals, medical clinics, medical offices or offices operated or staffed by nurse practitioners, physician assistants or midwives.

(e) Patients whose income is less than the federal poverty level.

(f) Other populations that the Oregon Board of Dentistry determines are underserved or lack access to dental hygiene services.

(2) **Unless different criteria for referral of a patient or resident to a dentist are included in an agreement described in subsection (3) of this section**, at least once each calendar year, an expanded practice dental hygienist shall refer each patient or resident to a dentist who is available to treat the patient or resident.

(3) An expanded practice dental hygienist may render the services described in paragraphs (a) to (d) of this subsection to the patients described in subsection (1) of this section if the expanded practice dental hygienist has entered into an agreement in a format approved by the board with a dentist licensed under ORS chapter 679. The agreement must set forth the agreed-upon scope of the dental hygienist's practice with regard to:

(a) Administering local anesthesia;

(b) Administering temporary restorations without excavation;

(c) Prescribing prophylactic antibiotics and nonsteroidal anti-inflammatory drugs specified in the agreement; and

(d) [Overall dental risk assessment and] Referral parameters.

(4) This section does not authorize an expanded practice dental hygienist to administer nitrous oxide except under the indirect supervision of a dentist licensed under ORS chapter 679.

(5) An expanded practice dental hygienist may assess the need for and appropriateness of sealants, apply sealants and write prescriptions for all applications of fluoride in which fluoride is applied or supplied to patients.

(6) An expanded practice dental hygienist must also procure all other permits or certificates required by the board under ORS 679.250.

**SECTION 3. The amendments to ORS 679.010 and 680.205 by sections 1 and 2 of this 2015 Act apply to agreements entered into on or after the effective date of this 2015 Act.**

**SECTION 4. This 2015 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2015 Act takes effect on its passage.**

Passed by Senate April 16, 2015

.....  
Lori L. Brocker, Secretary of Senate

.....  
Peter Courtney, President of Senate

Passed by House May 28, 2015

.....  
Tina Kotek, Speaker of House

Received by Governor:

.....M.,....., 2015

Approved:

.....M.,....., 2015

.....  
Kate Brown, Governor

Filed in Office of Secretary of State:

.....M.,....., 2015

.....  
Jeanne P. Atkins, Secretary of State

**Enrolled  
Senate Bill 302**

Sponsored by Senator GIROD (Presession filed.)

CHAPTER .....

AN ACT

Relating to prescription drugs used for purposes related to dentistry; amending ORS 679.010; and declaring an emergency.

**Be It Enacted by the People of the State of Oregon:**

**SECTION 1.** ORS 679.010 is amended to read:

679.010. As used in this chapter and ORS 680.010 to 680.205, unless the context requires otherwise:

(1) "Dental assistant" means a person who, under the supervision of a dentist, renders assistance to a dentist, dental hygienist, dental technician or another dental assistant or **who, under the supervision of a dental hygienist**, renders assistance [*under the supervision of*] to a dental hygienist providing dental hygiene.

(2) "Dental hygiene" [*means*] is that portion of dentistry that includes, **but is not limited to:**

(a) The rendering of educational, preventive and therapeutic dental services and diagnosis and treatment planning for such services[. "*Dental hygiene*" includes, *but is not limited to,*];

(b) Scaling, root planing, curettage, the application of sealants and fluoride and any related intraoral or extraoral procedure required in the performance of such services; **and**

(c) **Prescribing, dispensing and administering prescription drugs for the services described in paragraphs (a) and (b) of this subsection.**

(3) "Dental hygienist" means a person who, under the supervision of a dentist, practices dental hygiene.

(4) "Dental technician" means [*that*] a person who, at the authorization of a dentist, makes, provides, repairs or alters oral prosthetic appliances and other artificial materials and devices [*which*] **that** are returned to a dentist and inserted into the human oral cavity or [*which*] **that** come in contact with its adjacent structures and tissues.

(5) "Dentist" means a person who may perform any intraoral or extraoral procedure required in the practice of dentistry.

(6) "Dentist of record" means a dentist that either authorizes treatment for, supervises treatment of or provides treatment for a patient in a dental office or clinic owned or operated by an institution as described in ORS 679.020 (3).

(7)(a) "Dentistry" means the healing art [*which is*] concerned with:

(A) The examination, diagnosis, treatment planning, treatment, care and prevention of conditions within the human oral cavity and maxillofacial region, and of conditions of adjacent or related tissues and structures[.]; **and**

(B) **The prescribing, dispensing and administering of prescription drugs for purposes related to the activities described in subparagraph (A) of this paragraph.**

(b) [The practice of dentistry] "Dentistry" includes, but is not limited to, the cutting, altering, repairing, removing, replacing or repositioning of hard or soft tissues and other acts or procedures as determined by the Oregon Board of Dentistry and included in the curricula of:

(A) Dental schools accredited by the Commission on Dental Accreditation of the American Dental Association[,];

(B) Post-graduate training programs; or

(C) Continuing education courses.

(8) "Direct supervision" means supervision requiring that a dentist diagnose the condition to be treated, that a dentist authorize the procedure to be performed, and that a dentist remain in the dental treatment room while the procedures are performed.

(9) "Expanded practice dental hygienist" means a dental hygienist who performs dental hygiene services in accordance with ORS 680.205 as authorized by an expanded practice dental hygienist permit issued by the board under ORS 680.200.

(10) "General supervision" means supervision requiring that a dentist authorize the procedures by standing orders, practice agreements or collaboration agreements, but not requiring that a dentist be present when the authorized procedures are performed. The authorized procedures may also be performed at a place other than the usual place of practice of the dentist.

(11) "Indirect supervision" means supervision requiring that a dentist authorize the procedures and that a dentist be on the premises while the procedures are performed.

**SECTION 2. This 2015 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2015 Act takes effect on its passage.**

Passed by Senate February 10, 2015

Received by Governor:

.....M.,....., 2015

.....  
Lori L. Brocker, Secretary of Senate

Approved:

.....M.,....., 2015

.....  
Peter Courtney, President of Senate

.....  
Kate Brown, Governor

Passed by House March 16, 2015

Filed in Office of Secretary of State:

.....  
Tina Kotek, Speaker of House

.....M.,....., 2015

.....  
Jeanne P. Atkins, Secretary of State

**Enrolled**  
**Senate Bill 474**

Sponsored by Senator GELSER; Representatives MCLANE, PARRISH (Pre-session filed.)

CHAPTER .....

AN ACT

Relating to dental business entities for children with special needs; amending ORS 679.020; and declaring an emergency.

**Be It Enacted by the People of the State of Oregon:**

**SECTION 1.** ORS 679.020 is amended to read:

679.020. (1) A person may not practice dentistry without a license.

(2) Only a person licensed as a dentist by the Oregon Board of Dentistry may own, operate, conduct or maintain a dental practice, office or clinic in this state.

(3) The restrictions of subsection (2) of this section, as they relate to owning and operating a dental office or clinic, do not apply to a dental office or clinic owned or operated by any of the following:

(a) A labor organization as defined in ORS 243.650 and 663.005 (6), or to any nonprofit organization formed by or on behalf of such labor organization for the purpose of providing dental services. Such labor organization must have had an active existence for at least three years, have a constitution and bylaws, and be maintained in good faith for purposes other than providing dental services.

(b) The School of Dentistry of the Oregon Health and Science University.

(c) Public universities listed in ORS 352.002.

(d) Local governments.

(e) Institutions or programs accredited by the Commission on Dental Accreditation of the American Dental Association to provide education and training.

(f) Nonprofit corporations organized under Oregon law to provide dental services to rural areas and medically underserved populations of migrant, rural community or homeless individuals under 42 U.S.C. 254b or 254c or health centers qualified under 42 U.S.C. 1396d(1)(2)(B) operating in compliance with other applicable state and federal law.

(g) Nonprofit charitable corporations as described in section 501(c)(3) of the Internal Revenue Code and determined by the Oregon Board of Dentistry as providing dental services by volunteer licensed dentists to populations with limited access to dental care at no charge or a substantially reduced charge.

**(h) Nonprofit charitable corporations as described in section 501(c)(3) of the Internal Revenue Code and determined by the Oregon Board of Dentistry as having an existing program that provides medical and dental care to medically underserved children with special needs at an existing single fixed location or multiple mobile locations.**

(4) For the purpose of owning or operating a dental office or clinic, an entity described in subsection (3) of this section must:

(a) Except as provided in ORS 679.022, name an actively licensed dentist as its dental director, who shall be subject to the provisions of ORS 679.140 in the capacity as dental director. The dental director, or an actively licensed dentist designated by the director, shall have responsibility for the clinical practice of dentistry, which includes, but is not limited to:

(A) Diagnosis of conditions within the human oral cavity and its adjacent tissues and structures.

(B) Prescribing drugs that are administered to patients in the practice of dentistry.

(C) The treatment plan of any dental patient.

(D) Overall quality of patient care that is rendered or performed in the practice of dentistry.

(E) Supervision of dental hygienists, dental assistants or other personnel involved in direct patient care and the authorization for procedures performed by them in accordance with the standards of supervision established by statute or by the rules of the board.

(F) Other specific services within the scope of clinical dental practice.

(G) Retention of patient dental records as required by statute or by rule of the board.

(H) Ensuring that each patient receiving services from the dental office or clinic has a dentist of record.

(b) Maintain current records of the names of licensed dentists who supervise the clinical activities of dental hygienists, dental assistants or other personnel involved in direct patient care utilized by the entity. The records must be available to the board upon written request.

(5) Subsections (1) and (2) of this section do not apply to an expanded practice dental hygienist who renders services authorized by a permit issued by the board pursuant to ORS 680.200.

(6) Nothing in this chapter precludes a person or entity not licensed by the board from:

(a) Ownership or leasehold of any tangible or intangible assets used in a dental office or clinic. These assets include real property, furnishings, equipment and inventory but do not include dental records of patients related to clinical care.

(b) Employing or contracting for the services of personnel other than licensed dentists.

(c) Management of the business aspects of a dental office or clinic that do not include the clinical practice of dentistry.

(7) If all of the ownership interests of a dentist or dentists in a dental office or clinic are held by an administrator, executor, personal representative, guardian, conservator or receiver of the estate of a former shareholder, member or partner, the administrator, executor, personal representative, guardian, conservator or receiver may retain the ownership interest for a period of 12 months following the creation of the ownership interest. The board shall extend the ownership period for an additional 12 months upon 30 days' notice and may grant additional extensions upon reasonable request.

**SECTION 2. This 2015 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2015 Act takes effect on its passage.**

**Passed by Senate February 26, 2015**

**Repassed by Senate June 2, 2015**

.....  
Lori L. Brocker, Secretary of Senate

.....  
Peter Courtney, President of Senate

**Passed by House May 28, 2015**

.....  
Tina Kotek, Speaker of House

**Received by Governor:**

.....M.,....., 2015

**Approved:**

.....M.,....., 2015

.....  
Kate Brown, Governor

**Filed in Office of Secretary of State:**

.....M.,....., 2015

.....  
Jeanne P. Atkins, Secretary of State

**A-Engrossed  
Senate Bill 606**

Ordered by the Senate April 7  
Including Senate Amendments dated April 7

Sponsored by Senator MONNES ANDERSON, Representative KENY-GUYER

**SUMMARY**

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure.

Extends dental pilot project by [*five*] **seven** years. Appropriates moneys for pilot project.  
Declares emergency, effective on passage.

**A BILL FOR AN ACT**

Relating to dental pilot project; creating new provisions; amending section 2, chapter 716, Oregon Laws 2011; and declaring an emergency.

**Be It Enacted by the People of the State of Oregon:**

**SECTION 1. In addition to and not in lieu of any other appropriation, there is appropriated to the Oregon Health Authority, for the biennium beginning July 1, 2015, out of the General Fund, the amount of \$\_\_\_\_\_, which may be expended for extending the dental pilot project described in section 1, chapter 716, Oregon Laws 2011.**

**SECTION 2. Section 2, chapter 716, Oregon Laws 2011, is amended to read:**

**Sec. 2. (1) Section 1 [*of this 2011 Act*], chapter 716, Oregon Laws 2011, is repealed on January 2, [*2018*] **2025.****

**(2) Section 17, chapter 716, Oregon Laws 2011, as amended by section 2, chapter 113, Oregon Laws 2013, is repealed January 2, 2025.**

**SECTION 3. This 2015 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2015 Act takes effect on its passage.**

**NOTE:** Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

**Enrolled**  
**Senate Bill 662**

Sponsored by Senator GIROD

CHAPTER .....

AN ACT

Relating to dental instructor licensing; creating new provisions; and amending ORS 679.115.

**Be It Enacted by the People of the State of Oregon:**

**SECTION 1.** ORS 679.115 is amended to read:

679.115. (1) Notwithstanding any other provision of this chapter, the Oregon Board of Dentistry shall issue a dental instructor's license to practice dentistry to any person who furnishes the board with evidence satisfactory to the board that the applicant meets the requirements of subsection (2) of this section.

(2) An applicant for a dental instructor's license must be a full-time instructor of dentistry engaged in dental activities, including but not limited to participation in a faculty practice plan, within the scope of the applicant's employment at Oregon Health and Science University and **either**:

(a) Be a graduate of an accredited dental school; or

(b) If the applicant is not a graduate of an accredited dental school, have a certificate or degree [*in an accredited,*] **showing successful completion of an** advanced dental education program of at least two years' duration from an accredited dental school and:

(A) Be licensed to practice dentistry in another state or a Canadian province;

(B) Have held an instructor's or faculty license to practice dentistry in another state or a Canadian province immediately prior to becoming an instructor of dentistry at Oregon Health and Science University;

(C) Have successfully passed any clinical examination recognized by the board for initial licensure; or

(D) Be certified by the appropriate national certifying examination body in a dental specialty recognized by the American Dental Association.

(3) The board may refuse to issue or renew a dental instructor's license to an applicant or licensee:

(a) Who has been convicted of an offense or disciplined by a dental licensing body in a manner that bears, in the judgment of the board, a demonstrable relationship to the ability of the applicant or licensee to practice dentistry in accordance with the provisions of this chapter;

(b) Who has falsified an application for licensure; or

(c) For cause as described under ORS 679.140 or 679.170.

(4) A person issued a dental instructor's license is restricted to the practice of dentistry for or on behalf of Oregon Health and Science University.

(5) A license issued to an applicant qualifying for a dental instructor's license who is a specialist by virtue of successful completion of an [*accredited*] **advanced** dental education program is restricted to the specialty in which the dentist was trained.

(6) As used in this section, "accredited" means accredited by the Commission on Dental Accreditation of the American Dental Association or its successor agency, if any.

**SECTION 2. The amendments to ORS 679.115 by section 1 of this 2015 Act apply to applications for dental instructors' licenses received by the Oregon Board of Dentistry on or after the effective date of this 2015 Act.**

Passed by Senate March 19, 2015

Received by Governor:

Repassed by Senate June 2, 2015

.....M.,....., 2015

Approved:

.....  
Lori L. Brocker, Secretary of Senate

.....M.,....., 2015

.....  
Peter Courtney, President of Senate

.....  
Kate Brown, Governor

Passed by House May 28, 2015

Filed in Office of Secretary of State:

.....  
Tina Kotek, Speaker of House

.....M.,....., 2015

.....  
Jeanne P. Atkins, Secretary of State

**A-Engrossed**  
**Senate Bill 692**

Ordered by the Senate April 27  
Including Senate Amendments dated April 27

Sponsored by Senator MONNES ANDERSON, Representative KENY-GUYER

**SUMMARY**

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure.

*[Removes sunset on ability of Oregon Health Authority to approve dental pilot projects.]*  
**Provides that providers of dental services to certain patients in dental pilot project approved by Oregon Health Authority are eligible for reimbursement.**  
**Declares emergency, effective on passage.**

**A BILL FOR AN ACT**

1  
2 Relating to dental pilot projects; and declaring an emergency.

3 **Be It Enacted by the People of the State of Oregon:**

4 **SECTION 1. A provider of dental services in a dental pilot project approved by the Oregon**  
5 **Health Authority shall be eligible for reimbursement if the services are provided to a recip-**  
6 **ient of medical assistance.**

7 **SECTION 2. Section 1 of this 2015 Act applies to services provided on or after the effec-**  
8 **tive date of this 2015 Act.**

9 **SECTION 3. Section 1 of this 2015 Act is repealed on January 2, 2025.**

10 **SECTION 4. This 2015 Act being necessary for the immediate preservation of the public**  
11 **peace, health and safety, an emergency is declared to exist, and this 2015 Act takes effect**  
12 **on its passage.**

13

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**NOTE:** Matter in **boldfaced** type in an amended section is new; matter *[italic and bracketed]* is existing law to be omitted. New sections are in **boldfaced** type.

LC 3922

UNFINISHED  
BUSINESS  
&  
RULES

Secretary of State  
Certificate and Order for Filing  
**TEMPORARY ADMINISTRATIVE RULES**  
Generated on June 16, 2015 8:57AM  
D R A F T

Oregon Board of Dentistry	818
Agency and Division	Administrative Rules Chapter Number
Stephen Prisby	stephen.prisby@state.or.us
Rules Coordinator	Email Address
1500 SW 1st Ave., Suite 770, Portland, OR 97201	971-673-3200
Address	Telephone

Adopted on  
06/26/2015 thru 12/22/2015

Effective dates

**RULE CAPTION**

Implement a legislatively approved fee increase of \$75 on all licensees' biennial licensure fees.

Not more than 15 words

**RULEMAKING ACTION**

**ADOPT:**

**AMEND:** 818-001-0087

**SUSPEND:**

**Stat. Auth.:** Stat. Auth.: ORS 679 & 680

**Other Auth.:**

**Stats. Implemented:** Stats. Implemented: ORS 293.445, 679.060, 679.115, 679.120, 679.250, 680.050, 680.075, 680.200 & 680.205

**RULE SUMMARY**

The Board shall increase the biennial license fee by \$75 for all licensees.

**STATEMENT OF NEED AND JUSTIFICATION**

In the Matter of

HB 5014 (the OBD's 2015-17 Budget Bill) was signed by the Governor and authorizes the OBD to implement a \$75 per/licensee biennial fee increase effective July 1, 2015.

A copy of HB 5014, and a draft of OAR 818-001-0087 are available at the OBD's website [www.Oregon.gov/dentistry](http://www.Oregon.gov/dentistry)

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Documents Relied Upon, and where they are available

The purpose of this increase is to allow the Board to hire an additional 1.0 FTE Dental Investigator. For the past 20 years the Board has hired independent contractor dental consultant investigators on a part-time basis to assist with the investigation of dental cases, this process has simply not been able to keep up with the number of complaints as well as the complexity of those complaints.

The Oregon Board of Dentistry will promulgate permanent rules later in 2015, but for now it needs to implement a Temporary Rule to raise fees effective July 1, 2015: Dental License fees will be increased from \$315.00 to \$390.00 and Dental Hygiene License Fees will be increased from \$155.00 to \$230.00

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Need for the Temporary Rule(s)

The increased revenue from the fee increase is to add one full-time dental investigator to the OBD staff. Currently the OBD utilizes part-time investigators, and this is not an effective or efficient way to handle the large investigative case load. Full-time employees can handle more cases efficiently than part-time employees.

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Justification of Temporary Rules

**DIVISION 1  
PROCEDURES**

**818-001-0087**

**Fees**

(1) The Board adopts the following fees:

(a) Biennial License Fees:

(A) Dental — **\$315 390**;

(B) Dental — retired — \$0;

(C) Dental Faculty — **\$260 335**;

(D) Volunteer Dentist — \$0;

(E) Dental Hygiene — **\$155 230**;

(F) Dental Hygiene — retired — \$0;

(G) Volunteer Dental Hygienist — \$0.

(b) Biennial Permits, Endorsements or Certificates:

(A) Nitrous Oxide Permit — \$40;

(B) Minimal Sedation Permit — \$75;

(C) Moderate Sedation Permit — \$75;

(D) Deep Sedation Permit — \$75;

(E) General Anesthesia Permit — \$140;

(F) Radiology — \$75;

(G) Expanded Function Dental Assistant — \$50;

(H) Expanded Function Orthodontic Assistant — \$50;

(I) Instructor Permits — \$40;

(J) Dental Hygiene Restorative Functions Endorsement — \$50;

(K) Restorative Functions Dental Assistant — \$50;

(L) Anesthesia Dental Assistant — \$50;

(M) Dental Hygiene, Expanded Practice Permit — \$75;

(N) Non-Resident Dental Permit - \$100.00;

(c) Applications for Licensure:

(A) Dental — General and Specialty — \$345;

(B) Dental Faculty — \$305;

(C) Dental Hygiene — \$180;

(D) Licensure Without Further Examination — Dental and Dental Hygiene — \$790.

(d) Examinations:

(A) Jurisprudence — \$0;

(B) Dental Specialty:

(i) If only one candidate applies for the exam, a fee of \$2,000.00 will be required at the time of application; and

(ii) If two candidates apply for the exam, a fee of \$1,000.00 will be required at the time of application; and

(iii) If three or more candidates apply for the exam, a fee of \$750.00 will be required at the time of application.

(e) Duplicate Wall Certificates — \$50.

(2) Fees must be paid at the time of application and are not refundable.

(3) The Board shall not refund moneys under \$5.01 received in excess of amounts due or to which the

Board has no legal interest unless the person who made the payment or the person's legal representative requests a refund in writing within one year of payment to the Board.

Stat. Auth.: ORS 679 & 680

Stats. Implemented: ORS 293.445, 679.060, 679.115, 679.120, 679.250, 680.050, 680.075, 680.200 & 680.205

Hist.: DE 6-1985(Temp), f. & ef. 9-20-85; DE 3-1986, f. & ef. 3-31-86; DE 1-1987, f. & ef. 10-7-87; DE 1-1988, f. 12-28-88, cert. ef. 2-1-89, corrected by DE 1-1989, f. 1-27-89, cert. ef. 2-1-89; Renumbered from 818-001-0085; DE 2-1989(Temp), f. & cert. ef. 11-30-89; DE 1-1990, f. 3-19-90, cert. ef. 4-2-90; DE 1-1991(Temp), f. 8-5-91, cert. ef. 8-15-91; DE 2-1991, f. & cert. ef. 12-31-91; DE 1-1992(Temp), f. & cert. ef. 6-24-92; DE 2-1993, f. & cert. ef. 7-13-93; OBD 1-1998, f. & cert. ef. 6-8-98; OBD 3-1999, f. 6-25-99, cert. ef. 7-1-99; Administrative correction, 8-2-99; OBD 5-2000, f. 6-22-00, cert. ef. 7-1-00; OBD 8-2001, f. & cert. ef. 1-8-01; OBD 2-2005, f. 1-31-05, cert. ef. 2-1-05; OBD 2-2007, f. 4-26-07, cert. ef. 5-1-07; OBD 3-2007, f. & cert. ef. 11-30-07; OBD 1-2009(Temp), f. 6-11-09, cert. e. 7-1-09 thru 11-1-09; OBD 2-2009, f. 10-21-09, cert. ef. 11-1-09; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10; OBD 3-2011(Temp), f. 6-30-11, cert. ef. 7-1-11 thru 12-27-11; OBD 4-2011, f. & cert. ef. 11-15-11; OBD 1-2012, f. & cert. ef. 1-27-12; OBD 1-2013, f. 5-15-13, cert. ef. 7-1-13; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14

DRAFT

**Enrolled**  
**House Bill 5014**

Introduced and printed pursuant to House Rule 12.00. Pre-session filed (at the request of Oregon Department of Administrative Services)

CHAPTER .....

AN ACT

Relating to the financial administration of the Oregon Board of Dentistry; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

**SECTION 1.** Notwithstanding any other law limiting expenditures, the amount of \$3,010,692 is established for the biennium beginning July 1, 2015, as the maximum limit for payment of expenses from fees, moneys or other revenues, including Miscellaneous Receipts, but excluding lottery funds and federal funds, collected or received by the Oregon Board of Dentistry.

**SECTION 2.** This 2015 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2015 Act takes effect July 1, 2015.

Passed by House May 7, 2015

.....  
Timothy G. Sekerak, Chief Clerk of House

.....  
Tina Kotek, Speaker of House

Passed by Senate May 19, 2015

.....  
Peter Courtney, President of Senate

Received by Governor:

.....M.,....., 2015

Approved:

.....M.,....., 2015

.....  
Kate Brown, Governor

Filed in Office of Secretary of State:

.....M.,....., 2015

.....  
Jeanne P. Atkins, Secretary of State

## DIVISION 1 PROCEDURES

### 818-001-0002

#### Definitions

As used in OAR Chapter 818:

- (1) "Board" means the Oregon Board of Dentistry, the members of the Board, its employees, its agents, and its consultants.
- (2) "Dental Practice Act" means ORS Chapter 679 and 680.010 to 680.170 and the rules adopted pursuant thereto.
- (3) "Dentist" means a person licensed pursuant to ORS Chapter 679 to practice dentistry.
- (4) "Direct Supervision" means supervision requiring that a dentist diagnose the condition to be treated, that a dentist authorize the procedure to be performed, and that a dentist remain in the dental treatment room while the procedures are performed.
- (5) "General Supervision" means supervision requiring that a dentist authorize the procedures, but not requiring that a dentist be present when the authorized procedures are performed. The authorized procedures may also be performed at a place other than the usual place of practice of the dentist.
- (6) "Hygienist" means a person licensed pursuant to ORS 680.010 to 680.170 to practice dental hygiene.
- (7) "Indirect Supervision" means supervision requiring that a dentist authorize the procedures and that a dentist be on the premises while the procedures are performed.
- (8) "Informed Consent" means the consent obtained following a thorough and easily understood explanation to the patient, or patient's guardian, of the proposed procedures, any available alternative procedures and any risks associated with the procedures. Following the explanation, the licensee shall ask the patient, or the patient's guardian, if there are any questions. The licensee shall provide thorough and easily understood answers to all questions asked.
- (9)(a) "Licensee" means a dentist or hygienist.
- (b) "Volunteer Licensee" is a dentist or dental hygienist licensed according to rule to provide dental health care without receiving or expecting to receive compensation.
- (10) "Limited Access Patient" means a patient who, due to age, infirmity, or handicap is unable to receive regular dental hygiene treatment in a dental office.
- (11) "Specialty." Specialty areas of dentistry are as defined by the American Dental Association, Council on Dental Education. The specialty definitions are added to more clearly define the scope of the practice as it pertains to the specialty areas of dentistry.
  - (a) "Dental Public Health" is the science and art of preventing and controlling dental diseases and promoting dental health through organized community efforts. It is that form of dental practice which serves the community as a patient rather than the individual. It is concerned with the dental health education of the public, with applied dental research, and with the administration of group dental care programs as well as the prevention and control of dental diseases on a community basis.
  - (b) "Endodontics" is the branch of dentistry which is concerned with the morphology, physiology and pathology of the human dental pulp and periradicular tissues. Its study and practice encompass the basic and clinical sciences including biology of the normal pulp, the etiology, diagnosis, prevention and treatment of diseases and injuries of the pulp and associated periradicular conditions.
  - (c) "Oral and Maxillofacial Pathology" is the specialty of dentistry and discipline of pathology that deals with the nature, identification, and management of diseases affecting the oral and maxillofacial regions. It is a science that investigates the causes, processes, and effects of these diseases. The practice of oral pathology includes research and diagnosis of diseases using clinical, radiographic, microscopic, biochemical, or other examinations.

(d) "Oral and Maxillofacial Radiology" is the specialty of dentistry and discipline of radiology concerned with the production and interpretation of images and data produced by all modalities of radiant energy that are used for the diagnosis and management of diseases, disorders and conditions of the oral and maxillofacial region.

(e) "Oral and Maxillofacial Surgery" is the specialty of dentistry which includes the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region.

(f) "Orthodontics and Dentofacial Orthopedics" is the area of dentistry concerned with the supervision, guidance and correction of the growing or mature dentofacial structures, including those conditions that require movement of teeth or correction of malrelationships and malformations of their related structures and the adjustment of relationships between and among teeth and facial bones by the application of forces and/or the stimulation and redirection of functional forces within the craniofacial complex. Major responsibilities of orthodontic practice include the diagnosis, prevention, interception and treatment of all forms of malocclusion of the teeth and associated alterations in their surrounding structures; the design, application and control of functional and corrective appliances; and the guidance of the dentition and its supporting structures to attain and maintain optimum occlusal relations in physiologic and esthetic harmony among facial and cranial structures.

(g) "Pediatric Dentistry" is an age defined specialty that provides both primary and comprehensive preventive and therapeutic oral health care for infants and children through adolescence, including those with special health care needs.

(h) "Periodontics" is the specialty of dentistry which encompasses the prevention, diagnosis and treatment of diseases of the supporting and surrounding tissues of the teeth or their substitutes and the maintenance of the health, function and esthetics of these structures and tissues.

(i) "Prosthodontics" is the branch of dentistry pertaining to the restoration and maintenance of oral functions, comfort, appearance and health of the patient by the restoration of natural teeth and/or the replacement of missing teeth and contiguous oral and maxillofacial tissues with artificial substitutes.

(12) "Full-time" as used in ORS 679.025 and 680.020 is defined by the Board as any student who is enrolled in an institution accredited by the Commission on Dental Accreditation of the American Dental Association or its successor agency in a course of study for dentistry or dental hygiene.

(13) For purposes of ORS 679.020(4)(h) the term "dentist of record" means a dentist that either authorized treatment for, supervised treatment of or provided treatment for the patient in clinical settings of the institution described in 679.020(3).

**(14) "Dental Study Group" as used in ORS 679.050, OAR 818-021-0060 and OAR 818-021-0070 is defined as a group of licensees who come together for clinical and non-clinical educational study for the purpose of maintaining or increasing their competence. This is not meant to be a replacement for residency requirements.**

Stat. Auth.: ORS 679 & 680

Stats. Implemented: ORS 679.010 & 680.010

Hist.: DE 11-1984, f. & ef. 5-17-84; DE 1-1988, f. 12-28-88, cert. ef. 2-1-89; DE 1-1989, f. 1-27-89, cert. ef. 2-1-89; Renumbered from 818-001-0001; DE 3-1997, f. & cert. ef. 8-27-97; OBD 7-2001, f. & cert. ef. 1-8-01; OBD 2-2005, f. 1-31-05, cert. ef. 2-1-05; OBD 1-2006, f. 3-17-06, cert. ef. 4-1-06; OBD 1-2008, f. 11-10-08, cert. ef. 12-1-08; OBD 4-2011, f. & cert., ef. 11-15-11; OBD 1-2013, f. 5-15-13, cert. ef. 7-1-13

**DIVISION 1  
PROCEDURES**

**818-001-0087**

**Fees**

(1) The Board adopts the following fees:

(a) Biennial License Fees:

- (A) Dental — ~~\$315~~ **390**;
- (B) Dental — retired — \$0;
- (C) Dental Faculty — ~~\$260~~ **335**;
- (D) Volunteer Dentist — \$0;
- (E) Dental Hygiene — ~~\$155~~ **230**;
- (F) Dental Hygiene — retired — \$0;
- (G) Volunteer Dental Hygienist — \$0.

(b) Biennial Permits, Endorsements or Certificates:

- (A) Nitrous Oxide Permit — \$40;
- (B) Minimal Sedation Permit — \$75;
- (C) Moderate Sedation Permit — \$75;
- (D) Deep Sedation Permit — \$75;
- (E) General Anesthesia Permit — \$140;
- (F) Radiology — \$75;
- (G) Expanded Function Dental Assistant — \$50;
- (H) Expanded Function Orthodontic Assistant — \$50;
- (I) Instructor Permits — \$40;
- (J) Dental Hygiene Restorative Functions Endorsement — \$50;
- (K) Restorative Functions Dental Assistant — \$50;
- (L) Anesthesia Dental Assistant — \$50;
- (M) Dental Hygiene, Expanded Practice Permit — \$75;
- (N) Non-Resident Dental Permit - \$100.00;

(c) Applications for Licensure:

- (A) Dental — General and Specialty — \$345;
- (B) Dental Faculty — \$305;
- (C) Dental Hygiene — \$180;
- (D) Licensure Without Further Examination — Dental and Dental Hygiene — \$790.

(d) Examinations:

- (A) Jurisprudence — \$0;
- (B) Dental Specialty:
  - (i) If only one candidate applies for the exam, a fee of \$2,000.00 will be required at the time of application; and
  - (ii) If two candidates apply for the exam, a fee of \$1,000.00 will be required at the time of application; and
  - (iii) If three or more candidates apply for the exam, a fee of \$750.00 will be required at the time of application.

(e) Duplicate Wall Certificates — \$50.

(2) Fees must be paid at the time of application and are not refundable.

(3) The Board shall not refund moneys under \$5.01 received in excess of amounts due or to which the

Board has no legal interest unless the person who made the payment or the person's legal representative requests a refund in writing within one year of payment to the Board.

Stat. Auth.: ORS 679 & 680

Stats. Implemented: ORS 293.445, 679.060, 679.115, 679.120, 679.250, 680.050, 680.075, 680.200 & 680.205

Hist.: DE 6-1985(Temp), f. & ef. 9-20-85; DE 3-1986, f. & ef. 3-31-86; DE 1-1987, f. & ef. 10-7-87; DE 1-1988, f. 12-28-88, cert. ef. 2-1-89, corrected by DE 1-1989, f. 1-27-89, cert. ef. 2-1-89; Renumbered from 818-001-0085; DE 2-1989(Temp), f. & cert. ef. 11-30-89; DE 1-1990, f. 3-19-90, cert. ef. 4-2-90; DE 1-1991(Temp), f. 8-5-91, cert. ef. 8-15-91; DE 2-1991, f. & cert. ef. 12-31-91; DE 1-1992(Temp), f. & cert. ef. 6-24-92; DE 2-1993, f. & cert. ef. 7-13-93; OBD 1-1998, f. & cert. ef. 6-8-98; OBD 3-1999, f. 6-25-99, cert. ef. 7-1-99; Administrative correction, 8-2-99; OBD 5-2000, f. 6-22-00, cert. ef. 7-1-00; OBD 8-2001, f. & cert. ef. 1-8-01; OBD 2-2005, f. 1-31-05, cert. ef. 2-1-05; OBD 2-2007, f. 4-26-07, cert. ef. 5-1-07; OBD 3-2007, f. & cert. ef. 11-30-07; OBD 1-2009(Temp), f. 6-11-09, cert. e. 7-1-09 thru 11-1-09; OBD 2-2009, f. 10-21-09, cert. ef. 11-1-09; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10; OBD 3-2011(Temp), f. 6-30-11, cert. ef. 7-1-11 thru 12-27-11; OBD 4-2011, f. & cert. ef. 11-15-11; OBD 1-2012, f. & cert. ef. 1-27-12; OBD 1-2013, f. 5-15-13, cert. ef. 7-1-13; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14

DRAFT

**DIVISION 12  
STANDARDS OF PRACTICE**

**818-012-0030**

**Unprofessional Conduct**

The Board finds that in addition to the conduct set forth in ORS 679.140(2), a licensee engages in unprofessional conduct if the licensee does or permits any person to:

- (1) Attempt to obtain a fee by fraud or misrepresentation.
- (2) Obtaining a fee by fraud or misrepresentation.
  - (a) A licensee obtains a fee by fraud if the licensee obtains a fee by knowingly making or permitting any person to make a material, false statement intending that a recipient who is unaware of the truth rely upon the statement.
  - (b) A licensee obtains a fee by misrepresentation if the licensee obtains a fee through making or permitting any person to make a material, false statement.
  - (c) Giving cash discounts and not disclosing them to third party payors is not fraud or misrepresentation.
- (3) Offer rebates, split fees, or commissions for services rendered to a patient to any person other than a partner, employee, or employer.
- (4) Accept rebates, split fees, or commissions for services rendered to a patient from any person other than a partner, employee, or employer.
- (5) Initiate, or engage in, with a patient, any behavior with sexual connotations. The behavior can include but is not limited to, inappropriate physical touching; kissing of a sexual nature; gestures or expressions, any of which are sexualized or sexually demeaning to a patient; inappropriate procedures, including, but not limited to, disrobing and draping practices that reflect a lack of respect for the patient's privacy; or initiating inappropriate communication, verbal or written, including, but not limited to, references to a patient's body or clothing that are sexualized or sexually demeaning to a patient; and inappropriate comments or queries about the professional's or patient's sexual orientation, sexual performance, sexual fantasies, sexual problems, or sexual preferences.
- (6) Engage in an unlawful trade practice as defined in ORS 646.605 to 646.608.
- (7) Fail to present a treatment plan with estimated costs to a patient upon request of the patient or to a patient's guardian upon request of the patient's guardian.
- (8) Misrepresent any facts to a patient concerning treatment or fees.
- (9)(a) Fail to provide a patient or patient's guardian within 14 days of written request:
  - (A) Legible copies of records; and
  - (B) Duplicates of study models and radiographs, photographs or legible copies thereof if the radiographs, photographs or study models have been paid for.
- (b) The dentist may require the patient or guardian to pay in advance a fee reasonably calculated to cover the costs of making the copies or duplicates. The dentist may charge a fee not to exceed \$30 for copying 10 or fewer pages of written material and no more than \$0.50 per page for pages 11 through 50 and no more than \$0.25 for each additional page (including records copied from microfilm), plus any postage costs to mail copies requested and actual costs of preparing an explanation or summary of information, if requested. The actual cost of duplicating x-rays may also be charged to the patient. Patient records or summaries may not be withheld from the patient because of any prior unpaid bills, except as provided in (9)(a)(B) of this rule.
- (10) Fail to identify to a patient, patient's guardian, or the Board the name of an employee, employer, contractor, or agent who renders services.
- (11) Use prescription forms pre-printed with any Drug Enforcement Administration number, name of controlled substances, or facsimile of a signature.

(12) Use a rubber stamp or like device to reproduce a signature on a prescription form or sign a blank prescription form.

(13) Order drugs listed on Schedule II of the Drug Abuse Prevention and Control Act, 21 U.S.C. Sec. 812, for office use on a prescription form.

(14) Violate any Federal or State law regarding controlled substances.

(15) Becomes addicted to, or dependent upon, or abuses alcohol, illegal or controlled drugs, or mind altering substances.

(16) Practice dentistry or dental hygiene in a dental office or clinic not owned by an Oregon licensed dentist(s), except for an entity described under ORS 679.020(3) and dental hygienists practicing pursuant to ORS 680.205(1)(2).

(17) Make an agreement with a patient or person, or any person or entity representing patients or persons, or provide any form of consideration that would prohibit, restrict, discourage or otherwise limit a person's ability to file a complaint with the Oregon Board of Dentistry; to truthfully and fully answer any questions posed by an agent or representative of the Board; or to participate as a witness in a Board proceeding.

(18) Fail to maintain at a minimum a current [BLS](#) Health Care Provider **Basic Life Support (BLS)** /Cardio Pulmonary Resuscitation (CPR) training or its equivalent. (Effective January 1, 2015)

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 679 & 680

Stats. Implemented: ORS 679.140(1)(c), 679.140(2), 679.170(6) & 680.100

Hist.: DE 6, f. 8-9-63, ef. 9-11-63; DE 14, f. 1-20-72, ef. 2-10-72; DE 5-1980, f. & ef. 12-26-80; DE 2-1982, f. & ef. 3-19-82; DE 5-1982, f. & ef. 5-26-82; DE 9-1984, f. & ef. 5-17-84;

Renumbered from 818-010-0080; DE 3-1986, f. & ef. 3-31-86; DE 1-1988, f. 12-28-88, cert. ef. 2-1-89; DE 1-1989, f. 1-27-89, cert. ef. 2-1-89; Renumbered from 818-011-0020; DE 1-1990, f. 3-19-90, cert. ef. 4-2-90; DE 2-1997, f. & cert. ef. 2-20-97; OBD 3-1999, f. 6-25-99, cert. ef. 7-1-99; OBD 1-2006, f. 3-17-06, cert. ef. 4-1-06; OBD 1-2007, f. & cert. ef. 3-1-07; OBD 3-2007, f. & cert. ef. 11-30-07; OBD 1-2008, f. 11-10-08, cert. ef. 12-1-08; OBD 2-2009, f. 10-21-09, cert. ef. 11-1-09; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14

**DIVISION 21  
EXAMINATION AND LICENSING**

**818-021-0060**

**Continuing Education - Dentists**

- (1) Each dentist must complete 40 hours of continuing education every two years. Continuing education (C.E.) must be directly related to clinical patient care or the practice of dental public health.
- (2) Dentists must maintain records of successful completion of continuing education for at least four licensure years consistent with the licensee's licensure cycle. (A licensure year for dentists is April 1 through March 31.) The licensee, upon request by the Board, shall provide proof of successful completion of continuing education courses.
- (3) Continuing education includes:
  - (a) Attendance at lectures, [dental](#) study [clubs](#) [groups](#), college post-graduate courses, or scientific sessions at conventions.
  - (b) Research, graduate study, teaching or preparation and presentation of scientific sessions. No more than 12 hours may be in teaching or scientific sessions. (Scientific sessions are defined as scientific presentations, table clinics, poster sessions and lectures.)
  - (c) Correspondence courses, videotapes, distance learning courses or similar self-study course, provided that the course includes an examination and the dentist passes the examination.
  - (d) Continuing education credit can be given for volunteer pro bono dental services provided in the state of Oregon; community oral health instruction at a public health facility located in the state of Oregon; authorship of a publication, book, chapter of a book, article or paper published in a professional journal; participation on a state dental board, peer review, or quality of care review procedures; successful completion of the National Board Dental Examinations taken after initial licensure; a recognized specialty examination taken after initial licensure; or test development for clinical dental, dental hygiene or specialty examinations. No more than 6 hours of credit may be in these areas.
- (4) At least three hours of continuing education must be related to medical emergencies in a dental office. No more than four hours of Practice Management and Patient Relations may be counted toward the C.E. requirement in any renewal period.
- (5) All dentists licensed by the Oregon Board of Dentistry will complete a one-hour pain management course specific to Oregon provided by the Pain Management Commission of the Oregon Health Authority. All applicants or licensees shall complete this requirement by January 1, 2010 or within 24 months of the first renewal of the dentist's license.
- (6) At least 2 hours of continuing education must be related to infection control. (Effective January 1, 2015.)

Stat. Auth.: ORS 679

Stats. Implemented: ORS 679.250(9)

Hist.: DE 3-1987, f. & ef. 10-15-87; DE 4-1987(Temp), f. & ef. 11-25-87; DE 1-1988, f. 12-28-88, cert. ef. 2-1-89; DE 1-1989, f. 1-27-89, cert. ef. 2-1-89; Renumbered from 818-020-0072; DE 1-1990, f. 3-19-90, cert. ef. 4-2-90; OBD 9-2000, f. & cert. ef. 7-28-00; OBD 16-2001, f. 12-7-01, cert. ef. 4-1-02; OBD 3-2007, f. & cert. ef. 11-30-07; OBD 2-2009, f. 10-21-09, cert. ef. 11-1-09; OBD 3-2011(Temp), f. 6-30-11, cert. ef. 7-1-11 thru 12-27-11; OBD 4-2011, f. & cert. ef. 11-15-11; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14

**DIVISION 21  
EXAMINATION AND LICENSING**

**818-021-0070**

**Continuing Education - Dental Hygienists**

- (1) Each dental hygienist must complete 24 hours of continuing education every two years. An Expanded Practice Permit Dental Hygienist shall complete a total of 36 hours of continuing education every two years. Continuing education (C.E.) must be directly related to clinical patient care or the practice of dental public health.
- (2) Dental hygienists must maintain records of successful completion of continuing education for at least four licensure years consistent with the licensee's licensure cycle. (A licensure year for dental hygienists is October 1 through September 30.) The licensee, upon request by the Board, shall provide proof of successful completion of continuing education courses.
- (3) Continuing education includes:
  - (a) Attendance at lectures, [dental](#) study ~~clubs~~ [groups](#), college post-graduate courses, or scientific sessions at conventions.
  - (b) Research, graduate study, teaching or preparation and presentation of scientific sessions. No more than six hours may be in teaching or scientific sessions. (Scientific sessions are defined as scientific presentations, table clinics, poster sessions and lectures.)
  - (c) Correspondence courses, videotapes, distance learning courses or similar self-study course, provided that the course includes an examination and the dental hygienist passes the examination.
  - (d) Continuing education credit can be given for volunteer pro bono dental hygiene services provided in the state of Oregon; community oral health instruction at a public health facility located in the state of Oregon; authorship of a publication, book, chapter of a book, article or paper published in a professional journal; participation on a state dental board, peer review, or quality of care review procedures; successful completion of the National Board Dental Hygiene Examination, taken after initial licensure; or test development for clinical dental hygiene examinations. No more than 6 hours of credit may be in these areas.
- (4) At least three hours of continuing education must be related to medical emergencies in a dental office. No more than two hours of Practice Management and Patient Relations may be counted toward the C.E. requirement in any renewal period.
- (5) Dental hygienists who hold a Nitrous Oxide Permit must meet the requirements contained in OAR 818-026-0040(9) for renewal of the Nitrous Oxide Permit.
- (6) At least 2 hours of continuing education must be related to infection control. (Effective January 1, 2015.)

Stat. Auth.: ORS 679

Stats. Implemented: ORS 279.250(9)

Hist.: DE 3-1987, f. & ef. 10-15-87; DE 1-1988, f. 12-28-88, cert. ef. 2-1-89; DE 1-1989, f. 1-27-89, cert. ef. 2-1-89; Renumbered from 818-020-0073; DE 1-1990, f. 3-19-90, cert. ef. 4-2-90; OBD 9-2000, f. & cert. ef. 7-28-00; OBD 2-2002, f. 7-31-02, cert. ef. 10-1-02; OBD 2-2004, f. 7-12-04, cert. ef. 7-15-04; OBD 3-2007, f. & cert. ef. 11-30-07; OBD 2-2009, f. 10-21-09, cert. ef. 11-1-09; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10; OBD 3-2011(Temp), f. 6-30-11, cert. ef. 7-1-11 thru 12-27-11; OBD 4-2011, f. & cert. ef. 11-15-11; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14

## DIVISION 26 ANESTHESIA

### 818-026-0010

#### Definitions

As used in these rules:

- (1) "Anesthesia Monitor" means a person trained in monitoring patients under sedation and capable of assisting with procedures, problems and emergency incidents that may occur as a result of the sedation or secondary to an unexpected medical complication.
- (2) "Anxiolysis" means the diminution or elimination of anxiety.
- (3) "General Anesthesia" means a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.
- (4) "Deep Sedation" means a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.
- (5) "Moderate Sedation" means a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.
- (6) "Minimal Sedation" means minimally depressed level of consciousness, produced by non-intravenous pharmacological methods, ~~an enteral drug~~, that retains the patient's ability to independently and continuously maintain an airway and respond normally to tactile stimulation and verbal command. When the intent is minimal sedation for adults, the appropriate initial dosing of a single non-intravenous pharmacological method ~~enteral drug~~ is no more than the maximum recommended dose (MRD) of a drug that can be prescribed for unmonitored home use. Nitrous oxide/oxygen may be used in combination with a single non-intravenous pharmacological method ~~enteral drug~~ in minimal sedation.
- (7) "Nitrous Oxide Sedation" means an induced, controlled state of minimal sedation, produced solely by the inhalation of a combination of nitrous oxide and oxygen in which the patient retains the ability to independently and continuously maintain an airway and to respond purposefully to physical stimulation and to verbal command.
- (8) "Maximum recommended dose" (MRD) means ~~maximum Food and Drug Administration-recommended dose of a drug, as printed in Food and Drug Administration-Approved labeling for unmonitored dose~~ maximum Food and Drug Administration (FDA) recommended dose of a drug, as printed in FDA approved labeling for unmonitored home use.
- (9) "Incremental Dosing" means during minimal sedation, administration of multiple doses of a drug until a desired effect is reached, but not to exceed the maximum recommended dose (MRD).
- (10) "Supplemental Dosing" means during minimal sedation, supplemental dosing is a single additional dose of the initial drug that is necessary for prolonged procedures. The supplemental dose should not exceed one-half of the initial dose and should not be administered until the dentist has determined the clinical half-life of the initial dosing has passed. The total aggregate dose must not exceed 1.5x the MRD on the day of treatment.

**(11) “Enteral Route” means administration of medication via the gastrointestinal tract. Administration by mouth, sublingual (dissolving under the tongue), intranasal and rectal administration are included.**

**(12) “Parenteral Route” means administration of medication via a route other than enteral. Administration by intravenous, intramuscular, and subcutaneous routes are included.**

Stat. Auth.: ORS 679

Stats. Implemented: ORS 679.250(7) & 679.250(10)

Hist.: OBD 2-1998, f. 7-13-98, cert. ef. 10-1-98; OBD 6-1999, f. 6-25-99, cert. ef. 7-1-99; OBD 3-2003, f. 9-15-03, cert. ef. 10-1-03; OBD 1-2005, f. 1-28-05, cert. ef. 2-1-05; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10

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**DIVISION 26  
ANESTHESIA**

**818-026-0020**

**Presumption of Degree of Central Nervous System Depression**

(1) In any hearing where a question exists as to the degree of central nervous system depression a licensee has induced (i.e., general anesthesia, deep sedation, moderate sedation, minimal sedation or nitrous oxide sedation), the Board may base its findings on, among other things, the types, dosages and routes of administration of drugs administered to the patient and what result can reasonably be expected from those drugs in those dosages and routes administered in a patient of that physical and psychological status.

(2) The following drugs are conclusively presumed to produce general anesthesia and may only be used by a licensee holding a General Anesthesia Permit:

(a) Ultra short acting barbiturates including, but not limited to, sodium methohexital, thiopental, thiamylal;

(b) Alkylphenols — propofol (Diprivan) including precursors or derivatives;

(c) Neuroleptic agents;

(d) Dissociative agents — ketamine;

(e) Etomidate; **and**

**(f) Rapidly acting steroid preparations; and**

**(g) (f)** Volatile inhalational agents.

(3) No permit holder shall have more than one person under any form of sedation or general anesthesia at the same time exclusive of recovery.

(4) A licensee that does not hold a Moderate, Deep Sedation or General Anesthesia Permit may not administer, for purpose of anxiolysis or sedation, Benzodiazepines or narcotics in children under 6 years of age.

Stat. Auth.: ORS 679 & 680

Stats. Implemented: ORS 679.250(7) & 679.250(10)

Hist.: OBD 2-1998, f. 7-13-98, cert. ef. 10-1-98; OBD 6-1999, f. 6-25-99, cert. ef. 7-1-99; OBD 3-2003, f. 9-15-03, cert. ef. 10-1-03; OBD 1-2005, f. 1-28-05, cert. ef. 2-1-05; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10; OBD 1-2013, f. 5-15-13, cert. ef. 7-1-13

**DIVISION 26  
ANESTHESIA**

**818-026-0030**

**Requirement for Anesthesia Permit, Standards and Qualifications of an Anesthesia Monitor**

- (1) A permit holder who administers sedation shall assure that drugs, drug dosages, and/or techniques used to produce sedation shall carry a margin of safety wide enough to prevent unintended deeper levels of sedation.
- (2) No licensee shall induce central nervous system sedation or general anesthesia without first having obtained a permit under these rules for the level of anesthesia being induced.
- (3) A licensee may be granted a permit to administer sedation or general anesthesia with documentation of training/education and/or competency in the permit category for which the licensee is applying by any one the following:
  - (a) Initial training/education in the permit category for which the applicant is applying shall be completed no more than two years immediately prior to application for sedation or general anesthesia permit; or
  - (b) If greater than two years but less than five years since completion of initial training/education, an applicant must document completion of all continuing education that would have been required for that anesthesia/permit category during that five year period following initial training; or
  - (c) If greater than two years but less than five years since completion of initial training/education, immediately prior to application for sedation or general anesthesia permit, current competency or experience must be documented by completion of a comprehensive review course approved by the Board in the permit category to which the applicant is applying and must consist of at least one-half (50%) of the hours required by rule for Nitrous Oxide, Minimal Sedation, Moderate Sedation and General Anesthesia Permits. Deep Sedation and General Anesthesia Permits will require at least 120 hours of general anesthesia training.
  - (d) An applicant for sedation or general anesthesia permit whose completion of initial training/education is greater than five years immediately prior to application, may be granted a sedation or general anesthesia permit by submitting documentation of the requested permit level from another state or jurisdiction where the applicant is also licensed to practice dentistry or dental hygiene, and provides documentation of the completion of at least 25 cases in the requested level of sedation or general anesthesia in the 12 months immediately preceding application; or
  - (e) Demonstration of current competency to the satisfaction of the Board that the applicant possesses adequate sedation or general anesthesia skill to safely deliver sedation or general anesthesia services to the public.
- (4) Persons serving as anesthesia monitors in a dental office shall maintain current certification in Health Care Provider Basic Life Support (BLS)/Cardio Pulmonary Resuscitation (CPR) training, or its equivalent, shall be trained in monitoring patient vital signs, and be competent in the use of monitoring and emergency equipment appropriate for the level of sedation utilized. (The term "competent" as used in these rules means displaying special skill or knowledge derived from training and experience.)
- ~~(5) A licensee holding an anesthesia permit shall at all times hold a current Health Care Provider BLS/CPR level certificate or its equivalent, or a current Advanced Cardiac Life Support (ACLS) Certificate or Pediatric Advanced Life Support (PALS) Certificate, whichever is appropriate for the patient being sedated.~~
- (5) A licensee holding a nitrous or minimal sedation permit, shall at all times maintain a current BLS for Healthcare Providers certificate or its equivalent. A licensee holding an anesthesia permit for moderate sedation, at all times maintains a current BLS for

Healthcare Providers certificate or its equivalent, and a current Advanced Cardiac Life Support (ACLS) Certificate or Pediatric Advanced Life Support (PALS) Certificate, whichever is appropriate for the patient being sedated. If a licensee sedates only patients under the age of 12, only PALS is required. If a licensee sedates only patients age 12 and older, only ACLS is required. If a licensee sedates patients younger than 12 years of age as well as older than 12 years of age, both ACLS and PALS are required. For licensees with a moderate sedation permit only, successful completion of the American Dental Association's course "Recognition and Management of Complications during Minimal and Moderate Sedation" at least every two years may be substituted for ACLS, but not for PALS.

(a) Advanced Cardiac Life Support (ACLS) and or Pediatric Advanced Life Support (PALS) do not serve as a substitute for Health Care Provider Basic Life Support (BLS).

(6) When a dentist utilizes a single dose oral agent to achieve anxiolysis only, no anesthesia permit is required.

(7) The applicant for an anesthesia permit must pay the appropriate permit fee, submit a completed Board-approved application and consent to an office evaluation.

(8) Permits shall be issued to coincide with the applicant's licensing period.

Stat. Auth.: ORS 679 & 680

Stats. Implemented: ORS 679.250

Hist.: OBD 2-1998, f. 7-13-98, cert. ef. 10-1-98; OBD 3-2003, f. 9-15-03, cert. ef. 10-1-03; OBD 1-2005, f. 1-28-05, cert. ef. 2-1-05; OBD 2-2005, f. 1-31-05, cert. ef. 2-1-05; OBD 3-2005, f. 10-26-05, cert. ef. 11-1-05; OBD 1-2008, f. 11-10-08, cert. ef. 12-1-08; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10; OBD 2-2012, f. 6-14-12, cert. ef. 7-1-12

**DIVISION 26  
ANESTHESIA**

**818-026-0040**

**Qualifications, Standards Applicable, and Continuing Education Requirements for Anesthesia Permits: Nitrous Oxide Sedation**

- (1) The Board shall issue a Nitrous Oxide Permit to an applicant who:
- (a) Is either a licensed dentist or licensed hygienist in the State of Oregon;
  - (b) Holds a valid and current Health Care Provider BLS/CPR level certificate, or its equivalent; and
  - (c) Has completed a training course of at least 14 hours of instruction in the use of nitrous oxide from a dental school or dental hygiene program accredited by the Commission on Dental Accreditation of the American Dental Association, or as a postgraduate.
- (2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedure and during recovery:
- (a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow delivery of appropriate care in an emergency situation;
  - (b) An operating table or chair which permits the patient to be positioned so that the patient's airway can be maintained, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;
  - (c) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;
  - (d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;
  - (e) An oxygen delivery system with adequate full face masks and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;
  - (f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system; and
  - (g) Sphygmomanometer and stethoscope and/or automatic blood pressure cuff.
- (3) Before inducing nitrous oxide sedation, a permit holder shall:
- (a) Evaluate the patient;
  - (b) Give instruction to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian;
  - (c) Certify that the patient is an appropriate candidate for nitrous oxide sedation; and
  - (d) Obtain informed consent from the patient or patient's guardian for the anesthesia. The obtaining of the informed consent shall be documented in the patient's record.
- (4) If a patient chronically takes a medication which can have sedative side effects, including, but not limited to, a narcotic or benzodiazepine, the practitioner shall determine if the additive sedative effect of nitrous oxide would put the patient into a level of sedation deeper than nitrous oxide. If the practitioner determines it is possible that providing nitrous oxide to such a patient would result in minimal sedation, a minimal sedation permit would be required.**
- ~~(4)~~ **(5)** A patient under nitrous oxide sedation shall be visually monitored by the permit holder or by an anesthesia monitor at all times. The patient shall be monitored as to response to verbal stimulation, oral mucosal color and preoperative and postoperative vital signs.
- ~~(5)~~ **(6)** The permit holder or anesthesia monitor shall record the patient's condition. The record must include documentation of all medications administered with dosages, time intervals and route of administration.

~~(6)~~ **(7)** The person administering the nitrous oxide sedation may leave the immediate area after initiating the administration of nitrous oxide sedation only if a qualified anesthesia monitor is continuously observing the patient.

~~(7)~~ **(8)** The permit holder shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:

(a) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;

(b) The patient can talk and respond coherently to verbal questioning;

(c) The patient can sit up unaided or without assistance;

(d) The patient can ambulate with minimal assistance; and

(e) The patient does not have nausea, vomiting or dizziness.

~~(8)~~ **(9)** The permit holder shall make a discharge entry in the patient's record indicating the patient's condition upon discharge.

~~(9)~~ **(10)** Permit renewal. In order to renew a Nitrous Oxide Permit, the permit holder must provide proof of having a current Health Care Provider BLS/CPR level certificate, or its equivalent. In addition, Nitrous Oxide Permit holders must also complete four (4) hours of continuing education in one or more of the following areas every two years: sedation, nitrous oxide, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current Health Care Provider BLS/CPR level certification, or its equivalent, may not be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060 and 818-021-0070.

Stat. Auth.: ORS 679 & 680

Stats. Implemented: ORS 679.250(7) & (10)

Hist.: OBD 2-1998, f. 7-13-98, cert. ef. 10-1-98; OBD 3-2003, f. 9-15-03, cert. ef. 10-1-03; OBD 1-2005, f. 1-28-05, cert. ef. 2-1-05; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10

**DIVISION 26  
ANESTHESIA**

**818-026-0050**

**Minimal Sedation Permit**

Minimal sedation and nitrous oxide sedation.

(1) The Board shall issue a Minimal Sedation Permit to an applicant who:

(a) Is a licensed dentist in Oregon;

(b) ~~Maintains~~ ~~Holds~~ a valid and current ~~Health Care Provider~~ BLS/~~CPR level~~ for Health Care Providers certificate, or its equivalent; and

(c) Completion of a comprehensive training program consisting of at least 16 hours of training and satisfies the requirements of the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students (2007) at the time training was commenced or postgraduate instruction was completed, or the equivalent of that required in graduate training programs, in sedation, recognition and management of complications and emergency care; or

(d) In lieu of these requirements, the Board may accept equivalent training or experience in minimal sedation anesthesia.

(2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedures and during recovery:

(a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two individuals to freely move about the patient;

(b) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;

(c) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;

(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;

(e) An oxygen delivery system with adequate full facemask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;

(f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system;

(g) Sphygmomanometer, stethoscope, pulse oximeter, and/or automatic blood pressure cuff; and

(h) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the drugs used, vasopressors, corticosteroids, bronchodilators, antihistamines, antihypertensives and anticonvulsants.

(3) Before inducing minimal sedation, a dentist who induces minimal sedation shall:

(a) Evaluate the patient;

(b) Give written preoperative and postoperative instructions to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian;

(c) Certify that the patient is an appropriate candidate for minimal sedation; and

(d) Obtain written informed consent from the patient or patient's guardian for the anesthesia.

The obtaining of the informed consent shall be documented in the patient's record.

(4) No permit holder shall have more than one person under minimal sedation at the same time.

(5) While the patient is being treated under minimal sedation, an anesthesia monitor shall be present in the room in addition to the treatment provider. The anesthesia monitor may be the dental assistant.

- (a) After training, a dental assistant, when directed by a dentist, may administer oral sedative agents or anxiolysis agents calculated and dispensed by a dentist under the direct supervision of a dentist.
- (6) A patient under minimal sedation shall be visually monitored at all times, including recovery phase. The dentist or anesthesia monitor shall monitor and record the patient's condition.
- (7) The patient shall be monitored as follows:
- (a) Color of mucosa, skin or blood must be evaluated continually. Patients must have continuous monitoring using pulse oximetry. The patient's response to verbal stimuli, blood pressure, heart rate, and respiration shall be monitored and documented if they can reasonably be obtained.
- (b) A discharge entry shall be made by the dentist in the patient's record indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.
- (8) The dentist shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:
- (a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;
- (b) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;
- (c) The patient can talk and respond coherently to verbal questioning;
- (d) The patient can sit up unaided;
- (e) The patient can ambulate with minimal assistance; and
- (f) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.
- (g) A dentist shall not release a patient who has undergone minimal sedation except to the care of a responsible third party.
- (9) Permit renewal. In order to renew a Minimal Sedation Permit, the permit holder must provide documentation of having a current ~~Health Care Provider~~ BLS/CPR level Health Care Providers certificate, or its equivalent. In addition, Minimal Sedation Permit holders must also complete four (4) hours of continuing education in one or more of the following areas every two years: sedation, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current ~~Health Care Provider~~ BLS/CPR level Health Care Providers certification, or its equivalent, may not be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060.

Stat. Auth.: ORS 679

Stats. Implemented: ORS 679.250(7) & 679.250(10)

Hist.: OBD 6-1999, f. 6-25-99, cert. ef. 7-1-99; Administrative correction 8-12-99; OBD 3-2003, f. 9-15-03, cert. ef. 10-1-03; OBD 1-2005, f. 1-28-05, cert. ef. 2-1-05; OBD 2-2005, f. 1-31-05, cert. ef. 2-1-05; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14

**DIVISION 26  
ANESTHESIA**

**818-026-0060**

**Moderate Sedation Permit**

Moderate sedation, minimal sedation, and nitrous oxide sedation.

(1) The Board shall issue or renew a Moderate Sedation Permit to an applicant who:

(a) Is a licensed dentist in Oregon;

(b) In addition to a current BLS Health Care Provider certification or its equivalent, ~~E~~ either holds a current Advanced Cardiac Life Support (ACLS) and/or Pediatric Advanced Life Support (PALS) certificate, whichever is appropriate for the patient being sedated. ~~or s~~ Successfully completes ion of the American Dental Association's course "Recognition and Management of Complications during Minimal and Moderate Sedation" at least every two years may be substituted for ACLS, but not for PALS; and

(c) Satisfies one of the following criteria:

(A) Completion of a comprehensive training program in enteral and/or parenteral sedation that satisfies the requirements described in Part V of the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students (2007) at the time training was commenced.

(i) Enteral Moderate Sedation requires a minimum of 24 hours of instruction plus management of at least 10 dental patient experiences by the enteral and/or enteral-nitrous oxide/oxygen route.

(ii) Parenteral Moderate Sedation requires a minimum of 60 hours of instruction plus management of at least 20 dental patients by the intravenous route.

(B) Completion of an ADA accredited postdoctoral training program (e.g., general practice residency) which affords comprehensive and appropriate training necessary to administer and manage parenteral sedation, commensurate with these Guidelines.

(C) In lieu of these requirements, the Board may accept equivalent training or experience in moderate sedation anesthesia.

(2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedures and during recovery:

(a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two individuals to freely move about the patient;

(b) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;

(c) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;

(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;

(e) An oxygen delivery system with adequate full face mask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;

(f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system;

(g) A recovery area that has available oxygen, adequate lighting, suction and electrical outlets. The recovery area can be the operating room;

(h) Sphygmomanometer, precordial/pretracheal stethoscope, capnograph, pulse oximeter, oral and nasopharyngeal airways, laryngeal mask airways, intravenous fluid administration equipment, automated external defibrillator (AED); and

- (i) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the drugs used, vasopressors, corticosteroids, bronchodilators, antihistamines, antihypertensives and anticonvulsants.
- (3) No permit holder shall have more than one person under moderate sedation, minimal sedation, or nitrous oxide sedation at the same time.
- (4) During the administration of moderate sedation, and at all times while the patient is under moderate sedation, an anesthesia monitor, and one other person holding a **Health-Care Provider BLS/CPR—certificate or its equivalent** Health Care Provider certification or its equivalent, shall be present in the operatory, in addition to the dentist performing the dental procedures.
- (5) Before inducing moderate sedation, a dentist who induces moderate sedation shall:
- (a) Evaluate the patient and document, using the American Society of Anesthesiologists Patient Physical Status Classifications, that the patient is an appropriate candidate for moderate sedation;
- (b) Give written preoperative and postoperative instructions to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian; and
- (c) Obtain written informed consent from the patient or patient's guardian for the anesthesia.
- (6) A patient under moderate sedation shall be visually monitored at all times, including the recovery phase. The dentist or anesthesia monitor shall monitor and record the patient's condition.
- (7) The patient shall be monitored as follows:
- (a) Patients must have continuous monitoring using pulse oximetry, and End-tidal CO<sub>2</sub> monitors. Patients with cardio vascular disease shall have continuous ECG monitoring. The patient's blood pressure, heart rate, and respiration shall be recorded at regular intervals but at least every 15 minutes, and these recordings shall be documented in the patient record. The record must also include documentation of preoperative and postoperative vital signs, all medications administered with dosages, time intervals and route of administration. If this information cannot be obtained, the reasons shall be documented in the patient's record. A patient under moderate sedation shall be continuously monitored and shall not be left alone while under sedation;
- (b) During the recovery phase, the patient must be monitored by an individual trained to monitor patients recovering from moderate sedation.
- (8) A dentist shall not release a patient who has undergone moderate sedation except to the care of a responsible third party.
- (a) When a reversal agent is administered, the doctor shall document justification for its use and how the recovery plan was altered.
- (9) The dentist shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:
- (a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;
- (b) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;
- (c) The patient can talk and respond coherently to verbal questioning;
- (d) The patient can sit up unaided;
- (e) The patient can ambulate with minimal assistance; and
- (f) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.
- (10) A discharge entry shall be made by the dentist in the patient's record indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.
- (11) After adequate training, an assistant, when directed by a dentist, may dispense oral medications that have been prepared by the dentist permit holder for oral administration to a

patient under direct supervision or introduce additional anesthetic agents into an infusion line under the direct visual supervision of a dentist.

(12) Permit renewal. In order to renew a Moderate Sedation Permit, the permit holder must provide documentation of having current [BLS for Health Care Providers certification or its equivalent](#) and ACLS [and](#)/or PALS certification or current certification of successful completion of the American Dental Association's course "Recognition and Management of Complications during Minimal and Moderate Sedation" and must complete 14 hours of continuing education in one or more of the following areas every two years: sedation, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current ACLS or PALS certification or successful completion of the American Dental Association's course "Recognition and Management of Complications during Minimal and Moderate Sedation" may be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 679

Stats. Implemented: ORS 679.250(7) & 679.250(10)

Hist.: OBD 2-1998, f. 7-13-98, cert. ef. 10-1-98; OBD 1-1999, f. 2-26-99, cert. ef. 3-1-99; OBD 6-1999, f. 6-25-99, cert. ef. 7-1-99; Administrative correction 8-12-99; OBD 2-2000(Temp), f. 5-22-00, cert. ef. 5-22-00 thru 11-18-00; OBD 2-2001, f. & cert. ef. 1-8-01; OBD 3-2003, f. 9-15-03, cert. ef. 10-1-03; OBD 1-2005, f. 1-28-05, cert. ef. 2-1-05; OBD 2-2005, f. 1-31-05, cert. ef. 2-1-05; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10; OBD 2-2011(Temp), f. 5-9-11, cert. ef. 6-1-11 thru 1-27-11; OBD 4-2011, f. & cert. ef. 11-15-11; OBD 1-2013, f. 5-15-13, cert. ef. 7-1-13; OBD 3-2013, f. 10-24-13, cert. ef. 1-1-14; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14

**DIVISION 26  
ANESTHESIA**

**818-026-0065**

**Deep Sedation**

Deep sedation, moderate sedation, minimal sedation, and nitrous oxide sedation.

(1) The Board shall issue a Deep Sedation Permit to a licensee who holds a Class 3 Permit on or before July 1, 2010 who:

(a) Is a licensed dentist in Oregon; and

(b) [In addition to a current BLS Health Care Provider certification or its equivalent](#) **H** holds a current Advanced Cardiac Life Support (ACLS) [and/or](#) Pediatric Advanced Life Support (PALS) certificate, whichever is appropriate for the patient being sedated.

(2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedures and during recovery:

(a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two individuals to freely move about the patient;

(b) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;

(c) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;

(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;

(e) An oxygen delivery system with adequate full face mask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;

(f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system;

(g) A recovery area that has available oxygen, adequate lighting, suction and electrical outlets. The recovery area can be the operating room;

(h) Sphygmomanometer, precordial/pretracheal stethoscope, capnograph, pulse oximeter, electrocardiograph monitor (ECG), automated external defibrillator (AED), oral and nasopharyngeal airways, laryngeal mask airways, intravenous fluid administration equipment; and

(i) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the drugs used, vasopressors, corticosteroids, bronchodilators, antihistamines, antihypertensives and anticonvulsants.

(3) No permit holder shall have more than one person under deep sedation, moderate sedation, minimal sedation, or nitrous oxide sedation at the same time.

(4) During the administration of deep sedation, and at all times while the patient is under deep sedation, an anesthesia monitor, and one other person holding a Health Care Provider BLS/CPR level certificate or its equivalent, shall be present in the operatory, in addition to the dentist performing the dental procedures.

(5) Before inducing deep sedation, a dentist who induces deep sedation shall:

(a) Evaluate the patient and document, using the American Society of Anesthesiologists Patient Physical Status Classifications, that the patient is an appropriate candidate for deep sedation;

(b) Give written preoperative and postoperative instructions to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian; and

(c) Obtain written informed consent from the patient or patient's guardian for the anesthesia.

(6) A patient under deep sedation shall be visually monitored at all times, including the recovery phase. The dentist or anesthesia monitor shall monitor and record the patient's condition.

(7) The patient shall be monitored as follows:

(a) Patients must have continuous monitoring using pulse oximetry, electrocardiograph monitors (ECG) and End-tidal CO<sub>2</sub> monitors. The patient's heart rhythm shall be continuously monitored and the patient's blood pressure, heart rate, and respiration shall be recorded at regular intervals but at least every 5 minutes, and these recordings shall be documented in the patient record. The record must also include documentation of preoperative and postoperative vital signs, all medications administered with dosages, time intervals and route of administration. If this information cannot be obtained, the reasons shall be documented in the patient's record. A patient under deep sedation shall be continuously monitored;

(b) Once sedated, a patient shall remain in the operatory for the duration of treatment until criteria for transportation to recovery have been met.

(c) During the recovery phase, the patient must be monitored by an individual trained to monitor patients recovering from deep sedation.

(8) A dentist shall not release a patient who has undergone deep sedation except to the care of a responsible third party.

**(a) When a reversal agent is administered, the doctor shall document justification for its use and how the recovery plan was altered.**

(9) The dentist shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:

(a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;

(b) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;

(c) The patient can talk and respond coherently to verbal questioning;

(d) The patient can sit up unaided;

(e) The patient can ambulate with minimal assistance; and

(f) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.

(10) A discharge entry shall be made by the dentist in the patient's record indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.

(11) After adequate training, an assistant, when directed by a dentist, may administer oral sedative agents calculated by a dentist or introduce additional anesthetic agents into an infusion line under the direct visual supervision of a dentist.

(12) Permit renewal. In order to renew a Deep Sedation Permit, the permit holder must provide documentation of having current **BLS for Health Care Providers certification or its equivalent and** ACLS **and/or** PALS certification and must complete 14 hours of continuing education in one or more of the following areas every two years: sedation, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current ACLS or PALS certification may be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 679

Stats. Implemented: ORS 679.250(7) & 679.250(10)

Hist. : OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10; OBD 2-2011(Temp), f. 5-9-11, cert. ef. 6-1-11 thru 1-27-11; OBD 4-2011, f. & cert. ef. 11-15-11; OBD 1-2013, f. 5-15-13, cert. ef. 7-1-13; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14

**DIVISION 26  
ANESTHESIA**

**818-026-0070**

**General Anesthesia Permit**

General anesthesia, deep sedation, moderate sedation, minimal sedation and nitrous oxide sedation.

(1) The Board shall issue a General Anesthesia Permit to an applicant who:

(a) Is a licensed dentist in Oregon;

(b) [In addition to a current BLS Health Care Provider certification or its equivalent](#), [H](#) holds a current Advanced Cardiac Life Support (ACLS) [and/or](#) Pediatric Advanced Life Support (PALS) certificate, whichever is appropriate for the patient being sedated, and

(c) Satisfies one of the following criteria:

(A) Completion of an advanced training program in anesthesia and related subjects beyond the undergraduate dental curriculum that satisfies the requirements described in the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students (2007) consisting of a minimum of 2 years of a postgraduate anesthesia residency at the time training was commenced.

(B) Completion of any ADA accredited postdoctoral training program, including but not limited to Oral and Maxillofacial Surgery, which affords comprehensive and appropriate training necessary to administer and manage general anesthesia, commensurate with these Guidelines.

(C) In lieu of these requirements, the Board may accept equivalent training or experience in general anesthesia.

(2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedure and during recovery:

(a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least three individuals to freely move about the patient;

(b) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;

(c) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;

(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;

(e) An oxygen delivery system with adequate full face mask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;

(f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system;

(g) A recovery area that has available oxygen, adequate lighting, suction and electrical outlets. The recovery area can be the operating room;

(h) Sphygmomanometer, precordial/pretracheal stethoscope, capnograph, pulse oximeter, electrocardiograph monitor (ECG), automated external defibrillator (AED), oral and nasopharyngeal airways, laryngeal mask airways, intravenous fluid administration equipment; and

(i) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the drugs used, vasopressors, corticosteroids, bronchodilators, intravenous medications for treatment of cardiac arrest, narcotic antagonist, antihistaminic, antiarrhythmics, antihypertensives and anticonvulsants.

(3) No permit holder shall have more than one person under general anesthesia, deep sedation, moderate sedation, minimal sedation or nitrous oxide sedation at the same time.

(4) During the administration of deep sedation or general anesthesia, and at all times while the patient is under deep sedation or general anesthesia, an anesthesia monitor, and one other person holding a ~~Health Care Provider BLS/GPR certificate or its equivalent~~ Health Care Provider certification or its equivalent, shall be present in the operatory in addition to the dentist performing the dental procedures.

(5) Before inducing deep sedation or general anesthesia the dentist who induces deep sedation or general anesthesia shall:

(a) Evaluate the patient and document, using the American Society of Anesthesiologists Patient Physical Status Classifications, that the patient is an appropriate candidate for general anesthesia or deep sedation;

(b) Give written preoperative and postoperative instructions to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian; and

(c) Obtain written informed consent from the patient or patient's guardian for the anesthesia.

(6) A patient under deep sedation or general anesthesia shall be visually monitored at all times, including recovery phase. A dentist who induces deep sedation or general anesthesia or anesthesia monitor trained in monitoring patients under deep sedation or general anesthesia shall monitor and record the patient's condition on a contemporaneous record.

(7) The patient shall be monitored as follows:

(a) Patients must have continuous monitoring of their heart rate, heart rhythm, oxygen saturation levels and respiration using pulse oximetry, electrocardiograph monitors (ECG) and End-tidal CO<sub>2</sub> monitors. The patient's blood pressure, heart rate and oxygen saturation shall be assessed every five minutes, and shall be contemporaneously documented in the patient record. The record must also include documentation of preoperative and postoperative vital signs, all medications administered with dosages, time intervals and route of administration. The person administering the anesthesia and the person monitoring the patient may not leave the patient while the patient is under deep sedation or general anesthesia;

(b) Once sedated, a patient shall remain in the operatory for the duration of treatment until criteria for transportation to recovery have been met.

(c) During the recovery phase, the patient must be monitored, including the use of pulse oximetry, by an individual trained to monitor patients recovering from general anesthesia.

(8) A dentist shall not release a patient who has undergone deep sedation or general anesthesia except to the care of a responsible third party.

(a) When a reversal agent is administered, the doctor shall document justification for its use and how the recovery plan was altered.

(9) The dentist shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:

(a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;

(b) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;

(c) The patient can talk and respond coherently to verbal questioning;

(d) The patient can sit up unaided;

(e) The patient can ambulate with minimal assistance; and

(f) The patient does not have nausea or vomiting and has minimal dizziness.

(10) A discharge entry shall be made in the patient's record by the dentist indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.

(11) After adequate training, an assistant, when directed by a dentist, may introduce additional anesthetic agents to an infusion line under the direct visual supervision of a dentist.

(12) Permit renewal. In order to renew a General Anesthesia Permit, the permit holder must provide documentation of having current [BLS Health Care Provider certification or its equivalent and ACLS and/or PALS certification](#) and complete 14 hours of continuing education in one or more of the following areas every two years: deep sedation and/or general anesthesia, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, pharmacology of drugs and agents used in anesthesia. Training taken to maintain current ACLS or PALS certification may be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 679

Stats. Implemented: ORS 679.250(7) & 679.250(10)

Hist.: OBD 2-1998, f. 7-13-98, cert. ef. 10-1-98; OBD 6-1999, f. 6-25-99, cert. ef. 7-1-99; Administrative correction 8-12-99; OBD 2-2000(Temp), f. 5-22-00, cert. ef. 5-22-00 thru 11-18-00; Administrative correction 6-21-01; OBD 3-2003, f. 9-15-03, cert. ef. 10-1-03; OBD 1-2005, f. 1-28-05, cert. ef. 2-1-05; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10; OBD 2-2011(Temp), f. 5-9-11, cert. ef. 6-1-11 thru 1-27-11; OBD 4-2011, f. & cert. ef. 11-15-11; OBD 1-2013, f. 5-15-13, cert. ef. 7-1-13; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14

**DIVISION 26  
ANESTHESIA**

**818-026-0080**

**Standards Applicable When a Dentist Performs Dental Procedures and a Qualified Provider Induces Anesthesia**

(1) A dentist who does not hold an anesthesia permit may perform dental procedures on a patient who receives anesthesia induced by a physician anesthesiologist licensed by the Oregon Board of Medical Examiners, another Oregon licensed dentist holding an appropriate anesthesia permit, or a Certified Registered Nurse Anesthetist (CRNA) licensed by the Oregon Board of Nursing.

(2) A dentist who does not hold a Nitrous Oxide Permit for nitrous oxide sedation may perform dental procedures on a patient who receives nitrous oxide induced by an Oregon licensed dental hygienist holding a Nitrous Oxide Permit.

(3) A dentist who performs dental procedures on a patient who receives anesthesia induced by a physician anesthesiologist, another dentist holding an anesthesia permit, a CRNA, or a dental hygienist who induces nitrous oxide sedation, shall hold a current and valid Health Care Provider BLS/CPR level certificate, or equivalent, and have the same personnel, facilities, equipment and drugs available during the procedure and during recovery as required of a dentist who has a permit for the level of anesthesia being provided.

**(4) A dentist, a dental hygienist or an Expanded Functions Dental Assistant (EFDA) who performs procedures on a patient who receives anesthesia induced by a physician anesthesiologist, another dentist holding an anesthesia permit or a CRNA shall not schedule or treat patients for non emergent care during the period of time of the sedation procedure.**

**(5) Once anesthetized, a patient shall remain in the operatory for the duration of treatment until criteria for transportation to recovery have been met.**

~~(4)~~ **(6)** The qualified anesthesia provider who induces anesthesia shall monitor the patient's condition until the patient is discharged and record the patient's condition at discharge in the patient's dental record as required by the rules applicable to the level of anesthesia being induced. The anesthesia record shall be maintained in the patient's dental record and is the responsibility of the dentist who is performing the dental procedures.

~~(5)~~ **(7)** A dentist who intends to use the services of a qualified anesthesia provider as described in section 1 above, shall notify the Board in writing of his/her intent. Such notification need only be submitted once every licensing period.

Stat. Auth.: ORS 679

Stats. Implemented: ORS 679.250(7) & (10)

Hist.: OBD 2-1998, f. 7-13-98, cert. ef. 10-1-98; OBD 3-2003, f. 9-15-03, cert. ef. 10-1-03; OBD 1-2005, f. 1-28-05, cert. ef. 2-1-05; OBD 1-2006, f. 3-17-06, cert. ef. 4-1-06; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10

**DIVISION 26  
ANESTHESIA**

**818-026-0110**

**Office Evaluations**

(1) By obtaining an anesthesia permit or by using the services of a physician anesthesiologist, CRNA, an Oregon licensed dental hygienist or another dentist to administer anesthesia, a licensee consents to in-office evaluations by the Oregon Board of Dentistry, to assess competence in central nervous system anesthesia and to determine compliance with rules of the Board.

(2) The in-office evaluation ~~shall~~ **may** include, **but is not be limited to:**

(a) Observation of one or more cases of anesthesia to determine the appropriateness of technique and adequacy of patient evaluation and care;

(b) Inspection of facilities, equipment, drugs and records; and

(c) Confirmation that personnel are adequately trained, hold current Health Care Provider Basic Life Support level certification, or its equivalent, and are competent to respond to reasonable emergencies that may occur during the administration of anesthesia or during the recovery period.

(3) The evaluation shall be performed by a team appointed by the Board and shall include:

(a) A permit holder who has the same type of license as the licensee to be evaluated and who holds a current anesthesia permit in the same class or in a higher class than that held by the licensee being evaluated,

(b) A member of the Board's Anesthesia Committee; and

(c) Any licensed dentist, deemed appropriate by the Board President, may serve as team leader and shall be responsible for organizing and conducting the evaluation and reporting to the Board.

(4) The Board shall give written notice of its intent to conduct an office evaluation to the licensee to be evaluated. Licensee shall cooperate with the evaluation team leader in scheduling the evaluation which shall be held no sooner than 30 days after the date of the notice or later than 90 days after the date of the notice.

Stat. Auth.: ORS 679 & 680

Stats. Implemented: ORS 679.250(7) & (10)

Hist.: OBD 2-1998, f. 7-13-98, cert. ef. 10-1-98; OBD 3-2003, f. 9-15-03, cert. ef. 10-1-03; OBD 1-2005, f. 1-28-05, cert. ef. 2-1-05; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10

**DIVISION 35  
DENTAL HYGIENE**

**818-035-0025**

**Prohibitions**

A dental hygienist may not:

- (1) Diagnose and treatment plan other than for dental hygiene services;
- (2) Cut hard or soft tissue with the exception of root planing;
- (3) Extract any tooth;
- (4) Fit or adjust any correctional or prosthetic appliance except as provided by OAR 818-035-0030(1)(h);
- (5) **Prescribe, Administer** or dispense any drugs except as provided by OAR 818-035-0030, 818-035-0040, 818-026-0060(11) and 818-026-0070(11);
- (6) Place, condense, carve or cement permanent restorations except as provided in OAR 818-035-0072, or operatively prepare teeth;
- (7) Irrigate or medicate canals; try in cones, or ream, file or fill canals;
- (8) Use the behavior management techniques of Hand Over Mouth (HOM) or Hand Over Mouth Airway Restriction (HOMAR) on any patient.
- (9) Place or remove healing caps or healing abutments, except under direct supervision.
- (10) Place implant impression copings, except under direct supervision.

Stat. Auth.: ORS 679 & 680

Stats. Implemented: ORS 679.020(1)

Hist.: DE 2-1992, f. & cert. ef. 6-24-92; DE 2-1997, f. & cert. ef. 2-20-97; OBD 7-1999, f. 6-25-99, cert. ef. 7-1-99; OBD 2-2000(Temp), f. 5-22-00, cert. ef. 5-22-00 thru 11-18-00; OBD 2-2001, f. & cert. ef. 1-8-01; OBD 15-2001, f. 12-7-01, cert. ef. 1-1-02; OBD 2-2005, f. 1-31-05, cert. ef. 2-1-05; OBD 2-2007, f. 4-26-07, cert. ef. 5-1-07; OBD 1-2008, f. 11-10-08, cert. ef. 12-1-08; OBD 4-2011, f. & cert. ef. 11-15-11; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14

**DIVISION 35  
DENTAL HYGIENE**

**818-035-0030**

**Additional Functions of Dental Hygienists**

- (1) In addition to functions set forth in ORS 679.010, a dental hygienist may perform the following functions under the general supervision of a licensed dentist:
- (a) Make preliminary intra-oral and extra-oral examinations and record findings;
  - (b) Place periodontal dressings;
  - (c) Remove periodontal dressings or direct a dental assistant to remove periodontal dressings;
  - (d) Perform all functions delegable to dental assistants and expanded function dental assistants providing that the dental hygienist is appropriately trained;
  - (e) Administer and dispense antimicrobial solutions or other antimicrobial agents in the performance of dental hygiene functions.
  - (f) **Prescribe, Administer** and dispense fluoride, fluoride varnish, antimicrobial solutions for mouth rinsing or other non-systemic antimicrobial agents.
  - (g) Use high-speed handpieces to polish restorations and to remove cement and adhesive material.
  - (h) Apply temporary soft relines to complete dentures for the purpose of tissue conditioning.
  - (i) Perform all aspects of teeth whitening procedures.
- (2) A dental hygienist may perform the following functions at the locations and for the persons described in ORS 680.205(1) and (2) without the supervision of a dentist:
- (a) Determine the need for and appropriateness of sealants or fluoride; and
  - (b) Apply sealants or fluoride.

Stat. Auth.: ORS 679 & 680

Stats. Implemented: ORS 679.025(2)(j)

Hist.: DE 5-1984, f. & ef. 5-17-84; DE 3-1986, f. & ef. 3-31-86; DE 2-1992, f. & cert. ef. 6-24-92; OBD 7-1999, f. 6-25-99, cert. ef. 7-1-99; OBD 1-2001, f. & cert. ef. 1-8-01; OBD 15-2001, f. 12-7-01, cert. ef. 1-1-02; OBD 1-2004, f. 5-27-04, cert. ef. 6-1-04; OBD 2-2005, f. 1-31-05, cert. ef. 2-1-05; OBD 3-2007, f. & cert. ef. 11-30-07; OBD 1-2008, f. 11-10-08, cert. ef. 12-1-08; OBD 2-2009, f. 10-21-09, cert. ef. 11-1-09; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14

**DIVISION 35  
DENTAL HYGIENE**

**818-035-0065**

**Expanded Practice of Dental Hygiene Permit**

The Board shall issue an Expanded Practice Permit to a Dental Hygienist who holds an unrestricted Oregon license, and completes an application approved by the Board, pays the permit fee, and

- (1) Certifies on the application that the dental hygienist has completed at least 2,500 hours of supervised dental hygiene clinical practice, or clinical teaching hours, and also completes 40 hours of courses chosen by the applicant in clinical dental hygiene or public health sponsored by continuing education providers approved by the Board; or
- (2) Certifies on the application that the dental hygienist has completed a course of study, before or after graduation from a dental hygiene program, that includes at least 500 hours of dental hygiene practice on patients described in ORS 680.205; and
- (3) Provides the Board with a copy of the applicant's current professional liability policy or declaration page which will include, the policy number and expiration date of the policy.
- (4) Notwithstanding OAR 818-035-0025(1), prior to performing any dental hygiene services an Expanded Practice Dental Hygienist shall examine the patient, gather data, interpret the data to determine the patient's dental hygiene treatment needs and formulate a patient care plan.
- (5) An Expanded Practice Dental Hygienist may render the services described in paragraphs 6(a) to (d) of this rule to the patients described in ORS 680.205(1) if the Expanded Practice Dental Hygienist has entered into a written collaborative agreement in a format approved by the Board with a dentist licensed under ORS Chapter 679.
- (6) The collaborative agreement must set forth the agreed upon scope of the dental hygienist's practice with regard to:
  - (a) Administering local anesthesia;
  - (b) Administering temporary restorations without excavation;
  - (c) Prescribing prophylactic antibiotics and nonsteroidal anti-inflammatory drugs; and
  - (d) **Overall dental risk assessment and r**Referral parameters.
- (7) The collaborative agreement must comply with ORS 679.010 to 680.990.
- (8) From the date this rule is effective, the Board has the authority to grant a Limited Access Permit through December 31, 2011, pursuant to ORS 680.200.

Stat. Auth.: ORS 680

Stats. Implemented: ORS 680.200

Hist.: OBD 1-1998, f. & cert. ef. 6-8-98; OBD 3-2001, f. & cert. ef. 1-8-01; OBD 3-2007, f. & cert. ef. 11-30-07; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10; OBD 4-2011, f. & cert. ef. 11-15-11; OBD 2-2012, f. 6-14-12, cert. ef. 7-1-12

**DIVISION 42  
DENTAL ASSISTING**

**818-042-0040**

**Prohibited Acts**

No licensee may authorize any dental assistant to perform the following acts:

- (1) Diagnose or plan treatment.
- (2) Cut hard or soft tissue.
- (3) Any Expanded Function duty (818-042-0070 and 818-042-0090) or Expanded Orthodontic Function duty (818-042-0100) without holding the appropriate certification.
- (4) Correct or attempt to correct the malposition or malocclusion of teeth except as provided by OAR 818-042-0100.
- (5) Adjust or attempt to adjust any orthodontic wire, fixed or removable appliance or other structure while it is in the patient's mouth.
- (6) Administer **or dispense** any drug except fluoride, topical anesthetic, desensitizing agents, over the counter medications per package instructions or drugs administered pursuant to OAR 818-026-0030(6), OAR 818-026-0050(5)(a) OAR 818-026-0060(11), 818-026-0065(11), 818-026-0070(11) and as provided in 818-042-0070 and 818-042-0115.
- (7) Prescribe any drug.
- (8) Place periodontal packs.
- (9) Start nitrous oxide.
- (10) Remove stains or deposits except as provided in OAR 818-042-0070.
- (11) Use ultrasonic equipment intra-orally except as provided in OAR 818-042-0100.
- (12) Use a high-speed handpiece or any device that is operated by a high-speed handpiece intra-orally.
- (13) Use lasers, except laser-curing lights.
- (14) Use air abrasion or air polishing.
- (15) Remove teeth or parts of tooth structure.
- (16) Cement or bond any fixed prosthetic or orthodontic appliance including bands, brackets, retainers, tooth moving devices, or orthopedic appliances except as provided in 818-042-0100.
- (17) Condense and carve permanent restorative material except as provided in OAR 818-042-0095.
- (18) Place any type of cord subgingivally- except as provided by in OAR 818-042-0090.
- (19) Take jaw registrations or oral impressions for supplying artificial teeth as substitutes for natural teeth, except diagnostic or opposing models or for the fabrication of temporary or provisional restorations or appliances.
- (20) Apply denture relines except as provided in OAR 818-042-0090(2).
- (21) Expose radiographs without holding a current Certificate of Radiologic Proficiency issued by the Board (818-042-0050 and 818-042-0060) except while taking a course of instruction approved by the Oregon Health Authority, Oregon Public Health Division, Office of Environmental Public Health, Radiation Protection Services, or the Oregon Board of Dentistry.
- (22) Use the behavior management techniques known as Hand Over Mouth (HOM) or Hand Over Mouth Airway Restriction (HOMAR) on any patient.
- (23) Perform periodontal probing.
- (24) Place or remove healing caps or healing abutments, except under direct supervision.
- (25) Place implant impression copings, except under direct supervision.
- (26) Any act in violation of Board statute or rules.

Stat. Auth.: ORS 679 & 680

Stats. Implemented: ORS 679.020, 679.025 & 679.250

Hist.: OBD 9-1999, f. 8-10-99, cert. ef. 1-1-00; OBD 2-2000(Temp), f. 5-22-00, cert. ef. 5-22-00 thru 11-18-00; OBD 1-2001, f. & cert. ef. 1-08-01; OBD 15-2001; f. 12-7-01, cert. ef. 1-1-02; OBD 3-2005, f. 10-26-05, cert. ef. 11-1-05; OBD 3-2007, f. & cert. ef. 11-30-07; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10; OBD 4-2011, f. & cert. ef. 11-15-11; OBD 2-2012, f. 6-14-12, cert. ef. 7-1-12; OBD 6-2014, f. 7-2-2014, cert. ef. 8-1-2014

DRAFT

**DIVISION 42  
DENTAL ASSISTING**

**818-042-0050**

**Taking of X-Rays - Exposing of Radiographs**

1) A dentist may authorize the following persons to place films, adjust equipment preparatory to exposing films, and expose the films under general supervision:

- (a) A dental assistant certified by the Board in radiologic proficiency; or
- (b) A radiologic technologist licensed by the Oregon Board of Medical Imaging and certified by the Oregon Board of Dentistry (OBD) who has completed ten (10) clock hours in a Board approved dental radiology course and submitted a satisfactory full mouth series of radiographs to the OBD.

(2) A dentist or [dental hygienist](#) may authorize a dental assistant who has completed a course of instruction approved by the Oregon Board of Dentistry, and who has passed the written Dental Radiation Health and Safety Examination administered by the Dental Assisting National Board, or comparable exam administered by any other testing entity authorized by the Board, or other comparable requirements approved by the Oregon Board of Dentistry to place films, adjust equipment preparatory to exposing films, and expose the films under the indirect supervision of a dentist, dental hygienist, or dental assistant who holds an Oregon Radiologic Proficiency Certificate. The dental assistant must successfully complete the clinical examination within six months of the dentist authorizing the assistant to take radiographs.

Stat. Auth.: ORS 679

Stats. Implemented: ORS 679.025(2)(j) & 679.250(7)

Hist.: OBD 9-1999, f. 8-10-99, cert. ef. 1-1-00; OBD 2-2003, f. 7-14-03 cert. ef. 7-18-03; OBD 4-2004, f. 11-23-04 cert. ef. 12-1-04; OBD 4-2011, f. & cert. ef. 11-15-11; OBD 6-2014, f. 7-2-2014, cert. ef. 8-1-2014

**DIVISION 42  
DENTAL ASSISTING**

**818-042-0070**

**Expanded Function Dental Assistants (EFDA)**

The following duties are considered Expanded Function Duties and may be performed only after the dental assistant complies with the requirements of 818-042-0080:

- (1) Polish the coronal surfaces of teeth with a brush or rubber cup as part of oral prophylaxis to remove stains if a licensed dentist or dental hygienist has determined the teeth are free of calculus;
- (2) Remove temporary crowns for final cementation and clean teeth for final cementation;
- (3) Preliminarily fit crowns to check contacts or to adjust occlusion outside the mouth;
- (4) Place temporary restorative material (i.e., zinc oxide eugenol based material) in teeth providing that the patient is checked by a dentist before and after the procedure is performed;
- (5) Place and remove matrix retainers for alloy and composite restorations;
- (6) Polish amalgam or composite surfaces with a slow speed handpiece;
- (7) Remove excess supragingival cement from crowns, bridges, bands or brackets with hand instruments providing that the patient is checked by a dentist after the procedure is performed;
- (8) Fabricate temporary crowns, and temporarily cement the temporary crown. The cemented crown must be examined and approved by the dentist prior to the patient being released;
- (9) Under general supervision, when the dentist is not available and the patient is in discomfort, an EFDA may recement a temporary crown or recement a permanent crown with temporary cement for a patient of record providing that the patient is rescheduled for follow-up care by a licensed dentist as soon as is reasonably appropriate; and
- (10) Perform all aspects of teeth whitening procedures.

Stat. Auth.: ORS 679 & 680

Stats. Implemented: ORS 679.020, 679.025 & 679.250

Hist.: OBD 9-1999, f. 8-10-99, cert. ef. 1-1-00; OBD 1-2004, f. 5-27-04, cert. ef. 6-1-04; OBD 3-2005, f. 10-26-05, cert. ef. 11-1-05; OBD 2-2009, f. 10-21-09, cert. ef. 11-1-09

**DIVISION 42  
DENTAL ASSISTING**

**818-042-0090**

**Additional Functions of EFDAs**

Upon successful completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association, or other course of instruction approved by the Board, a certified Expanded Function Dental Assistant may perform the following functions under the indirect supervision of a dentist or dental hygienist providing that the procedure is checked by the dentist or dental hygienist prior to the patient being dismissed:

(1) Apply pit and fissure sealants provided the patient is examined before the sealants are placed. The sealants must be placed within 45 days of the procedure being authorized by a dentist or dental hygienist.

(2) Apply temporary soft relines to complete dentures for the purpose of tissue conditioning.

**(3) Place cord subgingivally.**

Stat. Auth.: ORS 679

Stats. Implemented: ORS 679.025(2)(j) & 679.250(7)

Hist.: OBD 9-1999, f. 8-10-99, cert. ef. 1-1-00; OBD 15-2001, f. 12-7-01, cert. ef. 1-1-02; OBD 1-2013, f. 5-15-13, cert. ef. 7-1-13; OBD 6-2014, f. 7-2-2014, cert. ef. 8-1-2014

# CORRESPONDENCE

-----Original Message-----

From: Stephen Prisby  
Sent: Thursday, May 14, 2015 8:56 AM  
To: 'Kenard Adams'  
Subject: RE: Standards of practice

Ok, I will.

Sincerely,  
Stephen

-----Original Message-----

From: Kenard Adams [mailto:kenardadams@icloud.com]  
Sent: Wednesday, May 13, 2015 7:09 PM  
To: OBD Info  
Subject: Standards of practice

Yes, take to full bd and let me know result.

Sent from my iPad

-----Original Message-----

From: Stephen Prisby  
Sent: Wednesday, May 13, 2015 3:50 PM  
To: 'Kenard Adams'  
Subject: RE: Standards of practice

Thank you for your feedback.

Would you like me to take your concerns to the Board, and share this email?

Sincerely,  
Stephen

Stephen Prisby  
Interim Executive Director  
Oregon Board of Dentistry  
1500 SW 1st Ave., Suite #770  
Portland, Or 97201  
p 971-673-3200  
f 971-673-3202  
[www.Oregon.gov/Dentistry](http://www.Oregon.gov/Dentistry)

"The Mission of the Oregon Board of Dentistry is to protect the public by assuring that the citizens of Oregon receive the highest possible quality oral health care."

-----Original Message-----

From: Kenard Adams [mailto:kenardadams@icloud.com]  
Sent: Wednesday, May 13, 2015 3:31 PM  
To: OBD Info  
Subject: Standards of practice

As a retired dentist, I think you should consider a slight change. I should be able to refuse recommended treatment by dentist such as x-Rays, exam, excetra on basis of expense or what I consider unnecessary treatment. I should be able to do this on basis of verbal or signed refusal. Kenard W Adams, UODS, 1955.

Sent from my iPad



OREGON ENDODONTIC GROUP

LEILA TARSA DDS, MS

*Specializing in Endodontics*

320 "A" AVENUE, LAKE OSWEGO, OR 97034

PHONE: 503.636.3383 FAX: 503.635.8632

RECEIVED

JUN 09 2015

Oregon Board  
of Dentistry

To Oregon Board of Directors,

I am Leila Tarsa, an Endodontist practicing in Lake Oswego. I do utilize Cone Beam CT scans in my practice and use Beam Readers to obtain a radiology report on the images. Beam Readers utilizes Oral and Maxillofacial radiologists who are not necessarily Oregon licensed to interpret the images.

**Does the Oregon board require interpretation of images to be made by a radiologist who has a dental license in state of Oregon?**

Respectfully,

Leila Tarsa DDS, MS

## Stephen Prisby

---

**From:** John Lee [leeto2atredies@gmail.com]  
**Sent:** Wednesday, June 10, 2015 11:18 AM  
**To:** OBD Info  
**Subject:** Mandatory Procedures

Hi,

I've just returned from a cleaning at my local DDS. I decided against X-rays because the bite wings hurt, I was short on time and I don't feel that annual X-rays are medically necessary. (Bi-annual, maybe..)

At this point, my dental hygienist informed me that doing so was "Below the Standard of Care" and that annual X-Rays are mandated by the State of Oregon via the Board of Dentistry. I've read former Governor Kitzhaber's letter located here:

[http://www.oregon.gov/dentistry/docs/Clarification\\_on\\_Radiographs.pdf](http://www.oregon.gov/dentistry/docs/Clarification_on_Radiographs.pdf)

I find it interesting that I can have my kids opt out of vaccinations, which would put both my children and the general public at risk, but I am not given an opt out for something that affects only me. Given Kitzhaber's statement that, "...Oregon Dentists and Expanded Practice Permit Dental Hygienists have the education and training to know when radiographs should be taken, not the patient." doesn't this also mean that I have no choice regarding the rest of my care? I mean, if I'm too stupid to know whether I should get an X-ray or not, isn't it fair to say that I also don't have the knowledge or training to have a given cavity filled or tooth crowned?

By defining the standard of care in such a way you are essentially setting a precedent for the state to mandate specific medical procedures...whether the patients consent or not. Where will this line be moved to in the future? Other states are mandating trans-vaginal ultrasounds prior to an abortion and mandating that abortion clinics comply with medical standards usually only reserved for hospitals as a "Standard of Care". By setting this precedent, the Oregon Dental Board is opening a potential pandora's box for government mandates in dental AND medical care. Do you really want to go there?

As a result, my dental care will suffer because I will not go back to my dentist. To do so would put their license at risk and I may not feel like X-rays the next time I'm there. I suspect that I am not be the only person who feels this way. I strongly suggest that the board reconsider this ill-advised mandate.

All I wanted to do was get my teeth cleaned.

John Lee



# Oregon

John A. Kitzhaber, MD, Governor

## Board of Dentistry

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### Clarification on Radiographs

In its February Newsletter the Oregon Board of Dentistry issued the following statement regarding radiographs, "The Standard of Care in Oregon requires that current radiographs are available prior to providing treatment to a patient. If a patient **without medical justification** refuses to allow radiographs to be taken, even with the offer to sign a waiver, then providing treatment to that patient would violate the Standard of Care in Oregon."

**This is not a change and there have been no law or rule changes regarding radiographs.**

**Please do not tell patients that there has been a law or rule change.**

The decision when to take or not to take radiographs is the responsibility of an Oregon Dentist or an Expanded Practice Permit Dental Hygienist and it is based on several factors including the patient's oral health, patient's age, the risk for disease and any sign or symptoms of oral disease that a patient may be experiencing. **This is called the standard of care.**

Further, Oregon Dentists and Expanded Practice Permit Dental Hygienists should follow the guidelines established by the American Dental Association and the Food and Drug Administration regarding radiographs.

The Bottom line is that Oregon Dentists and Expanded Practice Permit Dental Hygienists have the education and training to know when radiographs should be taken, not the patient.

It is below the standard of care to treat a patient who has refused to allow any radiographs to be taken unless there is a documented medical justification for the refusal.

# U.S. Food and Drug Administration guidelines for prescribing dental radiographs.\*

The recommendations in this table are subject to clinical judgment and may not apply to every patient. They are to be used by dentists only after reviewing the patient's health history and completing a clinical examination. Because every precaution should be taken to minimize radiation exposure, protective thyroid collars and aprons should be used whenever possible. This practice is strongly recommended for children, women of childbearing age and pregnant women.

TYPE OF ENCOUNTER	PATIENT AGE AND DENTAL DEVELOPMENTAL STAGE				
	Child With Primary Dentition (Prior to Eruption of First Permanent Tooth)	Child With Transitional Dentition (After Eruption of First Permanent Tooth)	Adolescent With Permanent Dentition (Prior to Eruption of Third Molars)	Adult, Dentate or Partially Edentulous	Adult, Edentulous
<b>New Patient† Being Evaluated for Dental Diseases and Dental Development</b>	Individualized radiographic examination consisting of selected periapical/occlusal views and/or posterior bitewings if proximal surfaces cannot be visualized or probed; patients without evidence of disease and with open proximal contacts may not require a radiographic examination at this time	Individualized radiographic examination consisting of posterior bitewings with panoramic examination or posterior bitewings and selected periapical images	Individualized radiographic examination consisting of posterior bitewings with panoramic examination or posterior bitewings and selected periapical images; a full-mouth intraoral radiographic examination is preferred when the patient has clinical evidence of generalized dental disease or a history of extensive dental treatment		Individualized radiographic examination, based on clinical signs and symptoms
<b>Recall Patient† With Clinical Caries or at Increased Risk of Developing Caries‡</b>	Posterior bitewing examination at six- to 12-month intervals if proximal surfaces cannot be examined visually or with a probe			Posterior bitewing examination at six- to 18-month intervals	Not applicable
<b>Recall Patient* With No Clinical Caries and Not at Increased Risk of Developing Caries‡</b>	Posterior bitewing examination at 12- to 24-month intervals if proximal surfaces cannot be examined visually or with a probe		Posterior bitewing examination at 18- to 36-month intervals	Posterior bitewing examination at 24- to 36-month intervals	Not applicable
<b>Recall Patient† With Periodontal Disease</b>	Clinical judgment as to the need for and type of radiographic images for the evaluation of periodontal disease; imaging may consist of, but is not limited to, selected bitewing and/or periapical images of areas in which periodontal disease (other than nonspecific gingivitis) can be demonstrated clinically				Not applicable
<b>Patient for Monitoring of Growth and Development</b>	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development		Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development; panoramic or periapical examination to assess developing third molars	Usually not indicated	
<b>Patient With Other Circumstances Including, but not Limited to, Proposed or Existing Implants, Pathology, Restorative/Endodontic Needs, Treated Periodontal Disease and Caries Remineralization</b>	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of these conditions				

\* Reprinted from U.S. Department of Health and Human Services, Public Health Service, Food and Drug Administration; and American Dental Association, Council on Dental Benefit Programs, Council on Scientific Affairs.<sup>5</sup>

† Clinical situations for which radiographs may be indicated include, but are not limited to, the following. **Positive historical findings:** Previous periodontal or endodontic treatment, history of pain or trauma, familial history of dental anomalies, postoperative evaluation of healing, remineralization monitoring, presence of implants or evaluation for implant placement. **Positive clinical signs/symptoms:** clinical evidence of periodontal disease, large or deep restorations, deep carious lesions, malposed or clinically impacted teeth, swelling, evidence of dental/facial trauma, mobility of teeth, sinus tract ("fistula"), clinically suspected sinus pathology, growth abnormalities, oral involvement in known or suspected systemic disease, positive neurologic findings in the head and neck, evidence of foreign objects, pain and/or dysfunction of the temporomandibular joint, facial asymmetry, abutment teeth for fixed or removable partial prosthesis, unexplained bleeding, unexplained sensitivity of teeth, unusual eruption, spacing or migration of teeth, unusual tooth morphology, calcification or color, missing teeth with unknown reason, clinical erosion.

‡ Factors increasing risk for caries may include, but are not limited to, the following: high level of caries experience or demineralization, history of recurrent caries, high titers of cariogenic bacteria, existing restoration of poor quality, poor oral hygiene, inadequate fluoride exposure, prolonged nursing (bottle or breast), diet with high sucrose frequency, poor family dental health, developmental or acquired enamel defects, developmental or acquired disability, xerostomia, genetic abnormality of teeth, many multisurface restorations, chemotherapy/radiation therapy, eating disorders, drug/alcohol abuse, irregular dental care.

Dear Dr. Kleinstub,

RECEIVED

APR 20 2015

4-14-15

Oregon Board  
of Dentistry

I know that the Dental Board puts Reprimands and other Dental Board actions on their Website for everyone on the Internet to read. At first, when I heard about this happening, a few years ago, I didn't like it and thought it was a very bad idea. Now, I know it is absolutely a very bad idea, not the right thing to do, and it needs to be taken off the Internet immediately. Something must be done now, because this information is falling into the wrong people's hands and it could ruin dentists, like me.

I thought such information was supposed to be confidential, between the dentist and the Board. Now it's everywhere! This stuff is on Healthgrades.com and several National Data Bases and Insurance Company data bases. I can download the Dental Board information directly from healthgrades.com, just a "click away." Right now I have drug-seekers using this information to try to blackmail me into giving them drugs. Isn't that great? Of course I won't give them any, but now out of revenge they put in bad reviews down and I can't get rid of it, and then they say, "Hey look at this Dude's Dental Board reprimands, we downloaded it just for you!" How many patients will I lose from that alone? Patients have HIPAA laws. What about HIPAA for dentists?

Now, I didn't go to dental school to do lousy dentistry. I went to learn dentistry and be the best I can be. Your Dental Board mission states that it is "to provide the best dentistry for patients." Well, if you want "perfect dentistry," then we all need "fantastic education" beyond dental school, because dental school only teaches us enough to get into trouble. We need good courses that are hands on, like Pankey Institute and Dawson courses, not the cheap ones that have little to do with dental work, such as Tobacco cessation or infection control. We all need courses on occlusion, implants, endodontics, orthodontics, cosmetic dentistry, you name it. But, as a chain-store hired dentist I can't afford any of these. Not anymore at least, since the Dental Board put, what I considered confidential, on the "Big Screen" for every idiot to see!

Now my boss knows I have some "dings" on my record, and now he pays me peanuts, because he knows I can't quit, because no other chain-store

dental office will hire me. I've actually looked for jobs at several offices, and this junk came up and I didn't get the job. This stuff is ruining older dentists who accumulated over the years, "dings" on their records. It's bound to happen. I can't perform "perfect dentistry", hardly anyone really can, I am not god, and I can't please everyone all of the time. Even perfectly looking root canals done by the best endodontists in the business, fail. I hardly ever had any complaints until 2008, when the economy got bad and everyone became "sue-happy". That's when the Board went for the "Big Screen".

Since I treat Oregon Health Plan patients a lot, how can I give the best dentistry when the insurance company dictates the treatment? They don't approve molar root canals, when the teeth could easily have been saved. I feel like I have a moral responsibility to help such patients, however. Once the tooth is gone, OHP pays for a crude acrylic "flipper" that won't stay in a person's mouth when eating. I had a patient missing all of his teeth and they only approved a lower full denture.

Now, I ask you, how in the world is this patient supposed to eat with only a lower denture and no upper one? Thank you Obamacare! Best Dentistry offered here? Hardly!

I don't appreciate the Board putting dentists with reprimands or anything else on the "Big Screen." The reason I got my "ding" in the first place was when I went to my insurance company to resolve a complaint and they "automatically" reported it to the Board, and to National Data bases. I felt totally backstabbed! Now, if anyone ever complains about anything at all, I will resolve it myself and never go to an insurance company, ever again! And, I know many dentists who do exactly that same thing!! So, why even have malpractice insurance any more? It's only because of insurance companies wanting it, that's the only reason for me.

This putting reprimands on the Internet has got to stop. If I had the money, I would sue the Dental Board right now over this. This is wrong!

I don't think any dentist should be blackmailed over this stuff. And when does it end? Insurance companies ask, "have you ever had a complaint or Board reprimand?" Some of the nicer insurance companies ask for only 5 years history. If the dentist was such a bad dentist, then the Board should revoke their license, and not subject them to endless paperwork and answering for this, for the rest of their dental careers. I want to do "perfect dentistry." I want no complaints. The only way I can do that is with fantastic education, and fantastic equipment! But, I can't afford it! With the pay I get now, I am lucky I can pay my electric bill, seriously! Things can go wrong in dentistry. Try doing a filling on a mentally challenged patient who is a moving target. IV Sedation you say? With no money to take the course, and the patient having no money, what options are there? Your mission statement doesn't mean much. It's there to "pacify" the masses! You can ask dentists to carry the financial burden

of better education and better equipment on their backs, but when the money just isn't there, nothing will happen.

I have seen how government and insurance companies ruined physicians. My brother was one. He was a fine surgeon, who saved many people's lives and taught other surgeons to save people's lives. He got so disgusted that he left the profession after 20 years. Now, he's heard that several patients have died at that hospital because he wasn't there! He feels terrible about it!

Is this what dentists are up against now, too?

What will you do when you go to a hospital when you need surgery? Do you want cheap, mediocre medical care by a doctor with little experience and no "dings" on his history, or a doctor with experience of doing it for 20 years? I know what I would want!

# OTHER ISSUES

7. **Soft Reline Course- Melissa Colasurdo, D.M.D. & Karley Schneider, D.M.D.**

The Board has received a request for approval of a Soft Reline Course. This course would be provided so the EFDA Dental Assistants could qualify to apply soft relines in accordance with OAR 818-042-0090.

"818-042-0090

Additional Functions of EFDAs

Upon successful completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association, or other course of instruction approved by the Board, a certified Expanded Function Dental Assistant may perform the following functions under the indirect supervision of a dentist providing that the procedure is checked by the dentist prior to the patient being dismissed:

(1) Apply pit and fissure sealants providing the patient is examined before the sealants are placed. The sealants must be placed within 45 days of the procedure being authorized by a dentist.

(2) Apply temporary soft relines to full dentures."

5/26/15

- 1  **SOFT RELINES FOR DENTURES  
AN EXPANDED FUNCTIONS COURSE FOR EFDA  
CERTIFIED DENTAL ASSISTANTS**  
Presented by : Melissa Colasurdo ,DMD  
For DCT and Gentech 2015
- 2  **WHAT WE WILL LEARN TODAY:**
  - ✗ Special needs of the edentulous pt
  - ✗ Physical and psychological challenges of dentures
  - ✗ Objectives of soft relines
  - ✗ Various types of soft reline materials and their ingredients
  - ✗ OTC denture products
  - ✗ Review medical/health history and any contra-indications/  
potential complications
  - ✗ Mix and place soft reline material on a cast / model and trim  
appropriately
  - ✗ Proper instructions for soft reline care
  - ✗ Chart entry/notes
- 3  **SPECIAL NEEDS/ CONSIDERATIONS OF EDENTULOUS  
PATIENT :**
  - ✗ Residual ridge resorption (compression of denture results in  
resorption, and no tension of teeth/PDL to create apposition =  
loss of RR)
  - ✗ Intraoral changes (overtime no ridge makes it increasingly  
difficult to chew/manipulate dentures during function)  
decreased masticatory function (mastication with natural teeth  
could be up to 175 lb dentures 20-25Lb)
  - ✗ Loss of facial support and muscle tone
  - ✗ Psycho - social effects (positive or negative)
    - +Pt has teeth where they previously didn't – helps with jobs/  
confidence.
    - +Pt had natural teeth and now they have dentures,  
frustrations of getting use to everything
- 4  **CHALLENGES OF A DENTURE (PHYSICAL AND  
PSYCHOLOGICAL)**
  - ✗ Excess saliva in the mouth (overtime the body adjusts to the  
denture)
  - ✗ Recent loss of teeth, pain from extractions and feeling like

- they will never get use to the denture
- ✗ Adjustment of learning how to talk with a denture and eat with a denture
- ✗ Frequent adjustments needed/multiple trips to the dental office

5  **OBJECTIVE OF SOFT RELINES:**

- ✗ Overtime whether due to recent extractions or wearing the denture for multiple years, the shape of the oral cavity changes, gradually due to dissolutions of alveolar bone that forms the alveolar ridge
- ✗ Overall fit of the denture becomes poor and the denture loses stability, If the denture is continued to be used non-uniformed pressure is exerted and ulcers and inflammation can occur
- ✗ New denture or rebasing/relining is needed

6  **TISSUE CONDITIONER:**

- ✗ Tissue conditioner is soft high-molecular material applied to the surface of the denture base that comes in contact with the mucosa to release the pressure/ irritation
- ✗ The soft reline is placed into the denture to recover the overall fitness between denture and oral mucosa
- ✗ Coe- comfort is a tissue conditioner (used for a few days):  
Tissue conditioner can be used for gingival infection (thrush, candida, etc)

7  **SOFT RELINE MATERIAL: (EX: COE-SOFT)**

- ✗ This is used when the tissue is healthy, but the fit is not fully secure.
- ✗ It acts as a cushion or shock absorber between the denture and the gums. It can last between 4-6 weeks
- ✗ Powder and liquid are mixed together and become a paste
- ✗ Ingredients:
  - + Polyethylmethacrylate Monomers (Tissue conditioner)
  - + Zinc Undecylenate (Coe-soft)
  - + Silicone Based
  - + Ethyl Methacrylate

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✖ **Coe-soft reaction:** polymerization reaction (a process of reacting monomer molecules together in a chemical reaction to form polymer chains or three-dimensional networks.) takes approx 15 min to fully complete and can last 1-3 months.

8  **HOW TO USE: (COE-SOFT)**

- ✖ Dentist to adjust any sore spot area
- ✖ Clean and dry the denture
- ✖ Mix the powder and liquid for 30-60 seconds until the mixture reaches creamy (honey like) consistency (8cc liquid to 2 mini cups of powder)
- ✖ Apply mixture evenly to denture base, seat the denture in the pt mouth and ask them to bite together. Do one denture at a time.
- ✖ Allow for proper setting, approx 5 minutes
- ✖ Remove denture and trim the excess

9  **CARE OF PT IN THE DENTIST OFFICE:**

- ✖ Dentures Need to be cleaned from time to time in a ultrasonic
- ✖ Denture should not be placed directly in the ultrasonic machine but in a zipper-lock plastic bag with a selected cleaning solution to avoid contamination with the ultrasonic solution
- +1. Place denture in plastic bag. Pour in denture solution. Carefully seal the plastic bag.
- +2. Place the bag in the ultrasonic machine, with the top of the closed bag lying over the rim. Run the machine for 10 minutes or more, depending on the deposit level or as indicated by manufacturer specification instructions.
- +3. Remove bag from machine. Open the bag and remove the denture, allowing the solution to go down the drain as the water is running. Carefully dispose of the plastic bag. Return the sealed container of cleaning solution to its place for future uses.
- +4. Rinse the denture completely under the running water to

remove the cleaning solution. Scrub any remaining debris with a cold sterilizable denture toothbrush. A nice touch is to put the cleaned denture into a paper cup with mouthwash and deliver a pleasant-tasting denture to the patient.

10  **AT HOME CARE OF A DENTURE, PT EDUCATION :**

- ✗ Denture has to be cleaned just like any other part of the oral cavity
- ✗ Within 30 minutes of exposure to saliva the denture becomes covered with a salivary pellicle which serves as a base for oral debris – this is more of an issue with pt with reduced saliva
- ✗ Calculus / plaque can deposit on the denture and if not cleaned regularly can mineralize and become difficult to remove

11  **OTC DENTURE PRODUCTS:**

- ✗ Soft liners
- ✗ Cleaners
- ✗ Temporary repair kits
- ✗ Fixadent
- ✗ Denture adhesive strips
- ✗ Denture adhesive removal wipes

12  **OTC DENTURE PRODUCT EXAMPLES:**

13  **DENTURE ADHESIVES:**

- ✗ Adhesives can help a ill fitting denture or a denture that has sore spots evenly distribute forces so to relieve the sore spot region.
- ✗ Studies have shown that even a well fitting denture has benefits from the use of adhesives.
  - + Allows denture to stay in better
  - + Allows pt to bite into a wider range of foods and denture can apply more force without dislodging
  - + Adhesives should be applied to a dry clean denture and can be placed in strips or dots on the tissue bearing surface of the denture (in the middle/ not close to edges of denture)
- ✗ Recommended to apply as minimal as a patient can and re-apply as needed.

Attachment #14  **HELPFUL DENTURE TIPS :**

- ✗ 1. To prevent breaking the denture, recommend that the

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patient brush it over a towel or over sink half-filled with water. They should lightly brush dentures with a soft nylon toothbrush or recommended denture brush, pt may use toothbrush.

✖2. Place in a commercial cleanser overnight or for at least 30 minutes daily. A morning quick soak also can be performed. This should reduce bacterial counts (achieving a 99 percent kill rate of most organisms) and remove most stains. The soak also will reduce the incidence of oral infections and halitosis (bad breath). After soaking, thoroughly remove all cleanser by light brushing under cold running water.

✖3. Denture cleaner should not be re-used.

✖4. Mouthwash is directed for oral use and not for denture cleaning.

✖5 To clean dentures with metal parts such as partial dentures, the patient should follow the above steps.

15  **AFTER CARE INSTRUCTIONS FOR SOFT RELINED DENTURE:**

✖Wear the denture as much as you can for the first 24 hours.

✖Rinse with warm water only, no denture cleaner solutions

✖Brush the tooth part of the denture a soft toothbrush. The soft liner is still very fragile and will tear if subjected to chemical or mechanical cleaning.

✖Try not to use any denture adhesive,

16  **VIDEO :**

✖Soft reline

✖Part 2

17  **CHART ENTRY :**

✖Key points:

+Pt presents for soft tissue reline using : Material (ex. Coe-soft) in (Maxillary/Mandibular complete/partial denture).

+Sore spots and denture evaluated by dentist

+Coe-soft placed in denture and excess material trimmed with (12 blade / hot knife)

+Pt happy with fit and POIG.

+Dr Name/Assistant Name – Dr. Signature

Attachment #1  **18 CLINICAL WORK**

✖Each person will place coe-soft reliner on denture / cast and

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allow for proper set up

✘Liner must be trimmed to appropriate dimensions for pt comfort and overall success of the reline material.

✘Denture cleaned completely

19  **SOURCES:**

✘Margaret J. Fehrenbach. Addressing The Needs Of Denture Patients. Website accessed on May 2015. <http://www.rdhmag.com/articles/print/volume-24/issue-2/feature/addressing-the-needs-of-denture-patients.html>

✘Hummel SK, et al. Quality of removable partial dentures worn by the adult U.S. population. *J Prosthet Dent.* 2002 Jul;88(1): 37-43.

✘Tallgren A. The continuing reduction of the residual alveolar ridges in complete denture wearers: A mixed-longitudinal study covering 25 years. *JPD*, May 2003, VOLUME 89 NUMBER 5

✘Ahmad F, et al. Shear bond strength of two chemically different denture base polymers to reline materials. *J Prosthodont.* 2009 Oct;18(7):596-602. doi: 10.1111/j.1532-849X.2009.00481.x. Epub 2009 Jun 8

✘Kevin Shearer. How to place durable comfortable soft relines. Tokuyama Dental America. May 2013.

✘Seifert I, Langer AMichmann J. Evaluation of psychologic factors in geriatric denture patients. *J Prosthet Dent* 1962; 12: 517-523.

✘Al Quran F, Clifford T, Cooper C, Lamey PJ. Influence of psychological factors on the acceptance of complete dentures. *Gerodontology* 2001; 18: 35-40.

D10095  
LICENSE NUMBER

OREGON BOARD OF DENTISTRY  
2014/2016 Dental License

Karley Schneider DMD



Permits:  
Nitrous Oxide

Expires: 03/31/2016

THIS LICENSE MUST BE POSTED IN A CONSPICUOUS PLACE IN PLAIN SIGHT OF LICENSEE'S PATIENTS

D10105  
LICENSE NUMBER

OREGON BOARD OF DENTISTRY  
2014/2016 Dental License

Melissa Kay Colasurdo DMD

Permits:  
Nitrous Oxide

Expires: 03/31/2016

THIS LICENSE MUST BE POSTED IN A CONSPICUOUS PLACE IN PLAIN SIGHT OF LICENSEE'S PATIENTS

**7. Board Approval of Local Anesthesia and Nitrous Oxide Course –  
Lake Washington Institute of Technology**

Ms. Beth Davis, Faculty Dental Hygienist, from Lake Washington Institute of Technology is requesting the Board approve Lake Washington Institute of Technology's continuing education programs for local anesthesia and nitrous oxide.

**Applicable Rules**

**818-035-0040**

**Expanded Functions of Dental Hygienists**

(1) Upon completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association or other course of instruction approved by the Board, a dental hygienist who completes a Board approved application shall be issued an endorsement to administer local anesthetic agents under the general supervision of a licensed dentist.



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Dental Hygiene program • 11605 132<sup>nd</sup> Ave NE, Office A 210F Kirkland WA 98034 • Office # 425-739-8386  
• (425) 739-8292 (fax)

Oregon Board of Dentistry  
1500 SW 1<sup>st</sup> Ave. Suite 770  
Portland, OR 97201-5837

Attention: Oregon Board of Dentistry

June 15, 2015

Lake Washington Institute of Technology's dental hygiene program offers a continuing education class in Local Anesthesia and Nitrous Oxide Sedation that is accredited by the Commission on Dental Accreditation of the American Dental Association and approved by the board. This course included 33 hours of didactic instruction and 30 hours of clinical experience with 14 hours dedicated to Nitrous Oxide Sedation.

The course instruction included all of the following listed below:

1. Theory of pain control.
2. Selection-of-pain-control modalities.
3. Anatomy.
4. Neurophysiology.
5. Pharmacology of local anesthetics.
6. Pharmacology of vasoconstrictors.
7. Psychological aspects of pain control.
8. Systematic complications.
9. Techniques of maxillary anesthesia.
10. Techniques of mandibular anesthesia.
11. Infection control.
12. Medical emergencies involving local anesthesia and Nitrous Oxide.
13. Ten hours of Nitrous Oxide Sedation lecture and 4 hours of lab participation.

If you have any questions or need any more documentation please do not hesitate to contact me at the address above.

Beth Davis RDH, MS  
Tenured Faculty  
1<sup>st</sup> Dental Hygiene Lead  
[beth.davis@lwtech.edu](mailto:beth.davis@lwtech.edu)  
425-739-8386

CODE 240 Local Anesthesia & Nitrous Oxide Sedation for Dental Hygienists  
LAKE WASHINGTON INSTITUTE OF TECHNOLOGY  
SUMMER 2015

**COURSE NUMBER:** CODE 240

**CONTINUING EDUCATION:** 33 HOURS

**DAY & TIME OF COURSE:** On-line lecture portion available from July 6<sup>th</sup> to August 14<sup>th</sup> 2015  
Clinical lab portion from August 12, 13, & 14 2015

**ROOM:** E 107 LWIT dental clinic

---

**INSTRUCTOR NAME:** Beth Davis RDH, MS

**LAB/CLINIC INSTRUCTORS:** None

**PHONE NUMBERS:** (425) 739-8386 office, (425) 418-9363 cell

**EMAIL ADDRESS:** beth.davis@lwtech.edu

**OFFICE LOCATION:** A 210F

**OFFICE HOURS:** By Appointment

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**COURSE DESCRIPTION:**

This course is designed to allow dental hygienists the opportunity to review and learn principles of pain control in preparation for the WREB Exam. The course will be divided into two sections consisting of a didactic on-line portion and clinical lab activities. Students must pass each section at an acceptable level of proficiency to be eligible to take the WREB Exam.

**COURSE OBJECTIVES:**

Upon completion of this course the students will be able to:

- Explain the pharmacology of local and topical anesthetics
- Explain local anesthetic procedures and techniques
- Properly prepare and use local anesthetic armamentarium
- Properly evaluate the medical history of the client prior to using a local anesthetic
- Identify complications and emergencies that could occur after administering an anesthetic to a patient
- Properly perform specific injections for maxillary and mandibular anesthesia, such as infiltrations, field blocks, nerve blocks, and aspirations
- Choose proper needle size for intraoral injections
- Determine insertion site, depth of penetration, and amount of anesthetic solution to be deposited
- Explain the pharmacology of nitrous oxide
- Properly perform nitrous oxide sedation procedure on clinical patients

## **SPECIFIC OBJECTIVES:**

Upon completion of this course the students will be able to:

- 1.0 Explain the pharmacology of local and topical anesthetics, and local anesthetic procedures and techniques.
  - 1.1 Recall knowledge of pain and pain perception
  - 1.2 Discuss the pharmacology of local anesthetics.
    - history of local anesthetics
    - properties of an ideal local anesthetic
    - basic differences between the ester and amide chemical classifications
    - mechanism of local anesthetic action on nerve
    - local anesthetic agents:
      - pharmacokinetics
      - pharmacologic effects
      - adverse reactions
    - composition of local anesthetic solutions including the action and purpose of each ingredient
    - concentration, duration and chemical classification of common local anesthetics
    - factors to consider when choosing an anesthetic agent
    - process for calculating maximum dosages for all types and ages of clients
  - 1.3 Discuss the pharmacology of vasoconstrictors.
    - mode of action
    - concentrations used
    - specific vasoconstrictors used in local anesthetics and their clinical action
    - drug interactions of vasoconstrictors with epinephrine
    - factors to consider when choosing specific vasoconstrictors
  - 1.4 Discuss topical anesthetics.
    - absorption and systemic effects of topical anesthetics
    - specific topical anesthetic agents
    - indications, contraindications and precautions for using topical anesthetics
    - toxic and allergic reactions to topical anesthetics
  - 1.5 Understand local anesthesia armamentarium and its preparation.
    - dental syringes, needles, anesthetic cartridges, supplies
    - safety devices for use with local anesthetic armamentarium
    - method for safely and aseptically assembling and disassembling a dental syringe, needle and cartridge
    - care and disposal of used dental needles and cartridges
    - routine maintenance procedures for the dental syringe

- safe needle capping procedures, and alternatives to needle capping
- 1.6 Understand evaluating the client prior to using local anesthetic.
  - how to assess the need for local anesthetics during dental hygiene care
  - key questions/responses to review on the health history form prior to the administration of local anesthetics, including the significance of “yes” responses
  - vital signs that contraindicate the administration of local anesthetic
  - signs and symptoms of client anxiety associated with the impending administration of local anesthetic
  - use of the problem-solving process to determine if a client is at risk for local anesthetics
  - given comprehensive information for a fictitious client:
    - evaluation of risk
    - choice of an appropriate anesthetic
- 1.7 Understand general principles for local anesthetic injections
  - principles for injection atraumatically and comfortably
  - interpersonal skills appropriate for the administration of local anesthesia
  - interpersonal skills appropriate for clients of various ages and needs, including anxious clients
- 1.8 Understand complications and emergencies that could occur.
  - local complications and their prevention and management
  - systemic complications and their prevention and management
  - signs and symptoms of impending emergencies
- 1.9 Understand local anesthetic injections used for dental hygiene care.
  - “infiltration”, “field block”, and “nerve block” defined
  - “aspiration” defined, and its purpose explained
  - specific injections for maxillary and mandibular anesthesia:
    - associated anatomy
    - choice of needle
    - insertion site
    - depth of penetration
    - amount of solution to deposit
    - hard and soft tissues anesthetized
  - methods of testing for adequate anesthesia
  - use of the problem-solving process when lack of anesthesia occurs
  - medicolegal terminology, symbols and abbreviations for recording specific local anesthetic injections in the client’s chart

- 1.10 Discuss modifications to anesthetic techniques used in dentistry.
  - considerations specific to periodontal care
  - considerations for other dental specialties
- 2.0 Discuss the pharmacology of nitrous oxide, and nitrous oxide sedation procedures and techniques.
  - 2.1 Discuss the pharmacology of nitrous oxide.
    - history of nitrous oxide
    - frequency of nitrous oxide use in United States dental offices
    - legal aspects of “administration” and “monitoring” of nitrous oxide in Washington and the United States
    - “conscious state” defined
    - nitrous oxide and oxygen sedation:
      - pharmacological effects on the CNS
      - properties
      - adverse reactions and side effects
    - nitrous oxide concentration calculations
    - client signs and symptoms at various nitrous oxide levels
  - 2.2 Understand evaluating the client prior to using nitrous oxide.
    - importance of careful client selection
      - physical and psychological considerations
    - indications for use
    - contraindications
  - 2.3 Understand nitrous oxide armamentarium including safety features.
    - portable or central units, tanks, regulators
    - safety features: universal color coding, indexing systems, minimum oxygen flow, fail-safe system, flow meter, nasal hood and scavenging system reservoir bag, flush valve
    - environmental contamination and health hazards
    - recommendations for the reduction of nitrous oxide concentrations in the operatory
  - 2.4 Understand techniques for induction and titration, monitoring clients and concluding nitrous oxide use.
    - benefits of a nitrous oxide experience prior to its use for dental procedures
    - information for clients prior to nitrous oxide/oxygen sedation
    - preparation of equipment
    - induction and titration procedures
    - monitoring process
      - signs and symptoms of too high and too low concentrations
    - conclusion process
    - medicolegal terminology, symbols and abbreviations for

- recording nitrous oxide/oxygen sedation in the client's chart
  - clean-up and sterilization/disinfection procedures
- 2.5 Understand complications and emergencies that could occur.
- client discomfort, nausea, vomiting
  - sexual phenomena: incidence and prevention
  - post-nitrous oxide precautions

**Required Text and References:**

Local Anesthesia for Dental Professionals, 2<sup>nd</sup> ed., Bassett, Pearson, 2010. (Required)  
Handbook of Local Anesthesia, 5<sup>th</sup> Ed., Malamed, Mosby, 2004. (Optional)  
 Handbook of Local Anesthesia Administration DVD.  
Medical Emergencies in the Dental Office, 5<sup>th</sup> Ed., Malamed, Mosby, 2000. (Optional)  
 Clark & Brunick (2003). *Handbook of nitrous oxide and oxygen sedation (2<sup>nd</sup> ed.)*.  
 Mosby: St. Louis, MO. **(Required)**

**Grading Procedures:**

- |                                 |   |
|---------------------------------|---|
| 1. Assignments (2)              | (at 15%)                                |
| 2. Quizzes (4)                  | (at 80%)                                |
| 3. Final Exam- Local Anesthesia | (at 2.5%)                               |
| 4. Final Exam- Nitrous Oxide    | (at 2.5%)                               |
| 5. Mock Board Clinical Exam     | (Pass/Fail according to WREB standards) |
| 6. Attendance                   | (100%)                                  |

**A Pass/Fail rating will be given upon successful completion of the course at the required levels mentioned above.**

**Outside Study Time:**

An estimated 2-3 hours per one hour of lecture is suggested for outside study time. Individual needs of the student may facilitate a change in this recommendation.

**Make-up procedures:**

Due to the accelerated and brief nature of this course students must maintain 100% attendance at all clinical sessions. **There will be no make-up procedures.** A "Fail" rating will be given to any student who does not attend *all* clinical sessions. **No exceptions.**

**If you have a documented medical condition (including pregnancy) or for any other reason are not able to receive local anesthetic as determined by your physician, other health care professional, or LWIT dentist, you must supply a patient for your lab partner. LWIT is not responsible for supplying patients. If you do not supply a patient for your lab partner, you will receive a "Fail" rating for the course.**

**COURSE CALENDAR (ON-LINE PORTION)  
DHYG 240 ANESTHESIA & NITROUS OXIDE  
SUMMER 2015**

<i>WEEK</i>	<i>DATE</i>	<i>LECTURE TOPICS</i>	<i>CHAPTERS</i>
WEEK 1	07/06/15- 07/14/15	<u>Material &amp; Lab Assignments</u> -Neurophysiology -Pharmacology of Local Anesthetic -pKa Value <b>ON-LINE QUIZ #1 will open on (Tuesday, July 14<sup>th</sup>) and will remain open until the end of the class session</b>	<u>BASSETT</u> Ch. 3 Ch. 4 Handout <u>MALAMED</u> Chapter 1 and 2 Read on-line lecture notes
WEEK 2	07/14/15- 07/21/15	Pharmacology of Vasoconstrictors Vasoconstrictor Dosage Calculations <b>ON-LINE ASSIGNMENT #1 (complete before quiz #2 and submit during lab on Wednesday August 12<sup>th</sup>)</b> <b>ON-LINE QUIZ #2 will open on (Tuesday, July 21<sup>st</sup>) and will remain open until the end of the class session</b>	<u>BASSETT</u> Ch. 5 & 6 Ch. 7 <u>MALAMED</u> Chapter 3 and 4 Read on-line lecture notes, Unit 3 and 4
WEEK 3	07/21/15- 07/28/15	Topical Anesthetics Armamentarium <b>ON-LINE QUIZ #3 (Tuesday, July 28<sup>th</sup>) and will remain open until the end of the class session</b>	<u>BASSETT</u> <u>Read before 1<sup>st</sup> Lab</u> Appendix 1 Ch. 1 Ch. 8 Ch. 9 <u>MALAMED</u> Chapter 5, 6, 7, 8, and 9 Read on-line lecture notes pertaining to these chapters
WEEK 4 & 5	07/28/15- 08/04/15	Systemic and Local Complications Emergency Management Pediatric Anesthesia Nitrous Oxide Sedation <b>ON-LINE QUIZ #4 (Tuesday, Aug. 4<sup>th</sup>) and will remain open until the end of the class session. Quiz 4 questions will focus mainly on the</b>	<u>BASSETT</u> Ch. 10 & 17 Ch. 19 & 20 <u>MALAMED</u> Chapter 16, 17, 18 Read on-line lecture notes pertaining to these

		<b>injections from your notebook. There will not be any Nitrous questions on this quiz. ON-LINE ASSIGNMENT #2 (Due Wednesday, Aug. 12<sup>th</sup> in Lab)</b>	chapters and Nitrous Oxide Sedation
WEEK 6	08/11/14-08/13/14	Lab Orientation Basic Injection Technique Anatomical Considerations Techniques of Maxillary Anesthesia Techniques of Mandibular Anesthesia Supplemental Injection Techniques Medical Emergencies DVD	<u>BASSETT</u> Ch. 2 & 18 Ch. 11 <u>Read before 1<sup>st</sup> Lab</u> Appendix 1 Ch. 1 Ch. 8 Ch. 9 Ch. 12-14 <u>MALAMED</u> Chapter 11, 12, 13, 14, 15** Read "Handbook of Nitrous Oxide and Oxygen Sedation" and on-line lecture notes

***\*\*All clinical instructors, at any time, reserve the right to deny admittance into the lab portion of the course if they feel a student is unprepared and/or may pose a safety risk for themselves or their fellow classmates.***

DATE	ACTIVITIES	READING
Wednesday, August 12th (8:30-1:00)  <b>AM</b>	<b>Lab Notebook Due:</b> Health History Review (Bring Filled Out Health History) Basic Injection Techniques Syringe Handling Anatomical Considerations Techniques of Maxillary Anesthesia Injections: PSA, MSA, ASA, infiltration	BASSETT Ch. 12-14 <u>MALAMED</u> Ch. 11,12, 13, 14, and 15.

(2:00-5:00) <b>PM</b>	Techniques of Mandibular Anesthesia Injections: IA, PSA, GP, NP, IO	
Thursday, August 13 <sup>th</sup> (8:30-12:00) <b>AM</b>	Anatomical Considerations Techniques of Mandibular Anesthesia (cont.) Supplemental Injection Techniques Injections: Mental/Incisive, IA, PSA, MSA	
(1:00- 5:00) <b>PM</b>	Nitrous Oxide Lecture and Lab Final Exam	
Friday, August 14 <sup>th</sup> (8:30- 12:00) <b>AM</b>	Injections: IA, PSA, MSA, ASA	
(1:00- 5:00) <b>PM</b>	Final Exam PSA and IA on lab partner PSA and IA on board patient	

**\*\*Chapters 12-14 in Bassett or Chapters 11, 12, 13, 14 and 15 in Malamed must be read prior to coming to lab on August 12<sup>th</sup>. The "Handbook of Nitrous Oxide and Oxygen Sedation" (required) and on-line lecture notes must be read prior to coming to lab on August 13<sup>th</sup>.**

**Best of luck to you on your board exam!!**

## CODE 240 Local Anesthetic & Nitrous Oxide

### **NOTEBOOK Lab Assignment**

#### **LOCAL ANESTHETIC NOTEBOOK**

To complete this project, each student will need to create notecards using a 1-1<sup>1/2</sup> inch, three ring binder notebook. With the cards put into page protectors. Create a card for each of the injections listed below. Use the information found in Local Anesthesia for the Dental Professional by Kathy Bassett and the lab power points. You need to use the pictures in the power point on your cards. Please do not take pictures from the internet unless they are of great quality and you can see them extremely well. I expect picture that look like the ones I have given you in the example below:

- Supraperiosteal (local infiltration)
- PSA (Posterior Superior Alveolar)
- MSA (Middle Superior Alveolar)
- ASA (Anterior Superior Alveolar)
- IO (Infraorbital)
- GP (Greater palatine)
- NP (Nasopalatine)
- IA (Inferior Alveolar)
- Buccal Nerve Block
- Mental/Incisive Nerve Block
- Gow-Gates

*Each card needs to include the following information:*

- Nerves anesthetized/Field of Anesthesia
- Penetration site
- Depth of Insertion

- Teeth anesthetized
- Periodontium/Soft Tissues anesthetized
- Needle size/selection
- Amount of anesthetic solution deposited and time
- Errors or failures of anesthesia and how to correct

Additionally create a card(s) containing:

- Blood Pressure Guidelines
- Dosage Calculation
- Nitrous Oxide Administration (steps for administration and calculating percentages)
- Pediatric Anesthesia

Each card should contain a description of the criteria mentioned above. **INCLUDE PICTURES** and or diagrams that may be of additional help to you. You need to have the following pictures for each card bone, tissue/retraction, example of injection site and area of anesthesia coverage (see example below of card design). Once your cards are complete, cover them with page protectors, or clear contact paper. This will allow them to be used in a clinical setting and to be wiped off with a disinfectant. Insert the cards into your notebook for easy reference. *Please be creative* as this will be part of your grade. You may add any additional cards with any content you may find helpful to your understanding of Pain Control. Have someone in your class or outside of class proofread them before covering.

**(Card Format Example)**  
**Middle Superior Alveolar Nerve Block**  
**(MSA)**

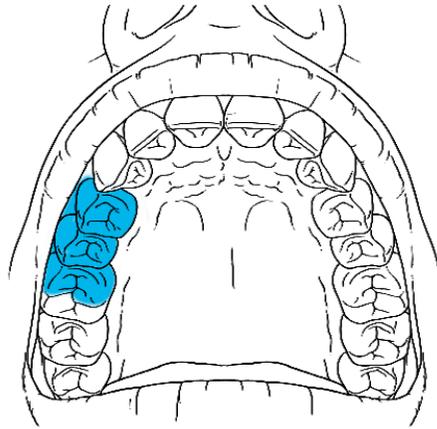
- **Nerves anesthetized/Field of Anesthesia**
  - MSA will anesthetize structures innervated by the MSA nerve (when Present)
- **Penetration site**
  - Height of the mucobuccal fold **above the maxillary second premolar.**



- **Depth of Insertion**
  - Insert the needle into the height of the mucobuccal fold above the second premolar.
  - The needle is advanced parallel to the long axis of the second premolar .
  - Advance it until the bevel is located well above the second premolar about **5 to 8 mm.**
- **Teeth anesthetized**
  - Pulp of the maxillary first and second premolars
  - MB root of the first molar

- **Periodontium/Soft Tissues anesthetized**

- Facial/Buccal tissue
- Periodontal Ligament and alveolar bone



- **Needle size/selection**

- Short 25/27 gauge

- **Amount of anesthetic solution deposited and time**

- deposit 0.9-1.2 ml (1/2-2/3rds of the cartridge) in 30-45 seconds

- **Errors or failures of anesthesia and how to correct**

- Needle tip and anesthetic not deposited high above the apex.
  - Correct by checking radiographs and increasing the depth of penetration.
- Deposition of solution too far from the maxillary bone with the needle placed in tissues lateral to the height of the mucobuccal fold.
  - Correct by reinserting at the height of the mucobuccal fold.
- Bone of the zygomatic arch at the site of injection preventing the diffusion of anesthetic.
  - Correct by using the infiltration, IO in place of the MSA.

STUDENT NAME: \_\_\_\_\_  
 LAKE WASHINGTON INSTITUTE OF TECHNOLOGY  
 REQUIREMENT CHECK OFF SHEET for **LA and NITROUS**  
**LEFT HANDED OPERATOR**

All requirements must be completed at a competent (exiting) level  
**INFERIOR ALVEOLAR (including lingual and buccal) =5**

Patients Name	Date	II
(R) IABL		
(L) IABL		
(R) IABL		
(L) IABL		
(R) IABL		

**POSTERIOR SUPERIOR ALVEOLAR (PSA) =5**

Patients Name	Date	II
(L) PSA		
(R) PSA		
(L) PSA		
(R) PSA		
(L) PSA		

**MIDDLE SUPERIOR ALVEOLAR (MSA) =3**

Patients Name	Date	II
(L) MSA		
(R) MSA		
(L) MSA		

**ANTERIOR SUPERIOR ALVEOLAR (ASA) =3**

Patients Name	Date	II
(L) ASA		
(R) ASA		
(L) ASA		

**MENTAL/INCISIVE =2**

Patients Name	Date	II
(L) MENTAL		
(R) MENTAL		

**GREATER PALATINE (GP) =1**

Patients Name	Date	II
(R) GP		

**NASOPALATINE (NP) =1**

<b>Patients Name</b>	<b>Date</b>	<b>II</b>
(1) NP		

**ADDITIONAL INJECTIONS**

<b>Patients Name</b>	<b>Date</b>	<b>II</b>
(R) INFILTRATION #5		
(R) IO		

**NITROUS OXIDE/OXYGEN SEDATION =1**

<b>Patients Name</b>	<b>Date</b>	<b>II</b>

Local Anesthesia/Nitrous Oxide Lab Schedule

DATE	ACTIVITIES <b>Right Handed Operators</b>	TIME LINE
Monday December 9 <sup>th</sup> (8:30-1:00)*  <b>AM</b>	-Meet and Greet -Health History Review -DVD Basic Injection Techniques -Lab Syringe Handling -Anatomic Considerations -Instructor Demo -Injections: (R) PSA, (R) MSA, (R) ASA, (L) IABL (L) Infiltration #12 -Paper work and set up for afternoon -Distribution of Final Exam -Lunch	8:30 9:00 9:15 10:00 11:00 11:15 12:30 12:45 1:00-2:00
(2:00-4:30)*  <b>PM</b>	-Injections: (R) IABL, (R) Mental/Incisive, (L) PSA, (L) IO -Paper work and clean up	2:00 4:30
Tuesday December 10 <sup>th</sup> (9:00-12:00)*  <b>AM</b>	-Anatomic Considerations -Instructor Demo -Injections: (L) Mental/Incisive, (L) IABL, (R) PSA, (R) MSA, (R) ASA -Paper work and set up for afternoon -Lunch	9:00 9:15 9:30 11:45 12:00-1:00
(1:00-4:30)*  <b>PM</b>	-Nitrous Oxide Lecture & Exam -Nitrous Oxide Demo and Lab -Injections: (L) GP, NP -Paper work and clean up	1:00 2:00 2:30 4:30
Wednesday December 11 <sup>th</sup> (9:00-4:30)*  <b>AM</b>	-Injections: (R) IABL, (L) PSA, (L) MSA, (L) ASA -Final Exam Due Lunch	9:00 10:45 11:00
(12:00-TBA)*  <b>PM</b>	Final Injections: (R) PSA, (L) IABL  FINAL CRITIQUES (Schedule times may be adjusted due to amount of students. This lab may end earlier or later then times posted)	12:00

\*(Schedule times may be adjusted due to amount of students. Labs may end earlier or later then times posted)

Name: \_\_\_\_\_

## PRE-ANESTHETIC EVALUATION

	<b>ASA</b>	<b>ABSOLUTE/ RELATIVE</b>	<b>ANESTHETIC CHOICE</b>	<b>OTHER CONSIDERATIONS/ COMMENTS</b>	<b>MEDICAL EMERGENCY PROTOCOL (If applicable)</b>
<b>ALLERGIES:</b> Methylparaben-  Sodium Bisulfite-  Sulfa-  Latex-					
<b>ANGINA:</b> Stable-          Unstable-					

	<b>ASA</b>	<b>ABSOLUTE/ RELATIVE</b>	<b>ANESTHETIC CHOICE</b>	<b>OTHER CONSIDERATIONS/ COMMENTS</b>	<b>MEDICAL EMERGENCY PROTOCOL (If applicable)</b>
<b>ASTHMA:</b>  Steroid Induced  Exercise Induced					
<b>ATYPICAL PSEUDOCHO- LINESTERASE DEFIENCY</b>					
<b>BLEEDING DISORDERS</b>					

	<b>ASA</b>	<b>ABSOLUTE/ RELATIVE</b>	<b>ANESTHETIC CHOICE</b>	<b>OTHER CONSIDERATIONS/ COMMENTS</b>	<b>MEDICAL EMERGENCY PROTOCOL (If applicable)</b>
<b>CARDIAC DYSRHYTHMIAS</b>					
<b>CONGESTIVE HEART FAILURE</b>					
<b>CVA OR TIA'S</b>					
<b>DIABETES</b>					

	<b>ASA</b>	<b>ABSOLUTE/ RELATIVE</b>	<b>ANESTHETIC CHOICE</b>	<b>OTHER CONSIDERATIONS/ COMMENTS</b>	<b>MEDICAL EMERGENCY PROTOCOL (If applicable)</b>
<b>EPILEPSY/ SEIZURES</b>					
<b>GERIATRIC PATIENTS</b>					
<b>HEART OPERATION HEART MURMUR, CONGENITAL HEART LESIONS, RHEUMATIC FEVER, SCARLET FEVER</b>					
<b>HIGH BLOOD PRESSURE</b>					
<b>KIDNEY DYSFUNCTION</b>					

	<b>ASA</b>	<b>ABSOLUTE/ RELATIVE</b>	<b>ANESTHETIC CHOICE</b>	<b>OTHER CONSIDERATIONS/ COMMENTS</b>	<b>MEDICAL EMERGENCY PROTOCOL (If applicable)</b>
<b>LIVER DYSFUNCTION</b>					
<b>MALIGNANT HYPERTHERMIA</b>					
<b>METHMO- GLOBINEMIA</b>					
<b>MYOCARDIAL INFARCTION</b>					

	<b>ASA</b>	<b>ABSOLUTE/ RELATIVE</b>	<b>ANESTHETIC CHOICE</b>	<b>OTHER CONSIDERATIONS/ COMMENTS</b>	<b>MEDICAL EMERGENCY PROTOCOL (If applicable)</b>
<b>PACEMAKERS</b>					
<b>PREGNANCY</b>					
<b>PSYCHIATRIC TREATMENT</b>					
<b>THYROID DISEASE:</b> Controlled-  Uncontrolled-					

## DRUG INTERACTIONS

	USED FOR	EXAMPLES/ NAMES OF	CONTRA- INDICATIONS	OTHER CONSIDERATIONS/ COMMENTS
<b>BETA BLOCKERS:</b>  Non-selective-  Selective-				
<b>COCAINE</b>				
<b>CIMETIDINE</b>				
<b>TRICYCLIC ANTI- DEPRESSANTS</b>				

<b>MONOAMINE OXIDASE INHIBITORS</b>				
<b>ACETOMINOPHEN</b>				
<b>PHENOTHIAZINES</b>				

## **NOTEBOOK Lab Assignment**

### **LOCAL ANESTHETIC NOTEBOOK**

To complete this project, each student will need to create notecards using a 1-1<sup>1</sup>/<sub>2</sub> inch, three ring binder notebook (one that holds 5x8 cards), 5x8 cards (lined or unlined), and clear contact paper, or page protectors. Create a card for each of these injections using the information found in Local Anesthesia for the Dental Professional by Kathy Bassett:

- Supraperiosteal (local infiltration)
- PSA (Posterior Superior Alveolar)
- MSA (Middle Superior Alveolar)
- ASA (Anterior Superior Alveolar)
- IO (Infraorbital)
- GP (Greater palatine)
- NP (Nasopalatine)
- IA (Inferior Alveolar)
- Buccal Nerve Block
- Mental/Incisive Nerve Block
- Gow-Gates

*Each card needs to include the following information:*

- Nerves anesthetized/Field of Anesthesia
- Penetration site
- Depth of Insertion
- Teeth anesthetized
- Periodontium/Soft Tissues anesthetized
- Needle size/selection
- Amount of anesthetic solution deposited and time

- Errors or failures of anesthesia and how to correct

Additionally create a card(s) containing:

- Blood Pressure Guidelines
- Dosage Calculation
- Nitrous Oxide Administration (steps for administration and calculating percentages)
- Pediatric Anesthesia

Each card should contain a description of the criteria mentioned above. **INCLUDE PICTURES** and or diagrams that may be of additional help to you. You need to have the following pictures for each card bone, tissue/retraction, example of injection site and area of anesthesia coverage (see example below of card design). Once your cards are complete, cover them with page protectors, or clear contact paper. This will allow them to be used in a clinical setting and to be wiped off with a disinfectant. Insert the cards into your notebook for easy reference. *Please be creative* as this will be part of your grade. You may add any additional cards with any content you may find helpful to your understanding of Pain Control. Have someone in your class or outside of class proofread them before covering.

**(Card Format Example)**  
**Middle Superior Alveolar Nerve Block**  
**(MSA)**

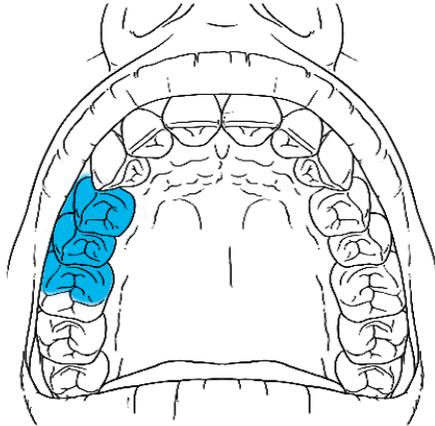
- **Nerves anesthetized/Field of Anesthesia**
  - MSA will anesthetize structures innervated by the MSA nerve (when Present)
- **Penetration site**
  - Height of the mucobuccal fold **above the maxillary second premolar.**



- **Depth of Insertion**
  - Insert the needle into the height of the mucobuccal fold above the second premolar.
  - The needle is advanced parallel to the long axis of the second premolar .
  - Advance it until the bevel is located well above the second premolar about **5 to 8 mm.**
- **Teeth anesthetized**
  - Pulp of the maxillary first and second premolars
  - MB root of the first molar

- **Periodontium/Soft Tissues anesthetized**

- Facial/Buccal tissue
- Periodontal Ligament and alveolar bone



- **Needle size/selection**

- Short 25/27 gauge

- **Amount of anesthetic solution deposited and time**

- deposit 0.9-1.2 ml (1/2-2/3rds of the cartridge) in 30-45 seconds

- **Errors or failures of anesthesia and how to correct**

- Needle tip and anesthetic not deposited high above the apex.
  - Correct by checking radiographs and increasing the depth of penetration.
- Deposition of solution too far from the maxillary bone with the needle placed in tissues lateral to the height of the mucobuccal fold.
  - Correct by reinserting at the height of the mucobuccal fold.
- Bone of the zygomatic arch at the site of injection preventing the diffusion of anesthetic.
  - Correct by using the infiltration, IO in place of the MSA.

## DHYG 138: CALCULATION PRACTICE ACTIVITIES

To perform some of the calculations listed below, you will need to know the MRD in mg/lb for the various local anesthetic drugs. For example, the MRD for Mepivacaine is 2.0 mg/lb.

1. Calculate the number of milligrams of local anesthetic drug present in a carpule of 2% Lidocaine with 1:100,000 epinephrine.
2. Calculate the number of milligrams of local anesthetic drug present in a carpule of 3% Mepivacaine.
3. Calculate the number of milligrams of local anesthetic drug present in a carpule of 0.5% Bupivacaine with 1:200,000 epinephrine.
4. Calculate the number of milligrams of vasoconstrictor present in a carpule of 2% Lidocaine with 1:100,000 epinephrine.
5. Calculate the number of milligrams of vasoconstrictor present in a carpule of 2% Lidocaine with 1:50,000 epinephrine.
6. Calculate the number of milligrams of vasoconstrictor present in a carpule of 2% Mepivacaine with 1:20,000 levenordefrin.
7. Calculate how many milligrams of local anesthetic drug could be administered to a healthy 132 lb. man when using 2% Lidocaine with 1:100,000 epinephrine.
8. Calculate how many milligrams of local anesthetic drug could be administered to a healthy 113 lb. woman when using 4% Prilocaine with 1:200,000 epinephrine.
9. Calculate how many carpules of 2% Mepivacaine with 1:20,000 levenordefrin could be administered to a healthy 140 lb. man.
10. Calculate how many carpules of 2% Lidocaine with 1:100,000 epinephrine could be administered to a healthy 163 lb. woman.
11. Calculate how many carpules of 0.5% Bupivacaine with 1:200,000 epinephrine could be administered to a healthy 128 lb. woman.
12. Calculate how many carpules of 2% Lidocaine with 1:50,000 epinephrine could be administered to a healthy 148 lb. man.
13. Calculate how many carpules of 2% Lidocaine with 1:100,000 epinephrine could be administered to a 124 lb. woman with significant cardiovascular concerns.
14. Calculate how many carpules of 3% Mepivacaine (with no vasoconstrictor) could be administered to a healthy 101 lb. woman.
15. Calculate how many carpules of 2% Lidocaine with 1:100,000 epinephrine could be administered to a 57 lb. child.

## Answer Key for the Calculation Practice Activities

1. Calculate the number of milligrams of local anesthetic drug present in a carpule of 2% Lidocaine with 1:100,000 epinephrine.  
**ANSWER: 36 mg**
2. Calculate the number of milligrams of local anesthetic drug present in a carpule of 3% Mepivacaine.  
**ANSWER: 54 mg**
3. Calculate the number of milligrams of local anesthetic drug present in a carpule of 0.5% Bupivacaine with 1:200,000 epinephrine.  
**ANSWER: 9mg**
4. Calculate the number of milligrams of vasoconstrictor present in a carpule of 2% Lidocaine with 1:100,000 epinephrine.  
**ANSWER: .018 mg**
5. Calculate the number of milligrams of vasoconstrictor present in a carpule of 2% Lidocaine with 1:50,000 epinephrine.  
**ANSWER: .036 mg**
6. Calculate the number of milligrams of vasoconstrictor present in a carpule of 2% Mepivacaine with 1:20,000 levonordefrin.  
**ANSWER: .09 mg**
7. Calculate how many milligrams of local anesthetic drug could be administered to a healthy 132 lb. man when using 2% Lidocaine with 1:100,000 epinephrine.  
**ANSWER: 264 mg**
8. Calculate how many milligrams of local anesthetic drug could be administered to a healthy 113 lb. woman when using 4% Prilocaine with 1:200,000 epinephrine.  
**ANSWER: 305.1 mg**
9. Calculate how many carpules of 2% Mepivacaine with 1:20,000 levonordefrin could be administered to a healthy 140 lb. man.  
**ANSWER: 7.5 carpules**
10. Calculate how many carpules of 2% Lidocaine with 1:100,000 epinephrine could be administered to a healthy 163 lb. woman.  
**ANSWER: 8 carpules**
11. Calculate how many carpules of 0.5% Bupivacaine with 1:200,000 epinephrine could be administered to a healthy 128 lb. woman.  
**ANSWER: 8.5 carpules**
12. Calculate how many carpules of 2% Lidocaine with 1:50,000 epinephrine could be administered to a healthy 148 lb. man.  
**ANSWER: 5.5 carpules**
13. Calculate how many carpules of 2% Lidocaine with 1:100,000 epinephrine could be administered to a 124 lb. woman with significant cardiovascular concerns.  
**ANSWER: 2 carpules**
14. Calculate how many carpules of 3% Mepivacaine (with no vasoconstrictor) could be administered to a healthy 101 lb. woman.  
**ANSWER: 3.5 carpules**
15. Calculate how many carpules of 2% Lidocaine with 1:100,000 epinephrine could be administered to a 57 lb. child.  
**ANSWER: 3 carpules**



# CODE 240 & 245 NITROUS OXIDE CONSCIOUS SEDATION

Beth Davis RDH, MS

6/15/2015

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## History of Nitrous Oxide

- Joseph Priestly discovered nitrous oxide in 1772.
- It was first used in dentistry in 1844.
- In 1868 it was combined with oxygen for use in pain control.

6/15/2015

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## Frequency of Use

- This conscious sedation is very useful in helping patients relax and it can provide pain control for procedures that are only slightly to moderately painful.
- If significant pain is present, it may be combined with local anesthetics.
- It is a weak anesthetic but a strong analgesic.
- It is commonly employed in dentistry today.
- Nitrous Oxide raises a patient's threshold for pain.

6/15/2015

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## NITROUS OXIDE SEDATION

WAC 246-817-560 (4) states the dental hygienists can administer nitrous oxide analgesia under close supervision.

6/15/2015

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## GOALS

- Relieve anxiety and fear
- Stress reduction
- Reduce pain perception
- Make patient more comfortable, calm and relaxed
- Possible amnesia and analgesia effects
- Light sedation and mood alteration
- Patient to remain conscious with protective reflexes intact

6/15/2015

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## Advantages

- Excellent choice for cardio patients
- Simple and safe
- Individual is awake
- Onset and recovery are fast (approximately 2-3 minutes)
- No accompaniment needed
- No preoperative lab tests
- No need for special recovery room

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## Disadvantages

- Production of Vertigo, nausea, vomiting if too much is given or if levels fluctuate too much
- Individuals with extreme behavior problems cannot be managed well
- Equipment is cumbersome
- Mask gets in the way
- Long term exposure may cause health problems for health care workers

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## CONTRAINDICATIONS (relative)

- Communication and cooperation difficulty
  - Ex., language barriers-constant communication is necessary when administering Nitrous Oxide.
  - You also need your patients to cooperate and respond to your directions.
- COPD (Chronic Obstructive Lung Disease)
  - (emphysema, chronic bronchitis) that results in high CO<sub>2</sub> blood levels.
  - N<sub>2</sub>O/O<sub>2</sub> administers high percentage of O<sub>2</sub> thus reducing patients respiratory drive.
- Nasal obstructions
  - Ex., deviated septum, cold, sinus infections, allergies
- Middle ear disturbances
  - N<sub>2</sub>O causes increased pressure on the tympanic membrane.
  - Postpone treatment until condition is resolved.

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## CONTRAINDICATIONS (relative)

- Pregnancy
  - N<sub>2</sub>O does cross the placenta-fetus will experience the same CNS depression as the mother.
  - Avoid during 1<sup>st</sup> and last trimester.
  - Obtain medical consult before using.
- Personality disorders and emotional instability
  - (mental illness, retardation, autism, Alzheimer's, chemical dependency) N<sub>2</sub>O can cause distortion of time and reality.
  - Unpleasant feelings may surface.
- Bowel obstructions
  - Air spaces in the gut can be displaced by N<sub>2</sub>O
- Claustrophobia and sever phobias-
  - Patient may feel threatened by the nasal hood and mask.
  - Phobic individuals may actually resist the calming effects of N<sub>2</sub>O; making the situation worse.
- Severe behavior problems
  - Especially children

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## CONTRAINDICATIONS (relative)

- \*\*The degree of contraindication needs to be evaluated on an individual case basis.
- It may be necessary to obtain a medical consult with the patient's physician to determine the individual's sensitivity to N<sub>2</sub>O.
- There are no absolute contraindications the N<sub>2</sub>O/O<sub>2</sub> sedation as long as oxygen is administered along with nitrous oxide at 20%.

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## INDICATIONS

- Management of fear, anxiety, or mild apprehension
- Reduces stress for medically compromised patient
  - Cardiovascular disease, angina, CHF, post MI, dysrhythmia's, HBP
- Reduces gagging
  - Helpful in taking impressions and x-rays
- Refusal of anesthesia
  - (general or local)

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## INDICATIONS

- Reduces pain sensation of dental procedures
  - Local anesthetic administration, scaling/RP, probing, ultrasonics, etc...
- Most children with *mild* anxiety
- Long appointments
  - N<sub>2</sub>O can make the patient perceive that time is passing quickly
- Allergy to local anesthetics
- Cerebral Palsy and mental retardation

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## INDICATIONS

### Patients with:

- Asthma
- Epilepsy (seizure disorders)
- Stroke
- Parkinson's Disease
- CP, MS, MD
- Fainting spells

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# QUIZ YOURSELF

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## Question #1

You can use Nitrous Oxide on a patient with a cold?

True or False

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## Question #2

Your patient has angina pectoris and has brought nitroglycerin with him today. Can you safely administer Nitrous Oxide?

Yes or No

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## Question #3

Nitrous Oxide *lowers* a patient's threshold for pain?

True or False

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## Question #4

How long will it take a typical patient to exhibit clinical signs and symptoms of nitrous oxide sedation?

- a) Immediately upon application
- b) 2-3 minutes
- c) 20-30 seconds

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## QUESTION #5

Nitrous Oxide will help to reduce gagging?

True or False

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NITROUS OXIDE	OXYGEN
Stored as a liquid, delivered as a gas	Stored as a gas
Colorless, sweet odor Non-irritating to respiratory membranes	Colorless, odorless Makes up ~21% of atmosphere
Stored in a <b>BLUE</b> cylinder	Stored in a <b>GREEN</b> cylinder
Supports combustion *Can explode if oil or grease is present under high pressure	Supports combustion *Can explode if oil or grease is present under high pressure
<b>Full tank = 750 psi (650-900 psi)</b>	<b>Full tank = 2100 psi</b>
Low solubility in blood Rapidly absorbed from lungs to blood supply	
Rapidly eliminated from blood to lungs	

Why is it important to administer 100% oxygen for 3-5 minutes to a patient following nitrous oxide/oxygen sedation?

- Prevents diffusion hypoxia
- To Provide an O<sub>2</sub> flush- provides the total tidal volume of oxygen to flush nitrous oxide out of the system

What is SCAVENGING?

- Removes excess nitrous oxide
- Minimizing trace amounts of nitrous oxide before, during, and after use by the patient.
- Scavenging nasal mask

**EFFECTS OF NITROUS OXIDE CONSCIOUS SEDATION**

- **Conscious Sedation:**
  - A method of pain control that decreases the clients pain and stress where the client is awake and able to respond to commands, breathe, and cough.

## PHARMACOLOGY

- Pharmacological effects on the CNS:
  - Nitrous oxide has no effect on the heart rate, blood pressure, liver or kidney as long as an adequate level of oxygen is also administered at the same time.
  - It does effect sensations such as hearing, touch, pain, and warmth.
  - Background sounds are heard better than close sounds.
  - The gag reflex is also reduced; therefore nitrous oxide-oxygen sedation can be helpful for a patient who has a problem with the gag reflex during dental procedures.

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$N_2O$  is transported through the lungs  
 $N_2O$  is rapidly into the pulmonary circulation

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## PHYSIOLOGY

- Nitrous is a CNS depressant:
  - It affects the cerebral cortex, thalamus, hypothalamus, and reticular activating system.
  - The exact mechanism of action is unknown
  - It either alters the relay of nerve impulses to the cerebral cortex or causes them to be interpreted differently.
  - Consequently, pain and anxiety are reduced.
  - Pain perception is not blocked, so local anesthesia may still be necessary.
  - It does not combine with any body tissues and it is not metabolized.
  - It enters the body through the lungs and exits unchanged through the lungs.

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## PHYSIOLOGY

- There still can be toxic reactions with oversedation.
- Diffusion Hypoxia (oxygen deficiency) is associated with too much nitrous oxide and not following up with proper oxygenation.

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## QUIZ YOURSELF

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## QUESTION #6

Nitrous Oxide acts on the body by:

- Exciting the CNS
- Depressing the CNS
- Exciting the cardiovascular system
- Depressing the cardiovascular system

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### QUESTION #7

Nitrous Oxide is stored in a cylinder of what color?

Green or Blue

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### QUESTION #8

Nitrous Oxide exits the body through the:

- a) lungs
- b) kidneys
- c) liver
- d) urinary system

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### QUESTION #9

You can smell Nitrous Oxide gas?

True or False

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### QUESTION #10

Nitrous Oxide administration can increase a patient's blood pressure?

True or False

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### LEVELS OF SEDATION AND ANESTHESIA

<b>STAGE I</b> Analgesia/Sedation	Patient feels pain but does not respond to it. This level of sedation is appropriate for dental hygiene care.
<b>STAGE II</b> Excitement/Delirium	Hyper-responsive to stimuli Exaggerated responses Loss of consciousness
<b>STAGE III</b> Planes of Surgical Anesthesia	Oral surgery
<b>STAGE IV</b> Medullary Paralysis/Death	Major surgery in hospital setting

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### SIGNS AND SYMPTOMS OF N<sub>2</sub>O/O<sub>2</sub> SEDATION

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## EARLY TO IDEAL SEDATION

- Facial muscles relax – slight smile
- Light headedness (dizziness)
- Tingling: hands, feet, lips, etc.
- Wave of warmth
- Numbness: hands, feet, lips, etc.
- Feeling of euphoria
- Light or floaty feeling or heaviness
- Analgesia
- Utterly relaxed

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## EARLY TO IDEAL SEDATION

- Mouth remains open
- Normal vital signs, regular breathing
- Slight flush to skin
- Patient responds readily to commands
- Eyes will glaze over

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## HEAVY SEDATION TO SLIGHT OVERDOSE

- Hearing becomes more acute
- Visual images become confused (ceiling patterns move)
- Sleepiness
- Laughing, crying, dreaming
- Less likely to respond to verbal commands
- Mouth tends to close
- Nausea
- Increased movement

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## OVERSEDATION

- Nausea/vomiting
- Loss of consciousness, patient responds irrationally
- Protective reflexes suppressed
- Mouth breathing- (rubber dam reduces this)
- Patient complains they are uncomfortable
- Needs repeated commands/responds sluggishly
- Patient feels like they are losing control
- Uncooperative
- Uncoordinated movements

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## MANAGEMENT OF OVERSEDATION

- **Observe continually** and question your patient to first prevent oversedation.
- If oversedation occurs, reduce N<sub>2</sub>O by 1 lpm and recovery to the optimum state should be returned within 30 seconds.
- Use 100% O<sub>2</sub>, flush if necessary – (30 lpm of 100% oxygen).
  - Turn off N<sub>2</sub>O
- Use basic life support if necessary
- Call 911 if needed.
- **EMESIS:** (Vomiting) turn off N<sub>2</sub>O and apply 100% oxygen.
  - Turn head to side and clear pharynx.
  - Reapply 100% O<sub>2</sub> for 3-5 minutes.

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## ADVERSE REACTIONS and COMPLICATIONS

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## DIFFUSION HYPOXIA

- Lack of O<sub>2</sub> to tissues
- Patient may have headache, feel groggy, or be nauseated "hung-over"
- This may occur if the patient is not oxygenated adequately following sedation.

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## NAUSEA and VOMITING

- This is associated with the patient being given too much nitrous oxide, although it may also occur if the patient eats a large meal before the appointment.
- It is also associated with "seesawing" the level too much during treatment.
- If nausea persists, the patient should be given 100% oxygen for several minutes.
- Reassure the patient that they will feel better after receiving oxygen.

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## CORNEAL IRRITATION

- Leakage of gas from the mask may dry eyes and cause irritation, especially for patients who wear contact lenses.
- You may choose to have the patient remove their contacts first.

6/15/2015

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## BEHAVIORAL PROBLEMS

- Repeated closing of mouth and a rigid mandible may indicate too high of a level.
  - Turn the nitrous oxide down 2 L and the oxygen up 2 L to see if the situation improves.
- Some patients may suddenly yank the mask off if the feeling of not having total control bothers them.
- If any unusual behavior occurs, follow the 2 lpm rule: turn nitrous down 2 lpm/oxygen up 2 lpm or administer 100% O<sub>2</sub>

6/15/2015

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## EQUIPMENT MALFUNCTIONS

- Contaminated nitrous oxide cylinders can contain nitrogen dioxide and on administration may produce nitric acid with serious consequences to your patient.
- Valves on the nitrous oxide cylinders must be closed when not in use to prevent this.

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## HAZARDS TO PERSONNEL

- Studies conducted on operating room personnel, oral surgeons, and others who are chronically exposed to nitrous oxide (1000-15,000 ppm) have shown:
- spontaneous abortions
  - birth defects
  - bone marrow suppression
  - anemia
  - hepatic and renal disease
  - cancer

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## HAZARDS TO PERSONNEL

Reduce N<sub>2</sub>O concentrations from 900 ppm to 30 ppm by using combinations of the following:

- scavenging system
- well fitting mask
- discourage talking and mouth breathing
- proper ventilation the suction machine containing the exhaled gases to the outside of the building
- use a fan
- check & maintain equipment for leaks
- wear a badge
- open a window

6/15/2015

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## QUIZ YOURSELF

6/15/2015

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### QUESTION #11

Indications that your patient has reached an undesirable level of nitrous oxide sedation include which of the following:

- a) flushing of the skin
- b) slow speech
- c) uncontrollable laughing
- d) mild perspiration
- e) All of the above

6/15/2015

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### QUESTION #12

While getting ready to dismiss your patient after a long appointment where you had him on nitrous oxide/oxygen sedation for 45 minutes, he complains of a headache and nausea. What most likely is the cause of this?

- a) he received the nitrous for too long
- b) he did not receive 100% oxygen for a sufficient amount of time after the nitrous was turned off
- c) he received too much 100% oxygen after the nitrous was turned off
- d) it has nothing to do with the administration of nitrous oxide/oxygen

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### QUESTION #13

The ideal stage of sedation and anesthesia for dental hygiene care is:

- a) Stage I
- b) Stage II
- c) Stage III
- d) Stage IV

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### QUESTION #14

Your patient complains of a "hung-over" feeling following nitrous oxide administration. What is most likely the cause?

- a) nausea
- b) corneal irritation
- c) diffusion hypoxia
- d) scavenger system

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## QUESTION #15

Which of the following can help to reduce hazards to personnel while operating nitrous?

- a) check equipment for leakage
- b) using a fan
- c) wearing a monitoring badge
- d) keeping conversations to a minimum
- e) a, b and d
- f) a, b and c
- g) All of the above

6/15/2015

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## Nitrous Oxide Administration Procedure

- Introducing nitrous can be done anytime when signs of anxiety or fear are expressed by a patient.
- A general description of the beneficial effects of N<sub>2</sub>O is recommended, as we all will respond differently.

6/15/2015

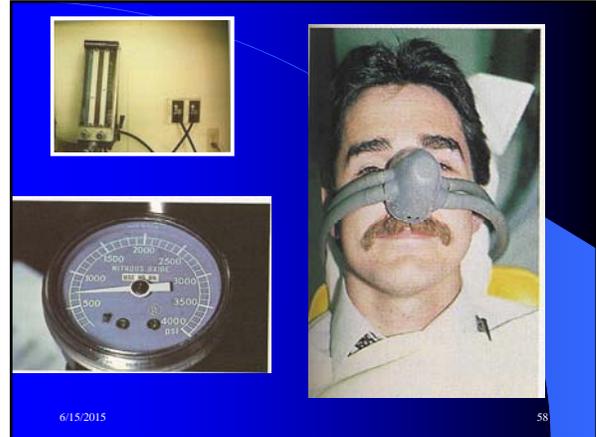
56

A, Flowmeter. B, Pressure gauge. C, Yoke. D, Gas hose. E, Reservoir bag.



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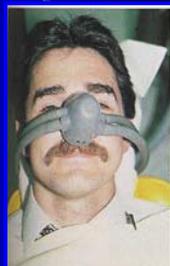


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## Administration of N<sub>2</sub>O/O<sub>2</sub>

- 1. Prepare the gas machine and related armamentaria before seating the client.
- Select appropriate sterilized nasal mask for size and attach it to mask tubing



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## Administration of N<sub>2</sub>O/O<sub>2</sub>

- 2. Open gas cylinder valves and check on gas supply.
  - Open oxygen tank slowly, then the nitrous oxide tank.
  - (Centralized systems are turned on at the beginning of the day).



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## Administration of N<sub>2</sub>O/O<sub>2</sub>

- 3. Adjust scavenger system.
  - Obtain suction calibrator.
- 4. Attach the suction calibrator to the high-speed vacuum system and adjust the suction until the steel ball in the calibrator is made to float in the clear zone of the calibrator's window




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## Administration of N<sub>2</sub>O/O<sub>2</sub>

- 5. Nose mask with two pairs of hoses.
- 6. The sterilized nose mask connects to two hoses coming off each side of it.
  - Each pair of hoses is joined by an adaptor.
  - The larger adaptor connects to the gas machine.
  - The smaller adaptor connects to the high-speed suction system.
- 7. Attach the smaller adaptor on the nose mask to the calibrated high-speed vacuum system




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## Administration of N<sub>2</sub>O/O<sub>2</sub>

- 8. Attach the larger adaptor of the sterilized nose mask to the gas machine.
  - Turn on the gas machine.
- 9. Seat the client, check and record the health history, blood pressure, and pulse.




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## Administration of N<sub>2</sub>O/O<sub>2</sub>

- 10. Familiarize client with procedures; discuss nasal breathing and nose mask, and describe sensations of warmth and tingling that will be experienced; reaffirm the relaxing, comfortable feeling the client will experience.
  - Assure clients that they will be aware of and in control of their actions.
- 11. Start oxygen flow at estimated tidal volume (6 to 8 L/min).




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## Administration of N<sub>2</sub>O/O<sub>2</sub>

- 12. Have client seat the nose mask on him- or herself and adjust it so it is comfortable.
  - Then, operator should adjust nose mask tubing to hold the mask in place, and confirm comfortable fit with the client.
- 13. If mask is impinging on a sensitive area on the face or if the mask is too big, place a gauze square under the edge of the mask.




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## Administration of N<sub>2</sub>O/O<sub>2</sub>

- 14. Determine exact tidal volume by asking the client if he or she has enough air to breathe comfortably.
  - Adjust volume or oxygen as per client response.
- 15. Introduce nitrous oxide in increments of 0.5 to 1 L/min and reduce oxygen by a corresponding amount.




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## Administration of N<sub>2</sub>O/O<sub>2</sub>

- 16. Repeat step 15 at 60-second intervals until a baseline level is established.
  - (This is called Titration)
- 17. Near the end of the appointment (eg., during tooth polishing), discontinue the nitrous oxide and increase the oxygen concentration to 100%.
  - Oxygenate 5 minutes for every 15 minutes of exposure to N<sub>2</sub>O/O<sub>2</sub>



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## Administration of N<sub>2</sub>O/O<sub>2</sub>

- 18. If the client feels normal, discharge him or her.
- 19. Document the experience in the client's record.
  - Note vital signs, concentrations of nitrous oxide and oxygen administered, length of time of sedation and oxygenation, the care provided, and the client's response to the sedation.



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## Nitrous Oxide Administration Procedure

- General procedures:
  - 1. Have patient sign a chart entry in the treatment record stating that no medication "substance" has been received in the last 48 hours.
  - 2. Remove contact lenses worn by the patient.
  - 3. Advise patient of our goal to reach an ideal level of relaxation definitely different than normal.
  - 4. With the equipment set-up at a flow of 6 liters per minute and approximately 85% oxygen (25% nitrous), place the nasal hood on the patient's nose.

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## Nitrous Oxide Administration Procedure

- General procedures:
  - 5. Determine the appropriate flow volume of nitrous oxide by observing the patient's signs and symptoms.
    - Constantly watch and question the patient to monitor their level of sedation.
  - 6. Advise the patient to breathe through their nose and see that they are breathing comfortably.
    - Adjust flow volume if necessary.
  - 7. Observe the reservoir bag – it should be filled and changing in size with patient's breathing.

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## Nitrous Oxide Administration Procedure

- General procedures:
  - 8. Adjust the gas volumes up to 20% N<sub>2</sub>O and 80% (approximately 1 liter/minute of nitrous oxide and 5 liters/minute of oxygen).
  - Be sure the total gas volume of both nitrous oxide and oxygen is sufficient for the patient (5-7 liters/minute is adequate).
  - 9. After 90 seconds ask the patient, "What are you feeling?"
    - If this level of N<sub>2</sub>O is inadequate to produce the "ideal sedation", adjust the N<sub>2</sub>O percentages upward, 0.5 liters each 1 ½ minutes.
    - (ex., move N<sub>2</sub>O to 25% - approximately 1.5 liters/minute of N<sub>2</sub>O and 4.5 liters/minute of O<sub>2</sub> wait 1 ½ minutes to check level of sedation).
  - \*\* As you turn up N<sub>2</sub>O, turn O<sub>2</sub> down to stay at the same total flow, NEVER reduce oxygen below 2—3 liters while in use!
  - 10. Repeat the adjustments of N<sub>2</sub>O flow percent until the ideal sedation is reached.

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## Nitrous Oxide Administration Procedure

- MAXIMUM N<sub>2</sub>O PERCENT IS AT 42%!!:
  - Example:  $\frac{2.5 \text{ lpm N}_2\text{O}}{3.5 \text{ lpm O}_2} = 42\% \text{ maximum}$

We usually adjust to the lighter side of sedation rather than oversedate.

Patient's sedation may alter during the appointment so be alert to alter N<sub>2</sub>O accordingly

Ex., the rubber dam may change their breathing pattern.

6/15/2015

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## Nitrous Oxide Administration Procedure

- When need for sedation is over:
  - 1. Return to 6 liters per minute of 100% O<sub>2</sub> for 3 minutes at least for scavenging purposes.
  - \*For every 15 minutes of nitrous oxide/oxygen sedation, the patient must receive 5 minutes of 100% oxygen.
  - 2. Remove nasal hood and clear machine of gas (using O<sub>2</sub> flush button).
  - 3. Suggest to your patient that they will feel refreshed and alert as N<sub>2</sub>O is eliminated quickly.
    - Make sure that the patient has fully recovered before releasing them.
  - 4. Record all: date of N<sub>2</sub>O, dosage, duration and patient condition during and after treatment.

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## Equipment for N<sub>2</sub>O/O<sub>2</sub> Administration

- Gas Cylinders:
  - Oxygen—**green** cylinder in U.S.
  - Nitrous Oxide—**blue** cylinder in U.S.
  - Pressure stays constant even as gas is removed.
    - Cylinder valves
    - Pressure gauges
    - Pin Index Safety System

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## Equipment for N<sub>2</sub>O/O<sub>2</sub> Administration

- Regulators:
  - Decrease high pressure from cylinders for patient delivery

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## Equipment for N<sub>2</sub>O/O<sub>2</sub> Administration

- Flowmeters:
  - Measures liters per minute of gas.
  - Oxygen minimum is \_\_\_\_\_ liters/minute on these machines.
  - Flowmeter Valves:
    - Fail safe mechanism which allows N<sub>2</sub>O flow only when there is a flow of O<sub>2</sub> to the system.
    - If O<sub>2</sub> flow is less than 30% N<sub>2</sub>O stops flowing.

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## Equipment for N<sub>2</sub>O/O<sub>2</sub> Administration

- Warning Whistle:
  - Goes off when the oxygen runs out
- Reserve Bag:
  - 3-liter bag allowing ample reserve gas for breathing.
- Conduction tubing:
- Scavenging Nasal Mask:
  - Vacuum system pulls off exhaled gases so nitrous oxide level to operate is minimized.
  - Masks are in 3 sizes.
- Oxygen Flush Button:
  - Delivers 30 lpm of oxygen now.

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## COMPUTING and ADMINISTERING N<sub>2</sub>O

- Tidal Volume-  
The amount of air needed for one respiration cycle.
- AVERAGE ADULT = 6-8 liters.
- Levels may vary from 5-9 liters.

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## COMPUTING and ADMINISTERING N<sub>2</sub>O

- Patient should always receive at least six (6) liters/minute of total gases (nitrous oxide and oxygen).
- Total levels of flow vary from 5-9 liters/minute per individual.
- "Percent of nitrous oxide" is the term we usually refer to when administering N<sub>2</sub>O/O<sub>2</sub> sedation.

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## COMPUTING and ADMINISTERING N<sub>2</sub>O

- Whatever you set the flow of oxygen and nitrous on it is the flow per minute.
- The mechanism doses per minute.
- So if you set the nitrous on 2; that's two liters of nitrous per minute.
- The same is true for oxygen.
  - Ex: 2 liters nitrous  
+6 liters oxygen  
8 total liters of flow

The important number to know the % of nitrous out of the total flow:

$$\frac{2 \text{ liters nitrous}}{8 \text{ total liter flow}} = 25\% \text{ nitrous}$$

6/15/2015

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## COMPUTING and ADMINISTERING N<sub>2</sub>O

- Common Mistake:
    - 2 liters nitrous
    - 4 liters oxygen
- First glance people might think the % is 50/50 (or 50%)  
Remember the % is out of the total flow, so...

$$\begin{array}{r} 2 \text{ liters nitrous} \\ +4 \text{ liters oxygen} \\ \hline 6 \text{ total liters of flow} \end{array}$$

The important number to know is the % of the nitrous out of the total flow.

$$\frac{2 \text{ liters nitrous}}{6 \text{ total liter flow}} = 33 \frac{1}{3}\%$$

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## COMPUTING and ADMINISTERING N<sub>2</sub>O

- Try this one:
  - Oxygen in liters 4.5
  - Nitrous in liters 1.5
- What is the total liter flow? \_\_\_\_\_ thus,  
\_\_\_\_\_ lpm = \_\_\_\_\_ N20%  
\_\_\_\_\_ lpm

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## COMPUTING and ADMINISTERING N<sub>2</sub>O

- Always make sure to divide the percentage of N<sub>2</sub>O used over the TOTAL TIDAL VOLUME!
- In this case, the TTV = 6 lpm
- $\frac{1.5}{6} = 25\% \text{ N}_2\text{O}$
- LWTC policy- NEVER exceed 42% N<sub>2</sub>O!

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## Signs and Symptoms

CONCENTRATION N <sub>2</sub> O	RESPONSE
10% TO 20%	Body warmth, Tingling of hands and feet
20% to 30%	Cirumoral numbness, Numbness of thighs
20% to 40%	Numbness of tongue Numbness of hands and feet Droning sounds present Hearing distinct but distant Dissociation begins and reached peak Mild Sleepiness Analgesia (maximum at 30%) Euphoria Feeling of heaviness or lightness of body

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### Signs and Symptoms

CONCENTRATION N <sub>2</sub> O	RESPONSE
30% to 50%	Sweating Nausea Amnesia Increased sleepiness
40 to 60%	Dreaming, laughing, giddiness Further increased sleepiness, tending toward unconsciousness Increased nausea and vomiting
50% and over	Unconsciousness and light general anesthesia

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# QUIZ YOURSELF

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### QUESTION #16

A patient with chronic emphysema is absolutely contraindicated to receive nitrous oxide/oxygen sedation:

- a) true
- b) false

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### QUESTION #17

The tidal volume of O<sub>2</sub> for the average healthy adult is generally \_\_\_\_\_ liters per minute.

- a) 1-2
- b) 3-5
- c) 5-9
- d) 8-10

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### QUESTION #18

Indications that your patient has reached a desirable level of nitrous oxide sedation include all the following except.

- a) Blood pressure is increased
- b) Drowsy, relaxed appearance
- c) Physical relaxation
- d) Lessened pain reaction
- e) Tingling or numbness floating sensation

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### QUESTION #19

Which of the following is not a sign or symptom characteristic of oversedation of nitrous oxide?

- a) nausea
- b) vomiting
- c) Wave of warmth
- d) Loss of consciousness
- e) All of the above are signs or symptoms of oversedation.

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## QUESTION #20

Administering 100% O<sub>2</sub> to your patient for a minimum of 3-5 minutes following a 45 minutes administration of N<sub>2</sub>O/O<sub>2</sub> will decrease the likelihood that diffusion hypoxia will occur.

- a) true
- b) false

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**THE END**

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7. **Radiologic Proficiency Course – The DANB RHS Review Course**

**818-042-0050**

**Taking of X-Rays — Exposing of Radiographs**

(1) A dentist may authorize the following persons to place films, adjust equipment preparatory to exposing films, and expose the films under general supervision:

(a) A dental assistant certified by the Board in radiologic proficiency; or

(b) A radiologic technologist licensed by the Oregon Board of Medical Imaging and certified by the Oregon Board of Dentistry (OBD) who has completed ten (10) clock hours in a Board approved dental radiology course and submitted a satisfactory full mouth series of radiographs to the OBD.

(2) A dentist may authorize a dental assistant who has completed a course of instruction approved by the Oregon Board of Dentistry, and who has passed the written Dental Radiation Health and Safety Examination administered by the Dental Assisting National Board, or comparable exam administered by any other testing entity authorized by the Board, or other comparable requirements approved by the Oregon Board of Dentistry to place films, adjust equipment preparatory to exposing films, and expose the films under the indirect supervision of a dentist, dental hygienist, or dental assistant who holds an Oregon Radiologic Proficiency Certificate. The dental assistant must successfully complete the clinical examination within six months of the dentist authorizing the assistant to take radiographs.

The Board has received a request for Mary Davidson, R.D.H (Attachment 1) requesting that the Board approve The DANB RHS Review Course as a Board approved course for Radiologic Proficiency. Dental assistants in Oregon are having a hard time finding a Board approved course in rural areas as well as locally in the Portland Metro area. Most dentists who have been approved to put on radiology courses tend to put the course on for their staff, but don't typically offer it any other time. This course would enable dental assistants to be able to take a Board approved course online, pass the written Radiation Health and Safety Examination and then be allowed to learn to take radiographs in a dental office. The dental assistant would be required to submit and pass their clinical examination (full mouth series) within 6 months of the dentist authorizing them to take radiographs.

To assist the Board, the Dale Foundation has granted Board Members access to the DANB RHS Review course.

Hello Teresa,

As a member of a rural dental community and dental hygienist in public health I am cognizant of barriers regarding dental assistants obtaining their Oregon Radiologic Proficiency Certification. Due to the driving time commitment and rising gasoline costs it is often prohibitive for local DAs to commute to Portland for an OBD approved course. I have given Oregon Board of Dentistry (OBD) approved courses in the past with little or no reimbursement to enable dental assistants to procure the requirements. Part of my planned course work included the Dale Radiation Health and Safety (RHS) Review: an online interactive learning experience covering topics required for OBD course instruction. This class has a cost of \$130.00 per student, is interactive, and has 13 course modules with pre and post assessment questions. The Dale Foundation permitted access to this educational tool prior to incorporating it in my class. I found it to be exceptionally informative, easy to navigate while providing consistent and standardized material on the required OBD subjects. Dental Assistant students were able to proceed through the Dale RHS at their own pace and review if needed. In a “didactic only” environment students with different learning styles or bilingual communication needs may not be able to have individual explanations during the class, but if “online” they are able to review then proceed when comfortable and/or ask questions at the next class.

A quick view can be seen at:

<https://youtu.be/2RxNdakcrTQ>

Thank you,  
Mary Davidson MPH, RDH

## Stephen Prisby

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**From:** Budo, Pat [Patricia.Budo@providence.org]  
**Sent:** Monday, June 15, 2015 11:48 AM  
**To:** Stephen Prisby  
**Cc:** Adamson, Jessica R; Downey, Kristen J  
**Subject:** Providence Specialty Pediatric Dental Clinic

Dear Mr. Prisby,

Providence Health & Services appreciates your continued support for our specialty pediatric dental clinic, located at the Providence Child Center. This clinic makes it possible for children with developmental, medical and behavioral disabilities to receive preventive and restorative dental care in a safe, child-friendly environment.

During the 2015 legislative session Providence, in collaboration with the Oregon Dental Association, worked with legislators to pass Senate Bill 474 which was signed into law by Governor Brown on June 11<sup>th</sup>. The bill amends Oregon Revised Statutes 679.020 regarding dental clinic ownership to allow "nonprofit charitable organizations as described in section 503(c)(3) of the Internal Revenue Code and determined by the Oregon Board of Dentistry as having an existing program that provides medical and dental care to medically underserved children with special needs at an existing single fixed location or multiple mobile locations."

Based on this new provision, we're writing to request that the Oregon Board of Dentistry determine that the Providence Child Center has an existing program, the Providence Specialty Pediatric Dental Clinic, that provides medical and dental care to medically underserved children with special needs at a single fixed location. Our clinic, located at 830 NE 47<sup>th</sup> Ave., Portland, OR, serves a population of children ages one to 21 who present with a wide variety of special needs including autism spectrum disorder, medical fragility, genetic syndromes and behavioral health issues. The special needs of these children have precluded their receiving dental care from pediatric and general dentists in the community. Additionally, most of the children that we serve are on Medicaid resulting in additional access challenges.

Thank you for your consideration of this request. Please let us know if you require any additional information.

Sincerely,  
Patricia Budo  
Executive Director, Children's developmental health  
[patricia.budo@providence.org](mailto:patricia.budo@providence.org)  
(503) 215-2413

*Pat*

Patricia Budo  
Executive Director - Children's Developmental Health  
830 NE 47th Ave.  
Portland, OR 97213  
(503)215-2413  
[patricia.budo@providence.org](mailto:patricia.budo@providence.org)

**Enrolled**  
**Senate Bill 474**

Sponsored by Senator GELSER; Representatives MCLANE, PARRISH (Presession filed.)

CHAPTER .....

AN ACT

Relating to dental business entities for children with special needs; amending ORS 679.020; and declaring an emergency.

**Be It Enacted by the People of the State of Oregon:**

**SECTION 1.** ORS 679.020 is amended to read:

679.020. (1) A person may not practice dentistry without a license.

(2) Only a person licensed as a dentist by the Oregon Board of Dentistry may own, operate, conduct or maintain a dental practice, office or clinic in this state.

(3) The restrictions of subsection (2) of this section, as they relate to owning and operating a dental office or clinic, do not apply to a dental office or clinic owned or operated by any of the following:

(a) A labor organization as defined in ORS 243.650 and 663.005 (6), or to any nonprofit organization formed by or on behalf of such labor organization for the purpose of providing dental services. Such labor organization must have had an active existence for at least three years, have a constitution and bylaws, and be maintained in good faith for purposes other than providing dental services.

(b) The School of Dentistry of the Oregon Health and Science University.

(c) Public universities listed in ORS 352.002.

(d) Local governments.

(e) Institutions or programs accredited by the Commission on Dental Accreditation of the American Dental Association to provide education and training.

(f) Nonprofit corporations organized under Oregon law to provide dental services to rural areas and medically underserved populations of migrant, rural community or homeless individuals under 42 U.S.C. 254b or 254c or health centers qualified under 42 U.S.C. 1396d(1)(2)(B) operating in compliance with other applicable state and federal law.

(g) Nonprofit charitable corporations as described in section 501(c)(3) of the Internal Revenue Code and determined by the Oregon Board of Dentistry as providing dental services by volunteer licensed dentists to populations with limited access to dental care at no charge or a substantially reduced charge.

**(h) Nonprofit charitable corporations as described in section 501(c)(3) of the Internal Revenue Code and determined by the Oregon Board of Dentistry as having an existing program that provides medical and dental care to medically underserved children with special needs at an existing single fixed location or multiple mobile locations.**

(4) For the purpose of owning or operating a dental office or clinic, an entity described in subsection (3) of this section must:

(a) Except as provided in ORS 679.022, name an actively licensed dentist as its dental director, who shall be subject to the provisions of ORS 679.140 in the capacity as dental director. The dental director, or an actively licensed dentist designated by the director, shall have responsibility for the clinical practice of dentistry, which includes, but is not limited to:

(A) Diagnosis of conditions within the human oral cavity and its adjacent tissues and structures.

(B) Prescribing drugs that are administered to patients in the practice of dentistry.

(C) The treatment plan of any dental patient.

(D) Overall quality of patient care that is rendered or performed in the practice of dentistry.

(E) Supervision of dental hygienists, dental assistants or other personnel involved in direct patient care and the authorization for procedures performed by them in accordance with the standards of supervision established by statute or by the rules of the board.

(F) Other specific services within the scope of clinical dental practice.

(G) Retention of patient dental records as required by statute or by rule of the board.

(H) Ensuring that each patient receiving services from the dental office or clinic has a dentist of record.

(b) Maintain current records of the names of licensed dentists who supervise the clinical activities of dental hygienists, dental assistants or other personnel involved in direct patient care utilized by the entity. The records must be available to the board upon written request.

(5) Subsections (1) and (2) of this section do not apply to an expanded practice dental hygienist who renders services authorized by a permit issued by the board pursuant to ORS 680.200.

(6) Nothing in this chapter precludes a person or entity not licensed by the board from:

(a) Ownership or leasehold of any tangible or intangible assets used in a dental office or clinic. These assets include real property, furnishings, equipment and inventory but do not include dental records of patients related to clinical care.

(b) Employing or contracting for the services of personnel other than licensed dentists.

(c) Management of the business aspects of a dental office or clinic that do not include the clinical practice of dentistry.

(7) If all of the ownership interests of a dentist or dentists in a dental office or clinic are held by an administrator, executor, personal representative, guardian, conservator or receiver of the estate of a former shareholder, member or partner, the administrator, executor, personal representative, guardian, conservator or receiver may retain the ownership interest for a period of 12 months following the creation of the ownership interest. The board shall extend the ownership period for an additional 12 months upon 30 days' notice and may grant additional extensions upon reasonable request.

**SECTION 2. This 2015 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2015 Act takes effect on its passage.**

**Passed by Senate February 26, 2015**

**Repassed by Senate June 2, 2015**

.....  
Lori L. Brocker, Secretary of Senate

.....  
Peter Courtney, President of Senate

**Passed by House May 28, 2015**

.....  
Tina Kotek, Speaker of House

**Received by Governor:**

.....M,....., 2015

**Approved:**

.....M,....., 2015

.....  
Kate Brown, Governor

**Filed in Office of Secretary of State:**

.....M,....., 2015

.....  
Jeanne P. Atkins, Secretary of State

**Oregon Board of Dentistry  
Committee and Liaison Assignments  
May 2015 - April 2016**

**STANDING COMMITTEES**

**Communications**

Purpose: To enhance communications to all constituencies

*Committee:*

Todd Beck, D.M.D., Chair	Barry Taylor, D.M.D., ODA Rep.
Yadira Martinez, R.D.H., E.P.P.	Gail Aamondt, R.D.H., M.S., ODHA Rep.
Alton Harvey, Sr.	Linda Kihs, CDA, EFDA, OMSA, MADAA, ODAA Rep.

*Subcommittees:*

- Newsletter – Amy B. Fine, D.M.D., Editor

**Dental Hygiene**

Purpose: To review issues related to Dental Hygiene

*Committee:*

Yadira Martinez, R.D.H., E.P.P., Chair	David J. Dowsett, D.M.D., ODA Rep.
Amy B. Fine, D.M.D.	Kristen L. Simmons, R.D.H., B.S., ODHA Rep.
Alicia Riedman, R.D.H., E.P.P.	Mary Harrison, CDA, EFDA, EFODA, FADAA, ODAA Rep.

**Enforcement and Discipline**

Purpose: To improve the discipline process

*Committee:*

Julie Ann Smith, M.D., D.D.S., Chair	Jason Bajuscak, D.M.D., ODA Rep.
Alicia Riedman, R.D.H., E.P.P.	Lynn Ironside, R.D.H., ODHA Rep.
Todd Beck, D.M.D.	Mary Harrison, CDA, EFDA, EFODA, FADAA, ODAA Rep.
James Morris	

*Subcommittees:*

Evaluators

- Julie Ann Smith, M.D., D.D.S., Senior Evaluator
- Todd Beck, D.M.D., Evaluator

**Licensing, Standards and Competency**

Purpose: To improve licensing programs and assure competency of licensees and applicants

*Committee:*

Amy B. Fine, D.M.D., Chair	Daren L. Goin, D.M.D., ODA Rep.
Gary Underhill, D.M.D.	Lisa J. Rowley, R.D.H., M.S., ODHA Rep.
Yadira Martinez, R.D.H., E.P.P.	Mary Harrison, CDA, EFDA, EFODA, FADAA, ODAA Rep.

**Rules Oversight**

Purpose: To review and refine OBD rules

*Committee:*

Brandon Schwindt, D.M.D., Chair	Bruce Burton, D.M.D., ODA Rep.
Jonna Hongo D.M.D.	Lynn Ironside, R.D.H., ODHA Rep.
Alicia Riedman, R.D.H., E.P.P.	Bonnie Marshall, CDA, EFDA, EFODA, MADAA, ODAA Rep.

## **LIAISONS**

American Assoc. of Dental Administrators (AADA) — Stephen Prisby, Interim Executive Director

American Assoc. of Dental Boards (AADB)

- Administrator Liaison – Stephen Prisby, Interim Executive Director
- Board Attorneys' Roundtable – Lori Lindley, SAAG - Board Counsel
- Dental Liaison – Amy B. Fine, D.M.D.
- Hygiene Liaison – Yadira Martinez, R.D.H., E.P.P.

American Board of Dental Examiners (ADEX)

- House of Representatives – Jonna Hongo, D.M.D.
- Dental Exam Committee – Jonna Hongo, D.M.D.

Commission on Dental Competency Assessments (CDCA)

- Amy Fine, D.M.D.
- Gary Underhill, D.M.D.
- Yadira Martinez, R.D.H., E.P.P.

Oregon Dental Association – Alton Harvey, Sr.

Oregon Dental Hygienists' Association Yadira Martinez, R.D.H., E.P.P.

Oregon Dental Assistants Association – Alton Harvey, Sr.

Western Regional Exam Board (WREB)

- Dental Exam Review Committee – Jonna Hongo, D.M.D
- Hygiene Exam Review Committee – Yadira Martinez, R.D.H., E.P.P.

## **OTHER**

### **Administrative Workgroup**

Purpose: To update Board and agency policies and guidelines. Consult with Executive Director on administrative issues. Conduct evaluation of Executive Director.

*Committee:*

Alton Harvey, Sr., Chair  
Jonna Hongo, D.M.D.  
Yadira Martinez, R.D.H., E.P.P.

*Subcommittee:*

Budget/Legislative – (*President, Vice President, Immediate Past President*)

- Alton Harvey, Sr.
- Julie Ann Smith, D.D.S, M.D.
- Brandon Schwindt, D.M.D.

### **Anesthesia**

Purpose: To review and make recommendations on the Board's rules regulating the administration of sedation in dental offices.

*Committee:*

Julie Ann Smith, D.D.S, M.D., Chair  
Brandon Schwindt, D.M.D.  
Rodney Nichols, D.M.D.  
Daniel Rawley, D.D.S.  
Mark Mutschler, D.D.S.  
Jay Wylam, D.M.D.  
Normund Auzins, D.M.D.  
Eric Downey, D.D.S.  
Ryan Allred, D.M.D.

\*Not Selected by the OBD

**NEWSLETTERS**  
**&**  
**ARTICLES OF**  
**INTEREST**

## Barriers Faced by Expanded Practice Dental Hygienists in Oregon

Amy E. Coplen, RDH, EPDH, MS; Kathryn P. Bell, RDH, MS

### Introduction

It has been over a decade since the U.S. Surgeon General issued a report stating that oral health is an essential component of overall health.<sup>1</sup> Yet getting access for all populations to quality dental care is still a major concern - reports consistently document a shortage of dentists in rural and inner city communities, and marginalized populations that do not receive regular dental care, with 45 million people living in these areas.<sup>2</sup> It has been proposed that expanding the role of dental hygienists is one way to increase access to care for the underserved.<sup>3,4</sup>

In order to expand opportunities for dental hygienists and improve access to care, some states and countries utilize a mid-level practitioner in the dental field. Examples include the Dental Health Aide Therapist in New Zealand, the Dental Health Aide Therapist in Alaska, and the Dental Therapist, as well as the Advanced Dental Therapist, in Minnesota. Mid-level providers can perform a wide range of clinical services such as basic restorative procedures and extractions, in addition to the traditional repertoire of dental hygiene services.<sup>5-7</sup> While most states do not utilize a mid-level practitioner, over the past decade many states have expanded the legal scope of practice of dental hygienists.<sup>8</sup> Currently, 35 states allow dental hygienists to initiate patient care in a setting outside of the private dental office without the presence of a dentist in what the American Dental Hygienists' Association (ADHA) defines as direct access states.<sup>9</sup> The term direct access means that the dental hygienist can initiate treatment based on his or her assessment of patients' needs without the specific au-

thorization of a dentist, treat patients without the presence of a dentist and can maintain a provider-patient relationship.<sup>10</sup>

### Abstract

**Purpose:** Oregon allows dental hygienists to provide services without the supervision of a dentist if they hold an expanded practice permit (EPP). This study surveyed practicing and non-practicing EPP holders with the purpose of assessing perceived barriers to practicing independently and better educating students to begin independent practice upon graduation.

**Methods:** A survey was developed, approved by the institutional review board and pilot tested with current Expanded Practice Dental Hygienists (EPDHs). A list of EPDHs was obtained from the Oregon State Dental Board, and 181 surveys were mailed in November 2011.

**Results:** The response rate was 39% (n=71). Data from this study indicate a large number of new EPP holders, with 62% (n=41) holding their permit for 3 years or less, but only 41% (n=29) of respondents are actually providing care in a setting requiring an EPP. Responding practicing EPDHs reported barriers including: challenges with insurance reimbursement, lack of knowledge/acceptance, equipment cost/maintenance, difficulty obtaining a collaborative agreement/cooperating facility, advertising and inability to make a living wage. Responding non-practicing EPDHs reported barriers including: currently working in another setting, lack of business knowledge, time, start-up cost, inability to make a living wage, lack of opportunity, reimbursement difficulties and lack of experience.

**Conclusion:** Perceived barriers to practicing independently differ between those practicing utilizing their EPP and those not practicing. Ways to eliminate barriers for both practicing and non-practicing EPDHs should be explored. There is potential to reduce the barriers to independent practice through curricular changes, public health partnerships among EPDHs, and new health care systems that specifically address barriers found through this study.

**Keywords:** dental Hygiene extended practice permits, access to oral health care, direct access, independent practice, dental hygiene, limited access, expanded practice

This study supports the NDHRA priority area, **Health Services Research:** Investigate how alternative models of dental hygiene care delivery can reduce health care inequities.

In the state of Oregon a mid-level practitioner does not exist, however, direct access does. Legislation was passed in 1997 to allow dental hygienists to attain a limited access permit.<sup>11</sup> Legislation was later passed in 2012 renaming the limited access permit to the expanded practice permit (EPP). The EPP enables dental hygienists to provide a variety of dental hygiene services, without the supervision of a dentist, for "limited access" regions or populations (Figure 1). Expanded practice dental hygienists (EPDHs) are required to refer patients to a dentist at least once annually for examination and treatment of active dental disease. EPDHs do not need a collaborative agreement with a dentist to initiate dental hygiene care for patient populations that qualify as having limited access to care. If an EPDH wishes to perform additional services, such as providing local anesthesia, placing temporary restorations, and prescription of prophylactic antibiotics and non-steroidal anti-inflammatory drugs (NSAIDs) (which are included in the law), they must have a collaborative agreement with a dentist to provide those additional services. Many EPDHs work as employees in non-dental settings like nursing homes or schools. Other EPDHs become private business owners. One pathway to obtain an EPP is to have 2,500 hours of clinical dental hygiene practice and complete 40 hours of continuing education of the individual's choosing. An additional pathway to obtaining an EPP credential is to complete a course of study approved by the Oregon State Dental Board and have at least 500 hours of dental hygiene practice on patients in "limited access" settings while under the direct supervision of dental or dental hygiene faculty of an accredited program (Figure 2). Until October 2010, there were no board-approved courses of study.<sup>12</sup> At that time, the Oregon Legislature passed a bill allowing applicants to apply hours spent during training (dental hygiene school) with patients in underserved or limited access settings to their 500-hour quota. Thus, under recently amended legislation, students are potentially able to attain an EPP upon graduation.

The goal of recent legislative changes is to facilitate a significant improvement in the access to care crisis in Oregon. To date, however, limited information exists regarding the impact of expanded practice dental hygienists as well as the barriers faced in pursuing expanded practice. The only study to date of Oregon EPDHs was conducted in 2005 by Battrell et al.<sup>13</sup> This qualitative study included 7 Oregon EPDHs as well as 2 dentists. Participants perceived a need for expansion of scope of education to prepare for independent practice and called for additional curricular experiences to include coursework on organizational structure,

Figure 1: Practice Settings in Which EPDHs Are Allowed to Work

Expanded Practice Settings:
An expanded practice dental hygienist may render all services within the scope of practice of dental hygiene without the supervision of a dentist to patients of the following facilities or programs who, due to age, infirmity or disability, are unable to receive regular dental hygiene treatment:
<ul style="list-style-type: none"> <li>• Nursing homes</li> <li>• Adult foster homes</li> <li>• Residential care facilities</li> <li>• Adult congregate living facilities</li> <li>• Mental health residential programs</li> <li>• Facilities for mentally ill persons</li> <li>• Facilities for persons with developmental disabilities</li> <li>• Local correctional facilities and juvenile detention facilities</li> <li>• Public and nonprofit community health clinics</li> <li>• Adults who are homebound</li> <li>• Students or enrollees of nursery schools and day care programs and their siblings under 18 years of age</li> <li>• Primary and secondary schools, including private schools and public charter schools</li> <li>• Persons entitled to benefits under the Women, Infants and Children Program</li> <li>• Patients in hospitals, medical clinics, medical offices or offices operated by nurse practitioners, physician assistants or midwives.</li> <li>• Patients whose income is less than the federal poverty level</li> <li>• Other populations that the Oregon Board of Dentistry determines are underserved or lack access to dental hygiene services</li> </ul>

Figure 2: Criteria Which Must be Met to Obtain an Expanded Practice Permit

Expanded Practice Permit Criteria:
To receive an expanded practice permit, dental hygienists must:
<p>Pathway 1</p> <ul style="list-style-type: none"> <li>• Hold a valid, unrestricted Oregon dental hygiene license</li> <li>• Present proof of current professional liability insurance</li> <li>• Completed 2,500 hours of supervised dental hygiene practice</li> <li>• Completed 40 hours of courses, chosen by applicant in:             <ol style="list-style-type: none"> <li>1. Clinical dental hygiene</li> <li>2. Public health</li> </ol> </li> </ul>
<p>Pathway 2</p> <ul style="list-style-type: none"> <li>• Complete a course of study approved by the board that includes 500 hours of dental hygiene practice, completed before or after graduation from a dental hygiene program on limited access patients while under the supervision of a member of the faculty of a dental program or dental hygiene program accredited by the Commission on Dental Accreditation of the American Dental Association.</li> </ul>

billing, coding, prescription writing and the public health delivery system. One dental hygiene school in Oregon, Pacific University, has implemented curricular changes aimed at decreasing the barriers to entering independent practice, but the influence these courses have on the likelihood of graduates pursuing independent practice has not been measured. The perceived barriers to date have also not been formally measured.

This study surveyed current EPDHs, both practicing and non-practicing, with the purpose of assessing perceived barriers to practicing unsupervised and better educating students to begin EPP practice upon graduation. Specific research questions included:

- If participants are currently practicing as an EPDH, what specific barriers do they face that make it challenging to practice in this role?
- If participants are not currently practicing as an EPDH, what specific barriers have kept them from practicing in that role?
- Do specific characteristics like level of education, years since graduation, or years holding an EPP increase the likelihood of utilizing the expanded practice permit?
- How well does a specific institution which grants at least 500 hours of practice on patients in "limited access" settings prepare students to begin independent practice upon graduation based on reported barriers?

The results of this study will be used to advise students, further develop the dental hygiene curriculum at the authors' institution in support of independent practice and to suggest future directions for eliminating barriers to independent practice in Oregon as a whole to address the need for improved access to care.

## Methods and Materials

In the fall of 2011, a list of all current EPDHs was obtained from the Oregon Board of Dentistry (n=186). A convenience sample of 2% was selected to pilot test the survey. Subsequent revisions were made according to feedback from the pilot testers. Following approval of the Pacific University Institutional Review Board with exempt status, the survey was mailed to all EPDHs in the state of Oregon in November 2011, with the exception of those included in the pilot test. Data were collected using a self-administered survey. A follow-up mailing was sent in December 2011 to all non-respondents. To maintain confidentiality, the surveys were numerically coded. The linkage file was maintained solely to facilitate the second mailing (a

second survey was only sent to non-respondents). Once data collection was completed, the linkage file was destroyed. The mailing included a consent document explaining the purpose of the study and that it was confidential. In addition to a copy of the survey and the consent document, a business-reply envelope was included (signed consent was not requested; consent was implied by return of the questionnaire).

The 16-item questionnaire contained both closed and open-ended questions that assessed the following areas: demographics, income from EPDH practice, amount of services provided, details of EPDH practice and perceived barriers to practicing as an EPDH. This article focuses on the demographics and perceived barriers sections. The amount of services provided and details of EPDH practice has been addressed in a separate report.<sup>14</sup>

When analyzing open-ended qualitative data related to barriers, 2 investigators determined preliminary categories to be able to do quantitative analysis of the data. Each investigator categorized the answers individually and the answers were then compared. Additional categories were added if at least 3 individuals answered similarly. If a response had less than 3 respondents reporting similarly the response was placed in the "other" category. Anywhere consensus could not be reached on a particular answer it was also placed in the "other" category. Ultimately, open-ended responses were categorized numerically for the purpose of statistical analysis.

The data were analyzed using SPSS (version 20, IBM). Frequency distributions are provided to describe the findings, and Chi-square tests using the Freeman-Halton extension of the Fisher exact test were used to investigate whether possible factors such as length of time holding EPP, level of education and years since graduation influenced the likelihood of EPDHs to be practicing in a setting which requires an EPP. For level of education, the sample contained 2 certificate holders; therefore, Certificate/Associates degrees were combined.

## Results

The response rate for the survey of EPDHs was 39% (n=71). Approximately 41% (n=29) of the respondents were currently using their EPP and an additional 21% (n=15) were planning to start their own independent practice. The average age of the EPDH was 49, with a range of reported ages from 25 to 71 years of age. Sixty-two percent of the sample has held their EPP for 3 years or less (n=41). Of the current practicing EPDHs, the average weekly

hours working unsupervised is 9.3 hours (n=25). On average, unsupervised practice comprises 22% of their total annual income (n=27). The highest level of education held by the sample was a bachelor's degree (58%, n=39). All demographic data is summarized in Table I.

Barriers faced by EPDHs were examined for both practicing and non-practicing EPDHs. The number of responses is larger than the sample size for each group because participants were allowed to report multiple barriers. For non-practicing EPDHs the most frequently perceived barriers were: currently working in another setting (21%, n=14), lack of business knowledge (15%, n=10), time (10%, n=7), inability to make a salary/living wage (10%, n=7) and start-up costs (10%, n=7) (Figure 3).

For practicing EPDHs, the most frequently cited barriers were: challenges with insurance reimbursement (39%, n=13), lack of knowledge/acceptance (21%, n=8), equipment cost/maintenance (11%, n=4), and lack of collaborative agreement/cooperating facility (11%, n=4) (Figure 4).

Chi-square tests using the Freeman-Halton extension of the Fisher exact test were used to explore possible relationships contributing to the likelihood of EPDHs to be practicing currently. While no statistically significant results were found, there were several trends identified in the sample of practicing EPDHs. The highest percentage of practicing EPDHs have held their EPP for 3 years or less at 21% (n=14) (Table II). The highest percentage of practicing EPDHs held a Bachelors degree or an Associates/Certificate at 19% (n=13) and 18% (n=12), respectively (Table III). The largest percent of practicing EPDHs had greater than 20 years since graduation, 20% (n=14) (Table IV).

## Discussion

Although some form of the EPP has existed in Oregon since 1997, the largest percentage of the existing EPDHs have only had their permit for 3 years or less, which indicates an increasing support of Oregon dental hygienists for unsupervised practice. According to the Oregon dental board, the number of EPDHs in Oregon has increased from 186 to 356 since this survey was completed. This is a near double increase in the past 2 years. This increase is likely due to the ability to obtain an EPP through the new pathway (pathway 2). While the majority have held their permit for 3 years or less, nearly half the sample of EPDHs are over 50 years old and have been out of dental hygiene school for longer than 20 years. This suggests that dental hygienists who have been prac-

Table I: Descriptive Statistics of Responding EPDHs

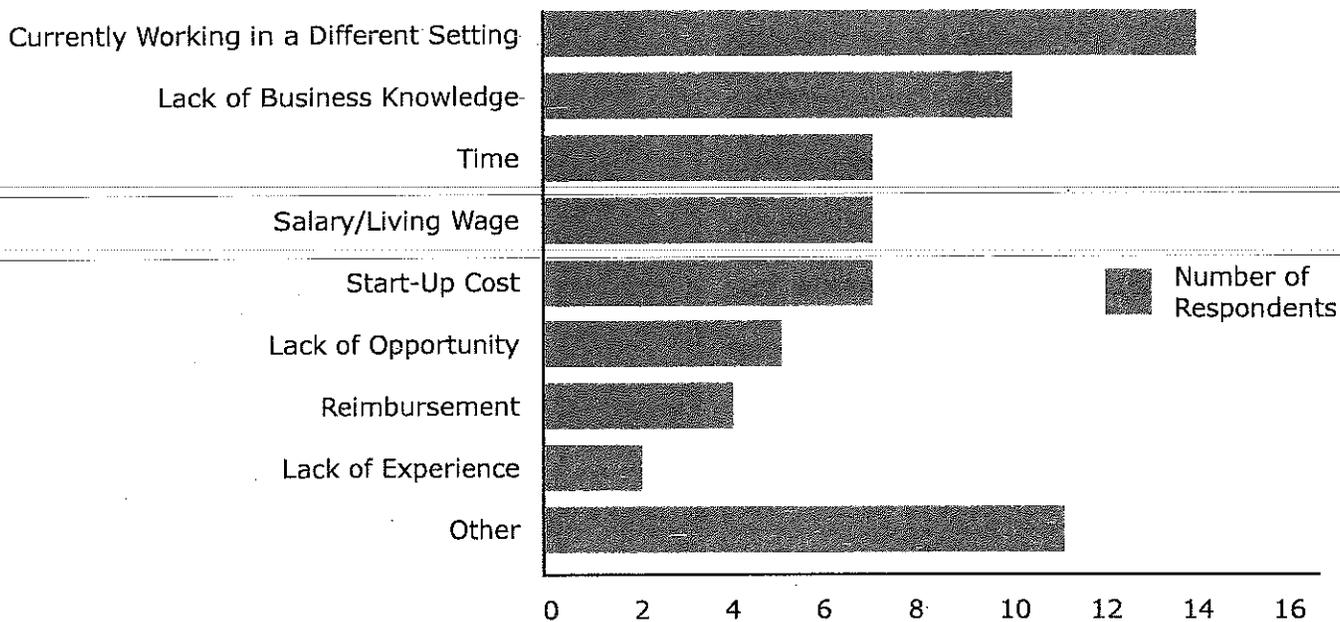
	Category	n	Percent
Age by Category (n=70)	20 to 30	6	9%
	31 to 40	10	14%
	41 to 50	15	21%
	>50	39	56%
Years held EPP (n=66)	0 to 3	41	62%
	4 to 6	9	14%
	7 to 9	5	8%
	≥10	11	17%
Practicing using EPP (n=71)	41%	-	-
Mean Hours Per Week using EPP (n=25)	9.3 (Std. Dev. 12.47)	-	-
Income from EPP (n=27)	≤10,000	18	67%
	10,001 to 20,000	4	15%
	20,001 to 30,000	3	11%
	30,001 to 40,000	1	4%
	40,001 to 50,000	0	0%
	>50,000	1	4%
Level of Education (n=67)	Certificate	2	3%
	Associate	22	33%
	Bachelors	39	58%
	Masters	4	6%

\*Not every respondent answered every question. The number of respondents who answered each is indicated in the left column. Percentages may not total 100% due to rounding.

ticing traditionally show strong interest in moving toward alternative settings to provide care. Authors attempted to evaluate whether concrete demographic characteristics like level of education, number of years holding an EPP and years since graduation influenced the likelihood of EPP holders to be practicing. Unfortunately, a significant indicator of whether participants were more likely to be utilizing their EPP to provide care was not found in this study. Characteristics that influence the likelihood of EPP holders to be practicing are much more difficult to measure, although one previous study found that a motivation to attain independent decision making and a strong dedication to providing services to underserved populations influence the likelihood of individuals to practice using their EPP.<sup>13</sup>

The data demonstrate that both practicing and non-practicing EPDHs perceive similar barriers to providing care to underserved populations. Both groups cited insurance reimbursement as a challenge, but a much higher percentage (61%) of practicing EPDHs reported reimbursement as an

Figure 3: Perceived Barriers of Non-Practicing EPDHs (n=46)



\*Total barriers exceeds number of participants because many participants reported more than one barrier.

issue and nearly half stated they have never received insurance reimbursement. This is contrary to what was reported in the Dental Hygiene Professional Practice Index, which gave Oregon a rank of excellent in the area of reimbursement compared to other states with independent practice legislation.<sup>15</sup> Non-practicing EPDHs reported reimbursement as a concern but much less so than practicing with only 4 individuals citing it as a barrier. This is most likely perceived as less of a challenge due to lack of experience in providing care in a limited access setting.

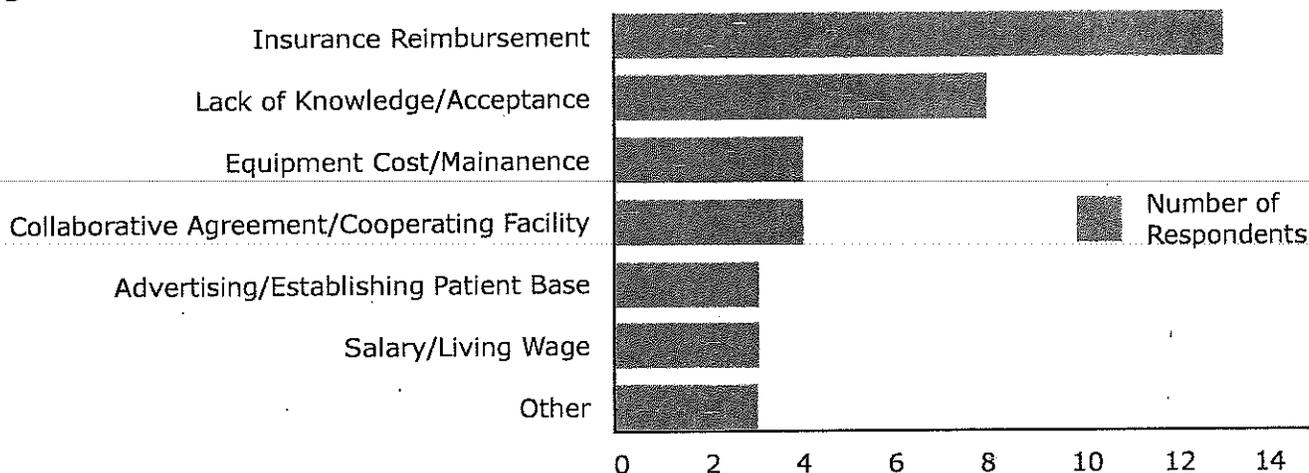
It has been suggested that expanding the practice of dental hygienists could be a potentially significant income source.<sup>16</sup> Yet both groups saw the inability to make a decent salary or living wage as a barrier. This study's findings suggest the majority of practicing EPDHs make less than \$10,000 a year using their EPP. A larger percent of non-practicing EPDHs, 15% compared to 10% of practicing EPDHs, saw this as a barrier. This may indicate that motivation for those utilizing their EPP is not directly linked to the income that it provides. Other motivating factors cited by Battrell et al included the desire to obtain independent decision making and a strong desire to serve underserved populations.<sup>13</sup> These factors may outweigh the need for independent practice to supply a significant portion of income to those utilizing it.

Finally, both groups cited lack of knowledge as a barrier. Non-practicing EPDHs reported lack of

knowledge regarding how to begin an independent practice, business knowledge and knowledge of the laws. Participants of the 2005 qualitative study of Oregon EPDHs identified a sense of entrepreneurship and marketing skills as keys to success.<sup>13</sup> In addition, Astroth, et al report that the majority of independently practicing dental hygienists in Colorado had additional education in business management.<sup>17</sup> For non-practicing EPDHs there is an apparent necessity of education associated with starting a business as well as a call for understanding the most current legislative advances in independent practice for dental hygienists in Oregon. Practicing EPDHs reported a different type of lack of knowledge which relates to acceptance and education on the part of dentists and the community. This included lack of knowledge for caregivers regarding the services provided by EPDHs, as well as lack of knowledge in the community as to what EPDHs can do. Removing this barrier would require additional education for the communities in which EPDHs serve.

Many barriers cited were unique to either practicing or non-practicing EPDHs. A barrier faced by practicing EPDHs was equipment cost and maintenance. In addition, establishing a patient base and advertising services were also cited as barriers. When minimal salary and ability to get reimbursed for services is low, unexpected costs of equipment and uncertainty of available patients to treat threaten EPDHs ability to continue providing care to underserved populations. As independent practice becomes more common,

Figure 4: Perceived Barriers of Practicing EPDHs (n=21)



\*Total barriers exceeds number of participants because many participants reported more than one barrier.

options to reduce barriers for EPDHs already practicing become extremely important.

Another barrier faced only by practicing EPDHs is securing a collaborative agreement with a dentist. A collaborative agreement allows an EPDH to administer local anesthetic and gives the EPDH additional prescriptive power. Lack of dentists' support for hygienists practicing independently has also been reported in other studies.<sup>16,18</sup> One reason dentists may not support independently practicing dental hygienists is the perceived threat they may pose to patients seeking care from a dentist. However, having care provided by an independently practicing dental hygienist may not necessarily deter patients from seeking routine dental care. This item was specifically measured in a survey of patients treated by independently practicing dental hygienists in California. In that study, at the 24 month follow-up almost 90% of the patients had been seen by a dentist within 12 months of being treated by an independently practicing hygienist.<sup>19,20</sup> It appears that, in California, patients who are treated by independently practicing dental hygienists are not less likely to seek routine care from a dentist as a result. In addition, EPDHs in Oregon are required by law to refer patients at least once per year to a dentist who is available to treat them. If patients treated in Oregon are similar to those treated in California, triage care with referral provided by the dental hygienist may increase the rate at which this population seeks care with a dentist. Further research is necessary to test this hypothesis.

The largest barrier seen by non-practicing EPDHs is that they are currently practicing somewhere else. These settings ranged from private

practice to public health and education. While working in another setting might be viewed as more of a personal choice rather than a barrier, participants stated it was a barrier. Another barrier reported was a lack of opportunity which may more accurately represent why working in another setting was cited. While holding an EPP shows strong support for dental hygienists practicing in unsupervised settings, additional barriers such as start up costs, too few internship settings and mentors, and lack of experience are preventing EPP holders from entering into unsupervised practice. When EPDHs spend the majority of their time practicing elsewhere there is little time to pursue the elimination of other barriers. With a growing number of EPDHs in the state of Oregon, there is a responsibility to give individuals the tools necessary to begin practicing independently so that this practice model does in fact reduce the access to care issue.

Non-practicing EPDHs had a variety of barriers that keep them from utilizing their EPP. Reasons varied widely which is why the "other" category received the second most responses. Since 3 or more respondents who cited a particular barrier were required to become a category, many responses were placed in the "other" category. Some examples included: "I'm holding an EPP in support for advancement of the profession but have no personal interest in using it," "I just haven't branched out yet, although I live in an underserved area," "I'm late in my career" and "I am not currently practicing."

### Implications for Education

The addition of pathway 2 to the Practice Act has made it easier for new graduates to obtain

an EPP. Targeting the population of new dental hygiene graduates who have not already obtained employment could potentially increase the number of hygienists practicing independently since already working in another setting was the greatest barrier for non-practicing EPDHs. Many of the documented barriers found through this study for both practicing and non-practicing EPDHs could be reduced through additional curriculum focused on practicing independently. With 35 states allowing direct access, the question of educating new dental hygienists to pursue this career path must be addressed. Argument could be made that educators have the responsibility to prepare students for the additional professional aspects of direct access in the states that allow it.

Table II: Percent of Practicing EPDHs Based on Length of Time Holding EPP (n=66)

Length of Time Holding EPDH	Practicing EPDH	Non-Practicing EPDH
0 to 3 years	21% (n=14)	41% (n=27)
4 to 6 years	8% (n=5)	6% (n=4)
7 to 9 years	3% (n=2)	5% (n=3)
10 years or longer	11% (n=7)	6% (n=4)
		Freeman-Halton extension of the Fisher exact p=0.29

\*Percentages may not total 100% due to rounding.

Table III: Percent of Practicing EPDHs Based on Degree Type (n=67)

Degree Type	Practicing EPDH	Non-Practicing EPDH
Certificate/Associates	18% (n=12)	18% (n=12)
Bachelors	19% (n=13)	39% (n=26)
Masters	3% (n=2)	3% (n=2)
		Freeman-Halton extension of the Fisher exact p=0.46

Table IV: Percent of Practicing EPDHs Based on Years Since Graduation (n=70)

Years Since Graduation	Practicing EPDH	Non-Practicing EPDH
Less than 5 years	1% (n=1)	16% (n=11)
6 to 10 years	7% (n=5)	4% (n=3)
11 to 20 years	13% (n=9)	14% (n=10)
Greater than 20 years	20% (n=14)	24% (n=17)
		Freeman-Halton extension of the Fisher exact p=0.053

\*Percentages may not total 100% due to rounding.

Currently, the Commission on Dental Accreditation (CODA) standards do not explicitly require dental hygiene programs to educate students on aspects relating to independent practice. However, CODA does require graduates to be competent in assessing, planning, implementing and evaluating community based oral health programs including health promotion and disease prevention activities, and the curriculum must include content in community dental/oral health.<sup>21</sup> CODA concepts that relate to independent practice are the ability to competently plan and implement community based oral health programs with the intention that students will be able to apply community dental health principles to prevent disease and promote health. With dental hygiene curriculums already being tightly constructed, it is difficult to entertain the idea of adding

additional material. Authors believe that courses being taught to fulfill these CODA requirements could slowly begin to incorporate independent practice as a topic. This is a good starting point and may already exist in many schools, but does not address all of the barriers perceived to entering independent practice.

At one educational institution in Oregon, Pacific University, curricular changes have been implemented to reduce the barriers for students graduating with the intention of practicing independently with limited access populations. Specific curricular changes address the barriers of lack of experience, business knowledge, and reimbursement. These include an expanded practice rotation, implemented in 2011, where stu-

dents provide dental hygiene services in limited access settings to gain experience with this patient population. For this rotation, students work alongside an EPDH to see firsthand what goes into practicing independently. In addition, students take an independent practice course in the summer of their senior year, also implemented in 2011. This course gives an overview of independent practice for dental hygienists including state regulation, employment opportunities, business models, marketing, reimbursement and community relations.

Business knowledge is also a key piece to having a successful independent practice and lack of business knowledge was reported as a barrier by non-practicing EPDHs. Since 2007, students at Pacific University have taken a business management course where they learn basic principles of business with emphasis on application of business management skills in dental health care settings.

Cultural competence has also been reported as an important skill for expanded practice dental hygienists in Oregon due to a large number of Hispanic populations being seen by EPDHs.<sup>13</sup> While this was not an aspect directly measured in this study, it is an additional way Pacific University prepares students to work with limited access patients. Since the program's inception, students have been required to take 2 semesters of Spanish for dental professionals and treat primarily Spanish speaking patients in the school's clinic as well as many of their off campus rotations.

Although Pacific graduates comprised only 9% of the EPDHs in the current survey, at the time Pacific had only graduated 4 cohorts of students. According to the Oregon dental board, since this study was completed the percent of Pacific University graduates holding an EPP has grown from 9 to 27% of the total EPP holders in Oregon. While the percentage of EPP holders who graduated from Pacific has grown significantly since many curricular changes were implemented, whether these changes have influenced their likelihood to practice in a setting which requires an EPP is yet to be measured. It is apparent, at least at one school in Oregon, that the addition of pathway 2 has been a successful way to increase the number of EPP-holders in the state.

Unfortunately, not all the barriers discovered through this study can be addressed in education. There are still many practicing and non-practicing EPDHs who have completed their education and need support to enter independent practice

in Oregon. The current sample is also primarily older and more experienced. Potential avenues to addressing these barriers are: business focused continuing education courses for individuals holding an EPP and mentorship programs with currently practicing EPDHs. Other avenues could include enlisting the help of community leaders, community clinics, Head Start programs and long term care facilities. The solution will no doubt need to be a multi-faceted endeavor.

### Study Limitations

There were several limitations to this study, with one of the most significant being the sample size. Because this survey was also an outcomes assessment asking EPDHs to report the amount of services provided and details of EPDH practice, EPP holders who are not currently practicing may not have thought the survey was applicable to them. The questions about perceived barriers were at the end of the survey. This limitation had an impact on the ability to conduct statistical analysis because there were not enough practicing and non-practicing EPDHs in each of the categories to be able to find any statistical significance. An additional limitation was anticipating how modest a salary EPDHs received with \$10,000 or less being the only possible option, which many EPDHs reported making much less than \$10,000 annually. If this had been an open-ended question, it would have better allowed for reporting smaller income ranges. When asked about reimbursement, a large number of practicing EPDHs reported never receiving any reimbursement but several individuals wrote in that they had never tried. This would have been a valuable option that was not included. Finally, the authors were not able to establish survey performance reliability. The survey has been administered only 1 time, so test-retest reliability could not be determined. In order to keep the survey to a minimal length, no redundant questions were included to evaluate internal reliability. To facilitate data entry and consistency of information, every survey mailed was identical, so no alternate-form reliability was established.

Recommendations for future research include exploring how curricular changes have influenced Pacific University graduates' likelihood to enter into independent practice settings. Whereas the business management and Spanish course have existed since the beginning of the program in 2006, the expanded practice rotation and independent practice course have only been taught since the fall of 2011 when this survey was conducted. In addition, Investigating how dental hy-

giene programs in other states with some type of independent practice prepare their students to pursue this avenue of providing care is important. Opinions as to whether dental hygiene programs should have the task of preparing dental hygienists to practice unsupervised in direct access states or if it should be done through other pathways should also be examined.

## Conclusion

Data from this study indicate that there are an increasing number of new EPP holders in Oregon, but less than half are actually providing care as an EPDH to underserved populations. Lack of business knowledge, lack of experience, insurance reimbursement, start-up costs and the inability to make a living wage are barriers non-practicing EP-

DHs face when deciding whether or not to utilize their EPP. If these barriers can be addressed during dental hygiene education, the potential exists to increase the number and impact of EPDHs in Oregon. For dental hygienists who have already completed their education without the benefit of new curriculum, addressing independent practice, continuing education courses in business management and independent practice strategies, and paid internships with experienced expanded practice dental hygienists may also be helpful in facilitating the transition to independent practice and to facilitate increased access to care.

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## Evaluating the Impact of Expanded Practice Dental Hygienists in Oregon: An Outcomes Assessment

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### Introduction

Lack of access to dental care has become a public health focus over the past several years in the U.S. and has led to much discussion and change in the profession of dental hygiene.<sup>1</sup> The past 20 years have seen an increase in the amount of decision-making responsibility of the dental hygienist, a reduction in the level of required supervision, and an increase in independent practice among dental hygienists.<sup>2-4</sup> The independent practice of dental hygienists and the mid-level dental provider are concepts that have gained momentum in an attempt to alleviate disparities in access to dental care. The most recent U.S. Department of Health and Human Services report states that there are 4,585 dental health professional shortage areas in which 45 million people live.<sup>5</sup> The utilization of dental hygienists working in independent practice is a logical approach to help alleviate this access to care challenge.

As of 2012, 35 states allow dental hygienists to provide patient care in a setting outside of a dental office and without a dentist present.<sup>6</sup> Alaska and Minnesota both license mid-level providers, who are allowed to provide basic restorative treatment in addition to the catalogue of typical dental hygiene services, also without the supervision of a dentist.<sup>6</sup> Mid-level dental providers have been recognized internationally for many years,<sup>2</sup> and 5 states are currently forwarding legislation to create dental hygiene based mid-level provider licensure (Vermont, Kansas, Washington, Connecticut and Maine).<sup>6</sup>

Currently, Oregon does not license or employ a mid-level dental provider. However, Oregon is one

state in which dental hygienists are allowed to practice without the supervision of a dentist. Expanded Practice Permit Dental Hygienists (EPDHs) (previously known as Limited Access Permit (LAP) dental hygienists) are allowed to render most services

### Abstract

**Purpose:** Currently the dental hygiene practice model in Oregon includes the Expanded Practice Dental Hygienist (EPDH), which allows dental hygienists with an Expanded Practice Permit (EPP) to provide care to limited access populations without the supervision of a dentist. The number and types of services provided by EPDH practitioners is thus far undocumented. The purpose of this study is to conduct an outcomes assessment of EPDH practitioners in order to quantify the impact, defined by count of services, on the access to care crisis in Oregon.

**Methods:** A 16 question confidential survey was developed and approved by the Pacific University institutional review board. The mail-based survey was sent to 181 EPDHs in Oregon in November 2011 (all EPDHs except pilot testers and one author). A second mailing was sent to non-respondents. Data were analyzed using descriptive statistics and chi-square analysis in SPSS.

**Results:** The response rate was 39% (n=71). Approximately 41% (n=29) of the respondents were currently using their EPP to provide care to limited access patients with an additional 21% (n=15) planning to start their own expanded practice. The majority of practicing EPDHs provide care in residential care facilities (n=21) and in school settings (n=13). Of the current practicing EPP holders, 76% practice  $\leq 10$  hours per week, and 66% make  $< \$10,000$  per year. Total services reported in an average month from all responding EPDH practitioners were: 254 adult prophylaxes, 1,003 child prophylaxes, 106 adult fluorides, 901 child fluorides and 1,994 fluoride varnishes, among many other preventive procedures.

**Conclusion:** To a limited extent, the amount and type of services provided by EPDHs has now been quantified, and EPDHs are making an impact on the access to care crisis in Oregon. Continued outcomes assessment is needed to further quantify the impact of EPDHs.

**Keywords:** dental hygienists, professional practice, outcome assessment, health services accessibility

This study supports the NDHRA priority area, **Health Services Research:** Investigate how alternative models of dental hygiene care delivery can reduce health care inequities.

within the typical dental hygiene scope of practice without the supervision of a dentist, in specified settings or for populations who experience lack of access to care (defined in ORS 680.205). EPDHs are required to refer patients to a dentist at least once annually for examination and treatment of active dental disease. An EPDH also has the ability to administer local anesthesia, place temporary restorations and prescribe prophylactic antibiotics and non-steroidal anti-inflammatory drugs, but must have a collaborative agreement with an Oregon-licensed dentist.<sup>7</sup> There are 2 pathways through which one may qualify for the expanded practice permit (EPP), which is the permit required to become an EPDH. The first pathway requires 2,500 hours of supervised clinical dental hygiene practice, as well as 40 hours of CE courses in either clinical dental hygiene or public health earned since licensure. The second pathway requires 500 hours of clinical practice (either before or after graduation from a dental hygiene program) working with patients defined in ORS 680.205, while under the direct supervision of faculty members of accredited dental or dental hygiene programs.<sup>8</sup> Despite the need for expanded access to care in Oregon and other states, support for the expansion of the dental hygiene scope of practice and the evolution of the mid-level provider has been mixed among dental hygienists and dentists.<sup>9-12</sup> One question central to the debate of independent practice in dental hygiene and the advancement of a mid-level provider is the question of need: is there a need to have dental hygienists practicing independently? In other words, what is the actual impact of dental hygienists in independent practice on access to care?

In 2008, Battrell et al conducted a qualitative study to analyze the impact of the LAP legislation in Oregon and to determine the nature of the relationships of dental hygienists and dentists who participated in the model. In addition to providing the history of the development of the LAP model, authors presented results of interviews with participating dentists and dental hygienists. Authors concluded that entrepreneurship, lifelong learning and a commitment to underserved populations were common motivations among study participants and that the relationships between the dental hygienists and dentists were positive. At the time of the study, there were 71 licensed LAP dental hygienists. Authors noted that while the number of licensed practitioners was relatively small, there were a growing number of individuals interested in pursuing this practice modality. This finding has proven true, as the number of practitioners has since more than doubled (at the time of the current study, there were 186 dental hygienists who held an EPP). Authors determined that at the time of the study,

there was not enough information to draw conclusions regarding the impact of LAP dental hygienists, and that an appropriate next step was evaluation of outcomes. As a qualitative study, this information provides a foundation for the continued assessment of this practice model, what is now the EPDH.<sup>13</sup>

While some form of unsupervised practice has existed since 1997, the settings and services provided by EPDHs have not been measured. The purpose of this study was to conduct an outcomes assessment of EPDH permit holders to assess the extent to which they are utilizing their permit, the scope of the services they are providing, and the number of patients who are being served.

## Methods and Materials

A cross-sectional survey of EPDHs was conducted in November 2011. The survey instrument was developed by the authors. The survey instrument and study protocol were reviewed by the Pacific University institutional review board, and the study was approved as exempt. A list of all EPDHs was obtained from the Oregon Board of Dentistry (n=186). A convenience sample of 2% was selected to pilot test the survey instrument. Improvements were made according to feedback from the pilot testers. Surveys were mailed to all EPDHs, with the exception of those who completed the pilot testing, and one of the authors who holds an EPP (n=181). The 16 item survey contained both closed and open-ended questions, as well as one Likert-scale question, that assessed the following areas: demographics, income from EPDH practice, amount and types of services provided, details of EPDH practice, and perceived barriers to practicing as an EPDH. This article focuses on the outcomes assessment sections. Perceived barriers to utilizing an EPP will be addressed in a separate report.

The survey tool was distributed via mail along with a cover letter explaining the purpose of the study and consent was implied by returning the survey. The first mailing was conducted in early November 2011, with the second mailing following after 3 weeks. To maintain confidentiality, the surveys were numerically coded, and the principal investigators were the only people with access to the coding file. The coding file was maintained solely to facilitate the second mailing (a second survey was only sent to non-respondents 3 weeks following the initial mailing). Once data collection was completed, the coding file was destroyed. Data entry was completed manually by the principal investigators. For open-ended questions, answers were categorized by each author independently and then reviewed. Any discrepancies in categorization

Table I: Demographics of Responding EPDHs

	Number of Respondents	Category	n	Percent
Age by Category	70	20 to 30	6	9%
		31 to 40	10	14%
		41 to 50	15	21%
		>50	39	56%
Years held EPP	66	0 to 3	41	62%
		4 to 6	9	14%
		7 to 9	5	8%
		≥10	11	17%
Practicing using EPP	71	41%	-	-
Mean Hours Per Week using EPP	25	9.3 (Std. Dev. 12.47)	-	-
Income from EPP	27	≤10,000	18	67%
		10,001 to 20,000	4	15%
		20,001 to 30,000	3	11%
		30,001 to 40,000	1	4%
		40,001 to 50,000	0	0%
		>50,000	1	4%
Level of Education	67	Certificate	2	3%
		Associate	22	33%
		Bachelors	39	58%
		Masters	4	6%

\*Not every respondent answered every question. The number of respondents who answered each question is indicated in the second column. The percentages may not total to 100% due to rounding.

were discussed and adjusted, with both authors in agreement regarding the classification. If at least 3 respondents provided similar responses, an additional category was created. If a response was reported in less than 3 instances, it was categorized as "other." Statistical analysis was completed using SPSS version 20 (IBM) and included descriptive statistics and chi-square analyses. Chi-square analysis using the Freeman-Halton extension of the Fisher exact test was used to determine if statistically significant differences existed among those respondents who reported practicing utilizing the EPP and those who did not, particularly in regards to practitioner age, number of years since graduation, type of dental hygiene degree, and length of time holding the EPP. The level of significance was set at 0.05.

**Results**

Responses were collected from 71 EPDHs, yielding a 39% response rate. The majority of responding EPDHs (56%, n=39) are 51 years of age or older, and most (66%, n=41) have held their EPP for 3 years or less. Respondent demographics are presented in Table I. Forty-one percent (n=29) of respondents report that they are currently practicing using their EPP. An additional 20% (n=15) indicated that they had plans to begin using their EPP in the future. The mean number of hours per week spent practicing using the EPP was 9.3 (SD=12.47).

Table II: Qualifying Populations under ORS 680.205 for Which Responding EPDHs Provide Care (n=30)

Population Treated by Practicing EPDHs	n
Residential Care Facilities	21
Primary and Secondary Schools	13
Homebound Adults	5
Populations deemed "limited Access" by dental board	5
Community Health Clinics	4
Nursing Homes	3
Foster Homes	2
Age (due to age are unable to receive regular dental hygiene treatment)	1
Correctional Facilities	1
Youth Centers	1
Nursery Schools or Daycares	1
Mental Health Residential Programs	0
Facilities for mentally ill patients or persons with mental retardation	0
Infirmity or disability	0

\*Total number greater than number of practicing EPDHs because respondents could provide more than one response.

Figure 1: Average Annual Income from Practice Using EPP (n=27)

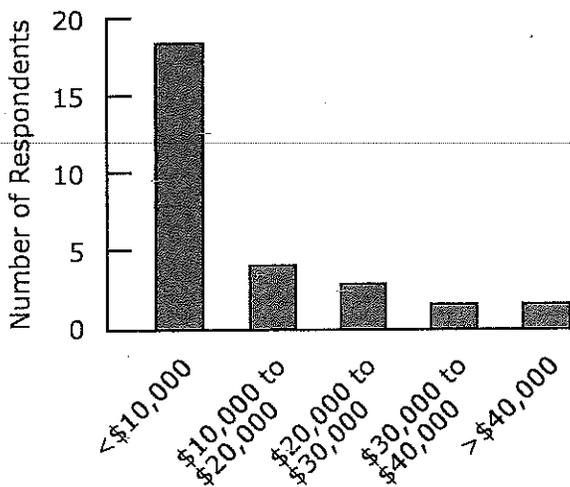


Figure 2: Rate of Reimbursement from Third Party Payers for Services Provided by EPDH (n=23)

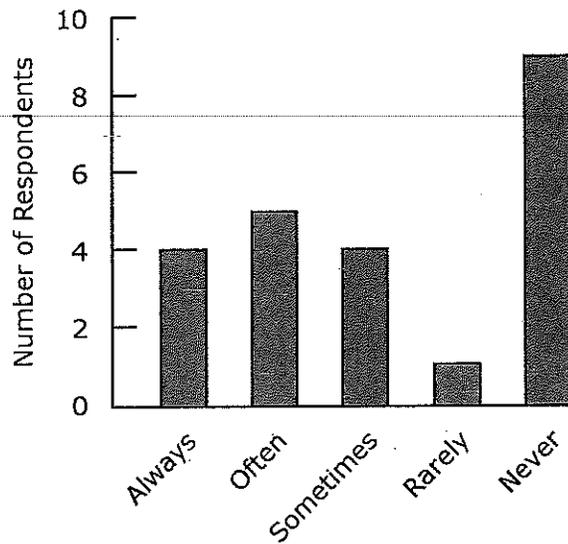


Table III: Total Number of Services Provided as Reported by Responding EPDHs (Time Period of 1 Month)

Procedure	Procedure Code	Number Provided
Adult Prophylaxis	D1110	254
Child Prophylaxis	D1120	1003
Adult Fluoride	D1204	106
Child Fluoride	D1203	901
Fluoride Varnish	D1206	1994
Scaling and Root Planing (SRP) ≥4 teeth/quadrant	D4341	56
SRP 1-3 Teeth/quadrant	D4342	24
Periodontal Maintenance	D4910	83
Full Mouth Debridement	D4355	45
Full Mouth Series of Radiographs (FMX)	D0210	3
4 Bitewing Radiographs (BWX)	D0274	0
2BWX	D0272	0
Panoramic Radiograph (Pano)	D0330	0
Sealants	D1351	885
Soft Denture Reline	D5730, D5731, D5740, D5741	19
Oral Hygiene Instruction (OHI)	D1330	1744
Comprehensive Periodontal Examination	D0180	162

Respondents who were currently practicing utilizing their EPP were asked to indicate in what manner their patient population qualified under ORS 680.205 as having limited access to care. The most frequently identified populations were patients in residential care facilities (n=21) and primary and

secondary schools (n=13). A complete listing of participants' qualifying patient populations is presented in Table II.

Sixty-six percent (n=18) of practicing EPDHs reported making less than \$10,000 per year from

Table IV: Average Number of Services Provided Per Month as Reported by Individual Responding EPDHs

Procedure	Mean (Standard Deviation)	Maximum
Adult Prophylaxis (n=25)	7.72 (11.2)	50
Child Prophylaxis (n=26)	37.00 (116.2)	500
Adult Fluoride Treatment (n=25)	2.8 (6.4)	30
Child Fluoride Treatment (n=25)	28.2 (106.1)	500
Fluoride Varnish (n=25)	75 (206.8)	1000
Scaling and Root Planing >4 teeth per quadrant (n=25)	1.3 (3.6)	15
Scaling and Root Planing 1 to 3 teeth per quadrant (n=25)	0.7 (2.1)	10
Full Mouth Debridement (n=25)	1.3 (4.1)	10
FMX (n=25)	0.1 (0.4)	2
4 BWX (n=25)	0 (0)	0
2 BWX (n=25)	0 (0)	0
Panoramic Radiograph (n=25)	0 (0)	0
Periapical Radiograph (n=25)	0.9 (4.0)	20
Sealant (n=25)	35.4 (103.4)	500
Soft Denture Reline (n=24)	0.1 (0.4)	2
Oral Hygiene Instruction (n=26)	60.2 (121.8)	500
Comprehensive Periodontal Examination (n=25)	5.0 (10.1)	50

their EPP practice (Figure 1). The majority of practicing EPDHs (70%, n=19) own and use portable equipment. Forty-one percent (n=12) of practicing EPDHs advertise for their services, and 36% (n=10) have reported difficulty in obtaining needed supplies.

Respondents who were currently practicing using the EPP were asked to indicate how often they had been successful in obtaining reimbursement from Oregon Health Plan (OHP) or other insurance plans. Thirty-nine percent (n=9) of those who answered responded that they had never been successful (Figure 2). Respondents were also asked to indicate the number of services they provided in an average month in their role as an EPDH. Child prophylaxes, child fluoride, fluoride varnish and sealants were the most frequently reported services among practicing EPDHs. The sum total of average monthly services provided by all respondents is presented in Table III. The average number of services provided per month by individual responding EPDHs is presented in Table IV. Most practicing EPDHs reported working  $\leq 10$  hours per week. Table V displays the average number of hours per week worked as reported by practicing EPDHs. The largest proportion of practicing EPDHs who answered the question (48%, n=12) indicated

Table V: Reported Hours per Week Spent in EPDH Practice

Hours per Week in EPDH Practice	Respondents (n=25)	
	n	Percent
$\leq 5$	12	48
6 to 10	7	28
11 to 20	2	8
21 to 30	0	0
31 to 40	4	16
>40	0	0

that they worked  $\leq 5$  hours per week, followed by 28% (n=7) who indicated that they worked 6 to 10 hours per week.

One of the open-ended survey questions asked practicing EPDHs to report the most commonly seen oral care needs that they were unable to meet, but would be able to meet if the scope of practice were expanded. Responses included temporary restorations, extractions (adult and pediatric), fissurotomy prior to sealants, and denture adjustments (Figure 3).

Bivariate analysis using the Chi-square test with

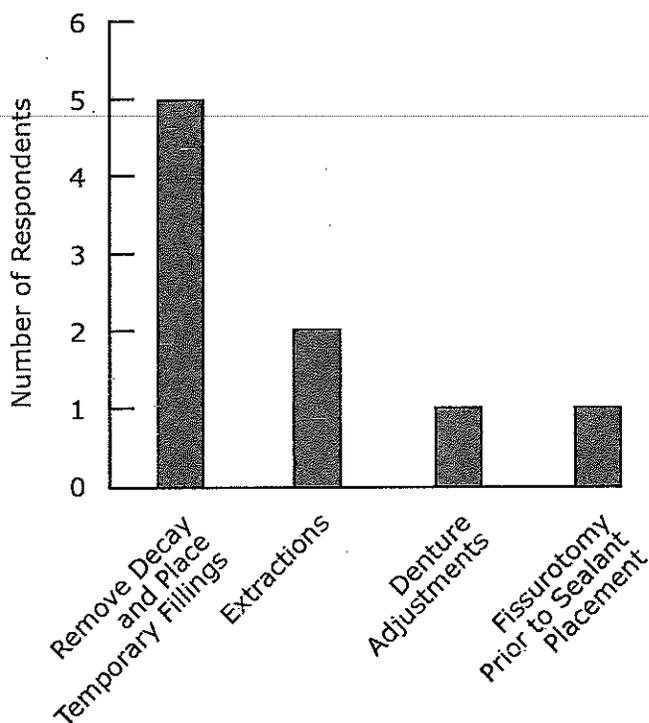
the Freeman-Halton extension of the Fisher exact test was conducted to see if there were any statistically significant differences among those currently practicing using an EPP and those who were not. Areas analyzed included age, number of years since graduation, education level and number of years holding the EPP. No statistically significant differences were found.

## Discussion

This is the first time that the amount of services provided by the EPDH workforce in Oregon has been quantified. The most frequently identified patient population served was "residential care facilities" with primary and secondary schools following behind it. Despite this result, child prophylaxis (D1120), child fluoride (D1203), fluoride varnish (D1206) and sealants (D1351) were the most numerous of the reported services, with relatively lower numbers of adult prophylaxes (D1110) and quadrants of scaling and root planing reported. These findings suggest that Oregon EPDHs have the most success providing care for pediatric patients. The apparent discrepancy between the most frequently served population (residential care facilities) and the most frequently provided services may be due to the nature of the survey questions. The question regarding patient populations was open ended, so the results lack some definition in this area. For example, were the reported "residential facilities" those in which pediatric patients reside, for the elderly or infirm, for patients with mental or physical disabilities, or a combination of all of these? Or is it perhaps that treating children in schools simply provides EPDHs with large numbers of patients resulting in relatively large numbers of these types of services? Is it easier for practicing EPDHs to get established working in the school system than it is to obtain the acceptance and cooperation needed to work in medical or other facilities? Is it potentially easier to be reimbursed for pediatric services? Due to this uncertainty, it appears that the most reliable measure of impact is the type of service provided, not the population served.

The prevalence of pediatric services in the results of this study represents a potential departure from the existing literature. Kushman et al conducted a study to evaluate practice characteristics of independently practicing dental hygienists in California who were participating in the California Health Manpower Pilot Project 139 (HMPP 139) which ran from 1987 to 1990. Their results indicated that the practices were primarily centered on preventive care measures (prophylaxes,

Figure 3: Reported Additional Patient Care Needs Outside of EPDH Scope of Practice (n=9)



fluoride applications, sealants and exams), but authors did not delineate between pediatric and adult services.<sup>14</sup> Astroth and Cross-Poline reported that among dental hygienists in independent practice in Colorado, more preventive services were provided for adults than for pediatric patients.<sup>15</sup> The independent practice models in Colorado and in California under the HMPP 139 differ from the Oregon practice model in that Oregon's model limits the settings and populations that may be served. This may account for the differences seen in the types of care provided. The California HMPP 139 facilitated an experimental environment in which independent practice dental hygiene could be evaluated. Dental hygienists were permitted to set up businesses to provide dental hygiene care independently, and could provide all services allowed under general supervision. No stipulations were made about populations that could receive care.<sup>16</sup> In Colorado, dental hygienists are permitted to practice independently as well as own and operate their own business or practice.<sup>15</sup>

The practice act in Oregon permits EPDHs to serve many populations that have been deemed "underserved." As presented in Table II, there are many populations that EPDHs are permitted to serve, but no respondents indicated that they work with these communities (e.g., patients with mental illness or in clinics operated or staffed by

nurse practitioners, physician assistants, or midwives). This may indicate that barriers exist in gaining access to these types of clinics, or that current permit holders are unaware that some of these populations qualify to be served by EPDHs. Even though significant services are being provided by Oregon EPDHs, the current findings indicate that current EPP-holders in Oregon may not be practicing to the full extent of their permitted abilities, which potentially lessens their impact.

There is considerable room for growth for independent practice in dental hygiene in Oregon. Coplen and Bell investigated perceived barriers to pursuing independent practice among EPDHs in Oregon.<sup>17</sup> With the majority of practicing EPDHs indicating that they work less than 10 hours per week, many more individuals could be served if EPDHs practiced in this manner full time. Many of the respondents hold an EPP but do not utilize it to practice in this realm. Permit holders face several barriers, and among non-practicing EPDHs, the most commonly reported reasons for not pursuing EPDH practice were "currently working in a different setting" and "lack of business knowledge." Insurance reimbursement and inability to make a living wage were two of the reported barriers among practicing and non-practicing EPDHs, and likely also contribute to this low utilization of the EPP.<sup>17</sup> To clarify, if EPDHs are unable to attain reimbursement from third party payers, patients typically pay for services out of pocket. Since the completion of this study, new legislation passed in Oregon that requires any services that would be paid to a dentist through insurance plans must also be paid to an EPDH providing the same services. This has the potential to increase the ability of EPDHs to make a living wage. In addition, practicing EPDHs cited difficulty in obtaining a collaborative agreement or cooperative facility in which to practice.<sup>17</sup> Some practicing EPDHs report difficulty obtaining supplies. This difficulty comes from several areas: some items (for example an emergency medical kit) require a DEA number to be purchased (this is a number assigned to medical providers by the Drug Enforcement Administration that is required for prescription writing), some vendors are reluctant to sell to people who are not an established dental office and some items are prohibitively expensive if they are not purchased in bulk (however, if they are purchased in too large a quantity, they expire before they can be used). To address this last difficulty, some EPDHs will place orders as a group, and then subdivide the bulk items.

Coordinated Care Organizations (CCOs) are a relatively new addition to the health care sys-

tem in Oregon. In June 2011, House Bill 3650 was signed into law, creating the framework for a state-wide system of health care networks that cover patients under the OHP which is the state Medicaid plan. CCOs are designed to address physical, mental and dental health with the intent that patients will have a better safety net to help ensure better overall health outcomes.<sup>18</sup> The full implementation of dental care organizations into the CCO framework has yet to occur. Once dental care is fully integrated into CCOs, it may be easier for EPDHs to work in a full time capacity and in different settings since dental care is required within the CCOs. It seems that an EPDH would be a logical fit for this new health care model. Hypothetically, the integration of EPDHs into these organizations would spread the dental safety net even farther.

The question of the need for a mid-level provider in Oregon cannot adequately be addressed by this survey alone. One may argue that while EPDHs are providing services to many people, there are still many more patients in need of care, particularly restorative care, which could be provided by a mid-level dental provider. Oregon is currently undergoing a shift in its health care system as CCOs are being integrated, with the full implementation of dental care yet to come. Currently there are 15 CCOs operating in Oregon.<sup>18</sup> Would a mid-level dental provider be more effective in filling the access to care gap that exists in Oregon, particularly if they were easily integrated into CCOs? The addition of basic restorative services to the traditional catalogue of dental hygiene services would allow for more dental needs to be met. If a mid-level provider model became the most effective way to provide dental care through CCOs in Oregon, EPDHs may no longer be necessary. However, the ease of integration of a mid-level provider into CCOs, or even in independent practice in Oregon, may be difficult to foresee at this point in time. With the implementation of the health insurance exchanges of the Affordable Care Act (ACA), this question may remain difficult to answer. The ACA requires each state to establish a health insurance "marketplace" or "exchange," which is an online marketplace where individuals can purchase health insurance. Participating insurance coverage providers will make their plans available on the exchanges for public consumption.<sup>19</sup> As the dental insurance plans are made available through the exchanges, the dental coverage playing field will shift, and it is likely that there will be changes in the number of patients who are served by OHP. There may be a change in the number of children who are eligible for guaranteed dental services. Adult dental care is

not included in Oregon's Essential Health Benefits benchmark plan,<sup>20</sup> therefore adults who qualify for Medicaid and others with lower incomes will still face financial difficulties in obtaining dental health care. It may be difficult to determine whether there is a need for a mid-level dental provider until the implementation of the ACA has happened and CCOs are well established. The effect of the ACA on the success of EPDHs will remain unknown until implementation has occurred.

Some limitations were inherent in the current study. The response rate was lower than anticipated, but respectable when compared to typical response rates of mail-based surveys (26 to 49%).<sup>21</sup> Due to the response rate, results may not be generalizable to the entire population of EPDHs, but only to the participants. A larger response rate would have provided more information and improved generalizability. While the survey contained questions specifically designed for EPDHs who were not currently practicing in that role, authors believe that recipients who weren't currently using their EPP may not have declined because they thought the survey did not apply. If these recipients did not read far enough through the survey, they would not have seen the directions to skip the bulk of the survey and answer only a few questions. Clearer instructions in the cover letter may have proven beneficial in increasing the response rate. Another limitation was found with the question regarding whether or not the permit holder was currently practicing using the permit. The only options included in the survey instrument were "yes" and "no," and there was no follow up to ask if the participant had plans to begin using it in the future. Several respondents indicated in the open response section at the end of the survey that even though they were not currently using their EPP, they had plans to do so. Had an option been included to capture this subset, authors may have a better idea of anticipated future usage rates. A third limitation to this study was that authors were not able to establish survey performance reliability. The survey has been administered only one time, so test-retest reliability could not be determined. In order to keep the survey to a minimal length, no redundant questions were included to evaluate internal

reliability. To facilitate data entry and consistency of information, every survey mailed was identical, so no alternate-form reliability was established.

Plans for future research include continued outcomes assessment of EPDHs to monitor the amount of services that are being provided. In addition, authors plan to poll program directors in states that allow independent practice to determine whether or not programs include specific curricular innovations to help prepare students for independent practice.

## Conclusion

To a limited extent, the services provided by EPDHs have now been quantified. While less than half of respondents indicated that they were currently practicing using the EPP, practicing EPDHs reported providing significant numbers of services to underserved populations in Oregon, which demonstrates that the provider model is effective. Most of the services provided were pediatric services, which indicates that EPDHs have had the most success in accessing and serving this group of patients. However, there is considerable room for growth as demonstrated by the low number of average hours worked per week by EPDHs. In addition, there are as yet many eligible populations who are not routinely being served by EPDHs. Continual outcomes assessment is needed to determine future need for independent practice dental hygienists and the need for the implementation of mid-level dental providers in Oregon, specifically after the full implementation of CCOs and the ACA.

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# LICENSE RATIFICATION

## **16. RATIFICATION OF LICENSES**

As authorized by the Board, licenses to practice dentistry and dental hygiene were issued to applicants who fulfilled all routine licensure requirements. It is recommended the Board ratify issuance of the following licenses. Complete application files will be available for review during the Board meeting.

### **DENTAL HYGIENISTS**

H6932	REBECKA A PRICE, R.D.H.	4/21/2015
H6933	IRINA CHUBINSKY, R.D.H.	4/21/2015
H6934	NIKKI HENDERSON, R.D.H.	4/21/2015
H6935	CARLY LORRAINE CHILDRESS, R.D.H.	4/21/2015
H6936	SARAH RUTH MOOSO, R.D.H.	4/30/2015
H6937	TRACY ANN CHADWICK, R.D.H.	4/30/2015
H6938	CODY ALLEN TORGERSON, R.D.H.	4/30/2015
H6939	MEGAN DETWILER, R.D.H.	5/7/2015
H6940	DANI R NOWAK, R.D.H.	5/7/2015
H6941	MICAELA M HESTER, R.D.H.	5/13/2015
H6942	MEGAN LOUISE KUENZI, R.D.H.	5/13/2015
H6943	KATELYN EMILY LASHLEY, R.D.H.	5/13/2015
H6944	JESSICA M WILLIAMS, R.D.H.	5/13/2015
H6945	KYRSTIN KAY CAMERON KAMINSKY, R.D.H.	5/13/2015
H6946	PAIGE MARIE BUSWELL, R.D.H.	5/13/2015
H6947	MICHAEL JOSEPH MC GOVERN, R.D.H.	5/13/2015
H6948	SYLVIANNA M MARQUEZ, R.D.H.	5/14/2015
H6949	CLARE W FOSTER, R.D.H.	5/14/2015
H6950	ALLIE M ENGLUND, R.D.H.	5/28/2015
H6951	NICOLE LEIGH BOEKENOOGEN, R.D.H.	5/28/2015
H6952	MARTI DAWN SEELIGER, R.D.H.	5/28/2015
H6953	HEIDI J SCHULTZ, R.D.H.	5/28/2015
H6954	KRISTIN NICHOLE MILLER, R.D.H.	5/28/2015
H6955	KENDA LEA WAVRA, R.D.H.	5/28/2015
H6956	SAMANTHA JO GLENDER, R.D.H.	5/28/2015
H6957	ERIN MICHELE LOMAX, R.D.H.	5/28/2015
H6958	BARBARA ANN SIGURDSON, R.D.H.	5/28/2015
H6959	RANDILYNN M TAFT, R.D.H.	5/28/2015
H6960	OLIVIA FAITH KAMAKA, R.D.H.	5/28/2015
H6961	JENNIFER M SIGEL, R.D.H.	5/28/2015
H6962	MELISSA M WOODMANSEE, R.D.H.	6/5/2015
H6963	KAYLA MARIE MOYSE, R.D.H.	6/5/2015
H6964	JORDYN ALEXIA TURNER, R.D.H.	6/5/2015
H6965	RICKIE L MARCHANT, R.D.H.	6/10/2015
H6966	MACKENZIE LEIGH ANN SRACK, R.D.H.	6/10/2015
H6967	BRYNNA L RUST, R.D.H.	6/10/2015
H6968	STEFANIE L VAN DE HEY, R.D.H.	6/10/2015
H6969	JENNIFER R BRAUN, R.D.H.	6/10/2015
H6970	MARISA ANN CALAVAN, R.D.H.	6/10/2015
H6971	TIFFANY K SETIONO, R.D.H.	6/10/2015

## DENTISTS

D10203	ARTI KHANNA, D.D.S.	4/7/2015
D10204	MATTHEW A JOHNSON, D.D.S.	4/7/2015
D10205	NICHOLAS J BRAMMER, D.D.S.	4/7/2015
D10206	MICHAEL J ISAAC, D.D.S.	4/7/2015
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D10208	ANDREA M FONNER, D.D.S.	4/7/2015
D10209	JULIE KATHLEEN LEZOTTE, D.D.S.	4/7/2015
D10210	NICHOLAS DAVID WHITE, D.D.S.	4/21/2015
D10211	THOMAS R PITTS, D.D.S.	4/21/2015
D10212	SCOTT C DONER, D.D.S.	4/21/2015
D10213	MICHAEL JOHN DUVALL, D.D.S.	4/21/2015
D10214	LUIS F PAGAN, D.M.D.	4/1/2015
D10215	NELS H WALTHER, D.M.D.	4/21/2015
D10216	DYLAN JAMES SORBER, D.M.D.	4/21/2015
D10217	RYAN J LE CLAIRE, D.D.S.	4/21/2015
D10218	BENJAMIN JAY WHITTED, D.D.S.	4/30/2015
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D10222	GARY V DIXON, D.D.S.	4/30/2015
D10223	EDWARD STEPHEN DOLAN, D.D.S.	5/7/2015
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D10225	JAMES C YOON, D.M.D.	5/7/2015
D10226	LAUREN BROOKE MANNING, D.D.S.	5/7/2015
D10227	TIMOTHY MARK ELLIS, D.M.D.	5/7/2015
D10228	TERESA NGOC NGUYEN, D.M.D.	5/13/2015
D10229	TODD DAVID SOUTHALL, D.D.S.	5/13/2015
D10230	ERINA YUN-YI HUNG, D.M.D.	5/14/2015
D10231	JESSICA L ADAMS, D.D.S.	5/28/2015
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D10234	SHANNON MALONEY WOODS, D.M.D.	5/28/2015
D10235	TREVOR RHODES PETERSON, D.M.D.	5/28/2015
D10236	DARIOUSH AFSHAR, D.M.D.	5/28/2015
D10237	THOMAS STEPHEN LLOYD, D.D.S.	5/28/2015
D10238	JOSHUA TROY MYERS, D.D.S.	5/28/2015
D10239	KENT B CHERRY, D.M.D.	5/28/2015
D10240	AUSTIN J COPE, D.M.D.	5/28/2015
D10241	BRENT DAVID ERICKSON, D.M.D.	5/28/2015
D10242	JOHN C HARDY, D.M.D.	6/5/2015
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D10247	SAMUEL DAVID SEO, D.M.D.	6/5/2015
D10248	ANTHONY ROYAL, D.M.D.	6/5/2015
D10249	ROBERT W KOHRT, D.D.S.	6/10/2015
D10250	LESTER BLAINE KENNINGTON, D.D.S.	6/10/2015
D10251	MARY-TUYEN NGOC PHAM, D.D.S.	6/10/2015
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D10253	DAVID A GORE, D.D.S.	6/10/2015
D10254	ERIK GORDON SMITH, D.D.S.	6/10/2015
D10255	PAUL G FAIRBANKS, D.D.S.	6/10/2015
D10256	KARLI M HERZOG, D.D.S.	6/10/2015

D10257	ASHLEY BROOKE SWAN, D.M.D.	6/10/2015
D10258	MARK T NUTTALL, D.M.D.	6/11/2015
D10259	MELISSA S AMUNDSON, D.D.S.	6/12/2015

**DENTAL FACULTY**

DF0029	SIVARAMAN PRAKASAM,	6/5/2015
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CERTIFICATION**

**Nothing to report under this tab**