

PUBLIC PACKET

**OREGON BOARD
OF
DENTISTRY**

**BOARD MEETING
AUGUST 28, 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 \$___ (\$2,000 for dentists OR \$1,000 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 the 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 15th 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 15th 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
June 26, 2015**

MEMBERS PRESENT: Alton Harvey Sr., President
Julie Ann Smith, D.D.S., M.D., 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.
Gary Underhill, D.M.D.
Brandon Schwindt, 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)
Daniel Blickenstaff, D.D.S., 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; Mary Harrison, ODAA; Ginny Jorgensen, The Dale Foundation; Alec Shebiel, ODHA; Christina Bodamer, ODA; Heidi Jo Grubbs, R.D.H.; Pamela Lynch, R.D.H.; Jessica Adamson, Providence Health & Services; Dr. Brad Fuller, D.D.S., Interdent; Kenneth Chung, D.D.S., ODA; T. Lant Haymore, D.M.D.; James C. Brown, Attorney at Law; Enrique Sama, DAS-HR

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

NEW BUSINESS

MINUTES

Dr. Hongo moved and Dr. Fine seconded that the minutes of the April 17, 2015 Board meeting be approved as amended. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye.

ASSOCIATION REPORTS

Oregon Dental Association

No report

Oregon Dental Hygienists' Association

Lynn Ironside returned from the national meeting in Nashville, which was very successful and had its highest attendance ever. Alec Shebiel had an update on SB 301 and SB 302, and that they were happy with the legislation, and wanted the use of an EpiPen approved for hygienists as well.

Oregon Dental Assistants Association

Mary Harrison discussed a recent Radiation Protection Services meeting that discussed Lead Aprons not being necessary when taking radiographs. There was general discussion, and Dr. Schwindt asked for the reference materials discussed. Ms. Harrison said she would provide them to the board.

COMMITTEE AND LIAISON REPORTS

WREB Liaison Report Jonna Hongo, D.M.D. had nothing to report, but will have report in August after the HERB and DERB meetings.

AADB Liaison Report Amy Fine, D.M.D. had no news at this time. She said she will be unable to attend in the fall, but that Yadira Martinez, R.D.H. would be attending.

ADEX Liaison Report Jonna Hongo, D.M.D. submitted a report.

CDCA Liaison Report Amy Fine, D.M.D. and Yadira Martinez, R.D.H. attended the last meeting in April. There was a brief review of Buffalo model and Dr. Fine asked Mr. Prisby to disseminate a report to the Board earlier. The CDCA has gone international and can provide additional information if asked.

Committee Meeting Dates

Anesthesia Committee –Meeting scheduled for August 18th at 6:30 p.m.

Enforcement & Discipline Committee – Met on May 7th and reviewed protocols. Recommended change to increasing the fines for false certification of continuing education.

Standard Protocols - False Certification Fines Increased

Dr. Underhill moved and Dr. Hongo seconded to increase the fines to \$2,000.00 for Dentists and \$1,000.00 for Hygienists for false certification of continuing education. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye.

EXECUTIVE DIRECTOR'S REPORT

Board Member Reappointment & Staff Updates

Mr. Prisby reported that Governor Kate Brown reappointed and the Senate confirmed Board Member Julie Ann Smith DDS, MD for another term that will expire on May 9, 2019. Dr. Bill Herzog is no longer with the OBD. The new Dental Consultant/Investigator, Dr. Daniel Blickenstaff was introduced. Mr. Prisby said that he was working with DAS-HR to finalize the job posting for a new full-time Dental Investigator. The 2015-17 OBD Budget was approved by the Governor, and this included a biennial fee increase of \$75.00/Licensee to help pay for the additional Dental Investigator.

OBD COMMITTEES May 2015 - April 2016

Mr. Prisby stated that OBD President Alton Harvey, Sr. had finalized the Committee appointments. He thanked the ODA, ODHA and ODAA for their feedback and cooperation in choosing their representatives.

OBD Budget Status Report

Mr. Prisby reported that he attached 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. The end of the 2013-15 Biennium budget period is on June 30th.

Proposal to recoup costs

Mr. Prisby reviewed his memo to the Board 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 \$400.00 per case.

Dr. Hongo moved and Dr. Beck seconded for the OBD to recoup costs of referrals to hearings. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye.

Customer Service Survey

Mr. Prisby reported that he attached a chart showing 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. Beginning July 1st the customer survey will be completed online.

Board and Staff Speaking Engagements

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

Friday, May 1, 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.

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

Friday, May 29, 2015 - Teresa Haynes, Exam and Licensing Manager made a License

Application Presentation to the graduating Dental Students at the OHSU Dental School in Portland.

Monday, June 1, 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.

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

Wednesday, April 22, 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.

AADB/AADA Annual Meeting

Mr. Prisby asked the Board to authorize the attendance of the OBD's Executive Director, whether him 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.

Dr. Fine moved and Dr. Hongo seconded to authorize Stephen Prisby to attend the American Association of Dental Administrators (AADA) and American Association of Dental Boards (AADB) Meeting. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye.

Legislative Update

Mr. Prisby stated that he attached 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.

Switching to laser embossed seals

Mr. Prisby reported that 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.

The Board discussed and approved switching to laser embossed seals.

Newsletter

Mr. Prisby said it was time to consider another newsletter and articles are welcome from the Board Members.

UNFINISHED BUSINESS

Temporary Rule- Secretary of State Filing- Fee Increase of the Biennial Licensure Renewal by \$75.00

Dr. Hongo moved and Dr. Smith seconded to approve the fee increase with this temporary rule until a permanent rule can be established. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye.

The Board discussed the fees charged and directed staff to research surrounding state Dental and Hygiene licensure fees.

Proposed Rules for August 27, 2015 Public Rulemaking Hearing

Dr. Hongo moved and Dr. Underhill seconded to hold a Public Rulemaking Hearing on August 27, 2015 to review the attached 22 proposed rule changes. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye.

CORRESPONDENCE

The Board received a letter from Dr. Kenard Adams regarding radiographs.

The Board received a letter from Leila Tarsa, DDS, MS requesting Board interpretation of radiograph rules/protocols.

The Board received a letter from John Lee regarding the Board's Clarification on Radiographs statement that is posted on the OBD website.

The Board received a letter from a person asking to be anonymous regarding reprimands/discipline and other Board action.

The Board directed staff to collaborate with Dr. Hongo on a new letter to clarify the OBD's position on radiographs.

OTHER BUSINESS

Soft Reline Course- Melissa Colasurdo, D.M.D. & Karley Schneider, D.M.D.

Dr. Fine moved and Dr. Beck seconded that the Board move to approve the presented Soft Reline Course for EFDA Dental Assistants. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye.

Board Approval of Local Anesthesia and Nitrous Oxide Course – Lake Washington Institute of Technology

Dr. Fine moved and Dr. Beck seconded that the Board approve Lake Washington Institute of Technology's continuing education programs for local anesthesia and nitrous oxide. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye.

Radiologic Proficiency Course – The DANB RHS Review Course

Dr. Fine moved and Dr. Underhill seconded that the Board approve The DANB RHS Review Course as a Board approved course for Radiologic Proficiency. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye.

Request from Providence Health & Services to own dental clinic

No vote was made. No need to approve if they meet statute.

Articles and News of Interest (no action necessary)

Barriers Faced by Expanded Practice Dental Hygienists in Oregon

Evaluating the Impact of Expanded Practice Dental Hygienists in Oregon an Outcome Assessment

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

Licenses appeared pursuant to their Consent Orders in case number **2008-0013**.

OPEN SESSION: The Board returned to Open Session.

CONSENT AGENDA

2015-0192, 2015-0196, 2015-0183, 2015-0203, 2015-0218, 2015-0184, 2015-0209 and 2015-0193. Dr. Smith moved and Dr. Beck seconded that the above referenced cases be closed with No Further Action per the staff recommendations. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye.

COMPLETED CASES

2014-0197, 2015-0191, 2014-0141, 2014-0127, 2015-0198, 2014-0163, 2013-0152, 2014-0172, 2014-0180, 2015-0159, 2014-0132, 2014-0066, 2015-0225, 2014-0185, 2014-0156, 2014-0125, and 2014-0194, 2014-0146 and 2014-0057. 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 Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye. Dr. Beck and Dr. Schwindt recused themselves on case 2014-0125.

BUTLER, CHRISTOPHER A. D.M.D., 2014-0139

Dr. Beck moved and Dr. Hongo seconded that the Board move to issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand and an \$800.00 restitution payment to patient DR. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye.

2014-0084

Dr. Schwindt moved and Dr. Smith 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/codes that support the continuing education log are maintained as proof for two licensure cycles. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye.

2015-0054

Mr. Morris moved and Dr. Hongo seconded that the Board close the matter with a Letter of Concern reminding the Licensee that OAR 818-012-0040(4) requires heat sterilizing devices shall be tested for proper function by means of a biological monitoring system that indicates micro-organisms kill each calendar week in which scheduled patients are treated & testing results shall be retained by the licensee for the current calendar year and the two preceding calendar years. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye.

OGAWA, KEITH F. D.D.S., 2015-0007

Ms. Riedman moved and Dr. Hongo seconded that the Board voted, with respect to Respondent #1, to close with No Further Action; with respect to Respondent #2, to issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand; completion of three hours of continuing education in record keeping within six months. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye.

2015-0176

Ms. Martinez moved and Dr. Hongo seconded that the Board close the matter with a Letter of Concern reminding the Licensee that it is his responsibility to assure the Board that each calendar week in which scheduled patients are treated heat sterilization devices are tested, per OAR 818-012-0040(4). The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye.

HSU, RICHARD PAO-YUAN, D.M.D., 2015-0189

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

2014-0212

Dr. Fine moved and Dr. Hongo seconded that the Board move the Board close the matter with a Letter of Concern reminding the Licensee that OAR 818-012-0040(4) requires "heat sterilizing devices shall be tested for proper function by means of a biological monitoring system that indicates micro-organisms kill each calendar week in which scheduled patients are treated." The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye.

Lynch, Theodore R., D.D.S., 2013-0195 and 2014-0114

Dr. Hongo moved and Dr. Smith seconded that the case 2013-0195, move to merge this case with the issues in case 2015-0114, issue a Notice of Proposed Disciplinary Action and offer the Licensee a Consent Order in which the Licensee would agree to be reprimanded, pay a \$1,000.00 civil penalty per Board protocols, pay \$4,200.00 in restitution in the form of a cashier's, bank, or official check made payable to patient guardian, CW, provide proof of installation of an amalgam separator within 60 days of the effective date of the Order, and complete three hours of Board approved continuing education in the area of record keeping within six months of the effective date of the Order. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye.

2014-0112

Dr. Beck moved and Dr. Hongo seconded that the Board move to close with a Letter of Concern reminding Licensee to assure all information is properly and completely documented in a patient's chart notes and that all office sterilizing units are spore tested weekly. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye.

NGUYEN, TUONG, 2015-0153

Dr. Schwindt moved and Dr. Hongo seconded that the Board move to issue a Consent Order in which the Licensee agrees to a civil penalty of \$500.00. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye. Dr. Fine recused herself.

2015-0182

Mr. Morris moved and Dr. Hongo seconded that the Board close the matter with a Letter of Concern reminding the Licensee that when reapplying for licensure, the Licensee not overlook past history from other venues when filing for licensure in Oregon. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye.

2014-0119

Ms. Riedman moved Dr. Smith seconded that the Board close the matter with a Letter of Concern addressing the issue of ensuring that when planning the position of implants next to existing teeth every effort is made to not place the implants too close to the existing teeth. The motion passed with Dr. Smith, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye. Dr. Beck and Dr. Schwindt recused themselves

2015-0171

Ms. Martinez and Dr. Hongo seconded that the Board close the matter with a Letter of Concern addressing the issue of ensuring that treatment notes accurately document the treatment that is provided to a patient. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Hongo,

Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye. Dr. Fine recused herself.

STRONG, SHAREN, D.M.D., 2015-0175

Dr. Underhill moved and Dr. Hongo seconded that the Board move to issue a Notice of Proposed Disciplinary Action and offer a Consent Order incorporating a reprimand and a civil penalty in the amount of \$10,000.00 and Licensee shall personally appear at least one time before the Board with the first appearance at the first Board meeting date immediately following the effective date of this Order. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye. Dr. Fine recused herself.

STRONG, SCOTT L., D.M.D., 2014-0151

Dr. Fine moved and Dr. Smith 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 to no longer be allowed to do third molar extractions. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye.

THURMAN, LESLIE S., R.D.H., 2015-0118

Dr. Hongo moved and Dr. Beck seconded that the Board issue a Notice of Proposed Disciplinary Action and offer a Consent Order incorporating a reprimand, a civil penalty of \$500.00 and an immediate suspension of the Licensee's license to practice dental hygiene in the state of Oregon until the Licensee complies fully with the Board's request for the requested information. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye.

2014-0082

Dr. Beck moved and Dr. Smith seconded that the Board move to close the case with a **Strongly** Worded Letter of Concern addressing the issues of ensuring that complete dental diagnoses are documented in the patient record, that when premedication is taken for dental treatment, the indications are clearly documented in the patient record and noted when not indicated, and that radiographs taken are of diagnostic quality. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye.

ZIMMERMAN, WALDON C., D.M.D. 2015-0190

Dr. Schwindt moved and Dr. Hongo seconded that the Board issue a Notice of Proposed Disciplinary Action and offer a Consent Order incorporating a reprimand and pay a civil penalty in the amount of \$2,500.00 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 60 days of the effective date of the Order. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye.

PREVIOUS CASES REQUIRING BOARD ACTION

COMBE, R. OWEN, D.M.D., 2005-0117

Mr. Morris moved and Dr. Smith seconded that the Board move to issue an Order of Dismissal dismissing Licensee from the terms of his Third Amended Consent Order, dated 3/13/14. The motion passed with Dr. Smith, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, and

Dr. Underhill voting aye. Dr. Beck and Dr. Schwindt recused themselves.

HENDY, JOHN A., D.D.S., 2013-0020

Ms. Riedman moved and Dr. Hongo seconded that the Board move to accept Licensee's offer of a Consent Order incorporating a reprimand, 40 hours of Board approved community service to be completed by 1/1/16, and a license restriction prohibiting endodontic treatment of molars. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye.

HOPKINS, NICHOLE M. R.D.H., 2015-0073

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

HSU, RICHARD PAO-YUAN, D.M.D., 2012-0019

Dr. Underhill moved and Dr. Hongo seconded that the Board accept the proposed Consent Order proposed by the Licensee, but only to resolve case 2012-0019. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, and Dr. Underhill voting aye. Dr. Schwindt recused himself.

KAUFMAN, FRANCIS E., D.D.S., 2015-0181

Dr Fine moved and Dr. Hongo seconded that the Board move to issue a Default Order, suspending Licensee's Oregon dental license. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye.

2010-0184

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

2010-0246

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

PIER, SHAUNA L., D.D.S., 2013-0210

Dr. Schwindt moved and Dr. Hongo moved that the Board move to issue an Order of Dismissal dismissing the Notice of Proposed Disciplinary Action, issued 12/30/14. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye.

SHISHKIN, IGOR, D.D.S., 2015-0049

Mr. Morris moved and Dr. Hongo moved that the Board accept the Consent Order proposed by the Licensee and close the matter. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye. Dr. Fine recused herself.

2013-0097, 2013-0119 and 2014-0094

Ms. Riedman moved and Dr Hongo seconded that the Board In the matters of cases 2013-0097, 2013-0119 and 2014-0094 move to reinstate Licensee’s dental license and offer Licensee a Consent Order incorporating a reprimand; 60 hours of community service to be completed within 18 months; successful completion of three hours of continuing education in the area of record keeping within one year; for a period of five years, Licensee is prohibited from having a DEA certificate, is required to only practice in a group practice, and is prohibited from ordering, storing, inventorying or having unilateral access to Scheduled controlled drugs; and agree to the Board’s protocols to support his recovery and protect the public, including enrollment with the State’s Health Professionals’ Services Program; personal appearances before the Board at an initial frequency of three times a year; and submission, with his license renewal applications, documentation verifying completion of 40 hours of continuing education for the licensure periods 4/1/15 to 3/31/17 and 4/1/17 to 3/31/19. The motion passed with Dr. Smith, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, and Dr. Underhill voting aye. Dr. Beck and Dr. Schwindt recused themselves.

LICENSURE AND EXAMINATION

Reinstatement of Licensee - Craig E. Robbins, D.M.D.

Ms. Martinez moved and Dr. Hongo seconded to reinstate the License of Craig E. Robbins, D.M.D. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye.

Reinstatement of Licensee - Henry M. Bumstead, D.D.S.

Dr. Underhill moved and Dr. Smith seconded to reinstate the License of Henry M. Bumstead, D.D.S. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye.

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

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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
D10207	PATRICE M YODER, D.D.S.	4/7/2015
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

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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
D10219	QUINN D MARTIN, D.M.D.	4/30/2015
D10220	JEFFREY M BATESOLE, D.D.S.	4/30/2015
D10221	KEVIN J FLASH, D.D.S.	4/30/2015
D10222	GARY V DIXON, D.D.S.	4/30/2015
D10223	EDWARD STEPHEN DOLAN, D.D.S.	5/7/2015
D10224	LAURA L RAILAND, D.M.D.	5/7/2015
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
D10232	NICOLE LINA SWEET, D.D.S.	5/28/2015
D10233	ELVI MARIE BARCOMA, D.D.S.	5/28/2015
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
D10243	TIFFANY DIANE BROWN, D.M.D.	6/5/2015
D10244	LEONARD B WILSON, D.M.D.	6/5/2015
D10245	JENNIFER H KIM, D.M.D.	6/5/2015
D10246	JONATHON KONZ, D.D.S.	6/5/2015
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
D10252	RYAN L HIRSCHI, D.D.S.	6/10/2015
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

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

DANB

Dr. Schwindt moved and Dr. Fine seconded to consider a pediatric dental assistants category and move it the Licensing Standards Committee for consideration. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye.

Recording of Executive Sessions

Dr. Hongo moved Dr. Beck seconded that the Board not electronically record Executive Sessions of Board meetings and to utilize written minutes. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye.

Marijuana

Dr. Schwindt brought up the use of recreational marijuana and led a discussion on what the position of the Board should be. The staff was directed to gather other Boards' (medical, nursing and pharmacy) positions on it.

EXECUTIVE SESSION: The Board met in Executive Session pursuant to ORS 192.660(2)(a) to consider the employment of a public officer, employee, staff member or individual agent.

OPEN SESSION: The Board returned to Open Session.

The Board announced their decision regarding their choice of Executive Director. Dr. Fine moved and Dr. Hongo seconded that Stephen Prisby be appointed as the Oregon Board of Dentistry's Executive Director. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye.

Announcement

No announcements

ADJOURNMENT

The meeting was adjourned at 3:30 p.m. President Harvey stated that the next Board meeting would take place August 28, 2015.

Alton Harvey Sr.
President

DRAFT

ASSOCIATION REPORTS

Nothing to report under this tab

COMMITTEE REPORTS

Dental Exam Review Board

July 24, 2015

Salt Lake City, UT

EXECUTIVE SUMMARY

Present:

Dr. James Ence, Chair, UT
Dr. Aimee Ameline, MT
Dr. Byron Blasco, NV
Dr. Dale Brewster, ND
Dr. Paul Bryan, WA
Dr. Stan Crawford, OK
Dr. Val Garn, ID
Dr. Randall Hancock, WY
Dr. Michael Hauer, AZ
Dr. Jonna Hongo, OR
Dr. Gary Jeffers, ADA Representative
Dr. Tom Kovaleski, AK
Dr. Huong Le, CA

Dr. Dennis Manning, IL
Dr. Mike Mulvehill, Educator Member
Dr. Rich Radmall, UT
Dr. Rudy Ramos, TX
Dr. Roger Stevens, KS
Dr. Burrell Tucker, NM
Dr. Nathaniel Tippit, President
Beth Cole, Chief Executive Officer
Dr. Bruce Horn, Dir. of Dental Exam Admin.
Dr. Jerri Ann Donahue, Dir. of Dental Exam Dev.
Dr. Charles Broadbent, Dir. of Dental Exam Dev.
Sharon Osborn Popp, PhD, Testing Specialist
Denise Diaz, Dental Manager

Dental Exam Schedule

The 2016 Dental Exam Schedule was approved.

Candidate Feedback Summary

Denise Diaz presented a summary of feedback collected from candidates in their post-exam surveys. Overall, those that responded are very satisfied with the dental exam. WREB reviews and considers all feedback.

WREB Update

Beth Cole gave an update on current WREB events. Some of the topics covered included the following:

- WREB will be switching from Pearson VUE to Prometric for written exams starting in the 2016 exam season.
- The internal database WIN was implemented during the last exam season and is still under construction.
- WREB has hired a new Administrative Manager, Julie McEntee. AnneMette Lavery has taken over many of Linda Paul's responsibilities.
- Expensewire, the system for reimbursement, is undergoing improvements to streamline its usability.
- WREB is exploring additional ways to expand educator involvement.
- WREB continues to develop new leadership for the future.
- Provisional acceptance will be implemented in 2016 for the dental operative exam.
- Hygiene onsite retakes were implemented in 2015 and have been a huge success. WREB has received positive feedback from both Candidates and educators. 133/178 candidates that failed retook onsite. Of those that retook onsite, 80% passed.

- WREB administered a dental exam at the University of Illinois in Chicago for the first time in 2015.
- Political environment:
 - Two candidates have successfully passed the California portfolio exam.
 - An ADA Licensure Task Force met last week.
 - An ADEA Task Force will be meeting soon to discuss issues of importance to candidates.
 - SRTA and ADEX are ending their affiliation.

ADA Report

Dr. Gary Jeffers presented the ADA report. The ADA licensure task force met recently to discuss candidate licensure concerns such as portability and the ethical treatment of patients.

CTP Committee Report

Dr. Jerri Ann Donahue presented the CTP committee report prepared by Committee Chair Dr. George McCully. The CTP exam was successfully implemented in the 2015 exam year. A sufficient number of cases have been acquired to last several years. The committee will continue to develop them, as well as continue to review and improve all other exam materials.

Perio Committee Report

Dr. Bruce Horn presented the Perio committee report prepared by Committee Chair, Dr. Eric Curtis. The committee met for the first time as a stand-alone entity in April 2015. Exam content and materials were reviewed for improvement. Several recommendations for the Candidate Guide were made by the committee. The following committee recommendation was approved by DERB:

1. The committee recommended that Examiners be encouraged to select key surfaces having pockets of 5.0 mm or greater over surfaces bearing lesser pocket depths. There was some concern that this would be too time consuming for the accepting Examiner, but after some discussion, the consensus was that Examiners should be encouraged to do this if there is detectable calculus present in the deeper pockets.

Provisional Acceptance

Denise Diaz presented a summary of provisional acceptance, a new process that will be implemented in 2016. Candidates will have the opportunity to submit preoperative radiographs for patient provisional acceptance prior to the clinical exam. If accepted, the patient will then be checked at the exam by a Floor Examiner and does not have to go to the grading area for acceptance. The process was tested at the Baylor dental exam in May 2015 and was very successful. 75% of the candidates participated and the feedback was very positive on their experience, even those that had submissions rejected. The peace of mind and lowered stress were significant benefits of the new process. Beta testing with radiographs is currently underway with schools and Examiners to help ensure smooth implementation.

Expanded Options for Operative Procedures

Dr. Jerri Ann Donahue presented a recommendation to change the options available to Candidates on the 2016 Dental Operative exam. Currently Candidates can choose from four different procedures in any combination they choose. Under the new recommendation candidates would be required to complete one direct posterior composite restoration and one additional restoration from the current options, plus the additional options of an indirect posterior Class II fabricated of ANY clinically acceptance restorative material. Currently WREB allows a cast gold crown. Under the new recommendation, porcelain/ceramic,

composite resin, and hybrid material would also be options. Candidates could also now choose to perform two posterior composite restorations. Support of the recommendation includes the more frequent use of composite material over amalgam in schools and in practice. There are also ethical concerns with Candidates placing amalgam for the WREB exam only to remove it days later at the patient's request. There was discussion amongst members regarding the skills required to place an amalgam versus a composite material. Some view a Class II composite as more difficult while others view an amalgam challenging in that the material must be handled correctly. A few members expressed the opinion that amalgam is still being widely used and should not be de-emphasized.

The DERB approved the recommendation for the 2016 operative exam to require one direct posterior composite restoration, plus one additional from the current four options, which could result in a Candidate completing a second direct posterior composite restoration, and b) refer the recommendation to add additional restorative material options for the bonded/cemented restorations to the operative committee to consider for 2017 implementation.

Endo Plastic Teeth

Dr. Bruce Horn summarized the research done by the Endo committee in 2014 on plastic teeth. Because this is a frequent request from candidates and educators, it was important to explore the possibility. Having done so, the topic was presented to DERB for discussion and input. The teeth evaluated by the committee were 3D replicas manufactured by two different vendors and had accurate anatomy. After working on them, however, the committee members found the material to be too soft. The committee's conclusion was that the current artificial teeth are not sufficiently comparable to real teeth to be used on the WREB exam. WREB is the only agency that uses natural teeth, but many states accept all other exams that use plastic, despite the fact that they do not have the fidelity of natural teeth. Comments from DERB members were that perforations are more common with the plastic teeth because the tactility is gone, the incidence of fractures with natural teeth is not significant and does not in itself result in failure, using plastic teeth removes the clinical judgment involved in choosing teeth for treatment. DERB concurred that the Endo committee should reconsider if better material becomes available in the future.

Frequency of Meetings

Dr. Ence asked the members if they still felt two meetings per year is useful and the best use of their time. The consensus was that two meetings per year promotes continuity and helps them stay engaged by giving them an opportunity to take issues back to their state boards and return with their thoughts without having to wait a year.

Election Results

Dr. Nathaniel Tippit was elected for a second term as President and Dr. Norman Magnuson was elected for a second year as President-elect. Diane Kleman was elected as the new Hygiene Member at-large to the Board of Directors.

Next Meeting

The 2016 meetings will be Friday, February 12, 2016 in Phoenix and Friday, June 24, 2016 in Austin, TX.

**EXECUTIVE
DIRECTOR'S
REPORT**

EXECUTIVE DIRECTOR'S REPORT

August 28, 2015

Board Member & Staff Updates

Dr. Fine will be representing the OBD during the Commission on Dental Accreditation's on-site evaluation of Umpqua Community College's Dental Assisting Program Oct. 8-9.

At the time of completing this report the OBD Office Manager position was in the process of being filled. The new Dental Investigator position has been slow to be approved by DAS and I should have an update on this at the meeting.

OBD Budget Status Report

Attached is the latest budget report for the 2013 - 2015 Biennium. This report, which is from July 1, 2013 through June 30, 2015, shows revenue of \$2,718,076.49 and expenditures of \$2,650,611.58. The OBD's approved expenditure limit was 2,656,916.00.

We have just started the 1st RDH Renewal for the 2015-17 Biennium. If Board members have questions on this budget report format, please feel free to ask me.

Attachment #1

Customer Service Survey

Attached is a chart which shows the OBD State Legislatively Mandated Customer Service Survey Results from July 1, 2014 – June 30, 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, can be made available for Board members to review.

Attachment #2

Board and Staff Speaking Engagements

Dr. Paul Kleinstub, Dental Director/Chief Investigator made a presentation on "Record Keeping" and "Updates from the OBD" to Advantage Dental at Eagle Crest in Redmond on Friday, July 31.

Dr. Paul Kleinstub, Dental Director/Chief Investigator made a presentation to the OHSU School of Dentistry students on sedation rules on Tuesday, August, 4.

HPSP Satisfaction Report

Please find the 5th Annual HPSP Report and summary. Mr. Wayson and I will be happy to answer questions that you might have on this report.

Attachment #3

Agency Head Financial Transaction Report July 1, 2014 – June 30, 2015

Board Policy requires that at least annually the entire Board review agency head financial transactions and that acceptance of the report will be placed in the minutes. The Board reviews and approves this report which follows the close of the recent fiscal year.

Attachment #4 ACTION REQUESTED

Board Best Practices Self Assessment

As a part of the legislatively approved Performance Measures, the Board needs to complete the attached Best Practices Self-Assessment so that it can be included as a part of the 2015 Performance Measures Report. I will provide the OBD's annual progress report at the next Board meeting incorporating the Self-Assessment results.

Attachment #5 ACTION REQUESTED

Tri-Met Contract

I am asking the OBD to ratify my entering into a contract with TRIMET for the Universal Pass Program which will have the OBD provide transportation passes for employees that are eligible to receive such passes for transportation to and from work.

Attachment #6 ACTION REQUESTED

Discussion on Strategic Planning Session

The last Strategic Planning Session was held in October 2007. The Board should consider holding another one.

Newsletter

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

Appn Year 2015
BOARD OF DENTISTRY
Fund 3400 BOARD OF DENTISTRY
For the Month of MONTH 13 2015

REVENUES

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
0505	FINES AND FORFEITS	101,500.00	0.00	101,500.00	136,085.00	34,585.00
0975	OTHER REVENUE	45,285.77	0.00	45,285.77	24,447.00	-20,838.77
0205	OTHER BUSINESS LICENSES	2,536,341.00	0.00	2,536,341.00	2,376,611.00	-159,730.00
0410	CHARGES FOR SERVICES	17,108.00	0.00	17,108.00	0.00	-17,108.00
0605	INTEREST AND INVESTMENTS	7,641.72	0.00	7,641.72	7,890.00	248.28
0210	OTHER NONBUSINESS LICENSES AND FEES	10,200.00	0.00	10,200.00	15,772.00	5,572.00
		2,718,076.49	0.00	2,718,076.49	2,560,805.00	-157,271.49

TRANSFER OUT

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
2443	TRANSFER OUT TO OREGON HEALTH AUTHORITY	201,939.50	0.00	201,939.50	215,500.00	13,560.50
		201,939.50	0.00	201,939.50	215,500.00	13,560.50

PERSONAL SERVICES

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
3110	CLASS/UNCLASS SALARY & PER DIEM	880,271.88	0.00	880,271.88	940,701.00	60,429.12
3170	OVERTIME PAYMENTS	9,900.00	0.00	9,900.00	13,384.00	3,484.00
3180	SHIFT DIFFERENTIAL	156.38	0.00	156.38	114.00	-42.38
3221	PENSION BOND CONTRIBUTION	54,500.25	0.00	54,500.25	52,001.00	-2,499.25
3220	PUBLIC EMPLOYES' RETIREMENT SYSTEM	128,050.72	0.00	128,050.72	133,173.00	5,122.28
3190	ALL OTHER DIFFERENTIAL	10,146.00	0.00	10,146.00	0.00	-10,146.00
3230	SOCIAL SECURITY TAX	67,812.52	0.00	67,812.52	73,795.00	5,982.48
3250	WORKERS' COMPENSATION ASSESSMENT	467.18	0.00	467.18	434.00	-33.18
3210	ERB ASSESSMENT	193.05	0.00	193.05	212.00	18.95
3260	MASS TRANSIT	4,951.18	0.00	4,951.18	5,414.00	462.82
3270	FLEXIBLE BENEFITS	196,934.43	0.00	196,934.43	209,350.00	12,415.57
3160	TEMPORARY APPOINTMENTS	0.00	0.00	0.00	15,434.00	15,434.00
		1,353,383.59	0.00	1,353,383.59	1,444,012.00	90,628.41

SERVICES and SUPPLIES

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
4315	IT PROFESSIONAL SERVICES	26,695.00	0.00	26,695.00	22,503.00	-4,192.00
4200	TELECOMM/TECH SVC AND SUPPLIES	27,487.38	998.21	28,485.59	26,077.00	-2,408.59
4715	IT EXPENDABLE PROPERTY	6,780.42	0.00	6,780.42	6,411.00	-369.42
4575	AGENCY PROGRAM RELATED SVCS & SUPP	96,434.94	4,600.75	101,035.69	104,286.00	3,250.31

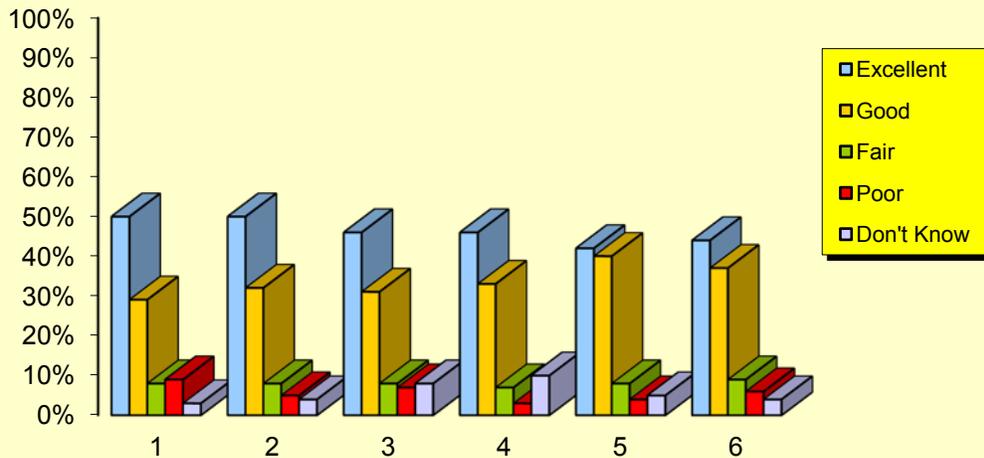
Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
4300	PROFESSIONAL SERVICES	185,939.13	2,642.80	188,581.93	104,922.00	-83,659.93
4325	ATTORNEY GENERAL LEGAL FEES	203,039.70	10,077.60	213,117.30	176,916.00	-36,201.30
4400	DUES AND SUBSCRIPTIONS	11,520.80	0.00	11,520.80	10,888.00	-632.80
4175	OFFICE EXPENSES	82,043.45	0.00	82,043.45	86,657.00	4,613.55
4250	DATA PROCESSING	4,197.93	98.50	4,296.43	4,702.00	405.57
4375	EMPLOYEE RECRUITMENT AND DEVELOPMENT	1,845.00	0.00	1,845.00	0.00	-1,845.00
4150	EMPLOYEE TRAINING	7,170.00	0.00	7,170.00	8,877.00	1,707.00
4275	PUBLICITY & PUBLICATIONS	23,240.80	0.00	23,240.80	22,866.00	-374.80
4225	STATE GOVERNMENT SERVICE CHARGES	72,850.21	234.11	73,084.32	75,916.00	2,831.68
4475	FACILITIES MAINTENANCE	5,314.95	0.00	5,314.95	3,977.00	-1,337.95
4425	FACILITIES RENT & TAXES	163,622.48	0.00	163,622.48	164,950.00	1,327.52
4650	OTHER SERVICES AND SUPPLIES	58,028.31	1,354.64	59,382.95	55,077.00	-4,305.95
4700	EXPENDABLE PROPERTY \$250-\$5000	2,980.66	0.00	2,980.66	3,182.00	201.34
4125	OUT-OF-STATE TRAVEL	36,997.43	195.00	37,192.43	48,487.00	11,294.57
4100	INSTATE TRAVEL	52,817.31	285.48	53,102.79	55,994.00	2,891.21
		1,069,005.90	20,487.09	1,089,492.99	982,688.00	-106,804.99

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
		207,735.00	0.00	207,735.00	230,216.00	22,481.00

		3400		
		Monthly Activity	Biennium Activity	Financial Plan
REVENUES	REVENUE	0	2,718,076.49	2,560,805.00
	Total	0	2,718,076.49	2,560,805.00
EXPENDITURES	PERSONAL SERVICES	0	1,353,383.59	1,444,012.00
	SERVICES AND SUPPLIES	20,487.09	1,089,492.99	982,688.00
	SPECIAL PAYMENTS	0	207,735	230,216.00
	Total	20,487.09	2,650,611.58	2,656,916.00
TRANSFER OUT	TRANSFER OUT	0	201,939.5	215,500.00
	Total	0	201,939.5	215,500.00

Oregon Board of Dentistry Customer Service Survey July 1, 2014 - June 30, 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= 50% G= 32% F= 8% 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= 46% G= 33% F= 7% P= 3% DK= 10%

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

E= 42% G= 40% F= 8% P= 4% DK= 5%

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

E= 44% G= 37% F= 9% P= 6% DK= 4%



**Reliant Behavioral Health, LLC
Health Professionals' Services Program (HPSP)
Satisfaction Report**

Year 5 Annual Report: July 1, 2014 – June 30, 2015

RBH Health Professionals' Services Program
1220 SW Morrison Street, Suite 600
Portland, Oregon 97205
1.888.802.2843
Fax: 503.961.7142

Executive Summary

Health Professionals' Services Program Satisfaction Survey: Year Five Annual Report

Overview: This Health Professionals' Services Program report reviews the survey results for the fifth year of the program, covering July 1, 2014 through June 30, 2015. Surveys were sent to the following groups of stakeholders at the beginning of both January 2015 and July 2015: Licensees, Employers (Workplace Monitors), Treatment Providers, Health Associations, and the Boards. Each of these groups of stakeholders will be surveyed again in January 2016. An overview of the combined number of surveys sent, combined number of responses received and the combined response rate for both January 2015 and July 2015 is displayed below and broken down by stakeholder group:

Table 1: Response Rate - Year 5	Licensees	Employers (Workplace Monitors)	Treatment Providers	Health Associations	Boards
# Sent	455	340	343	18	14
# of Responses	125	70	42	2	7
Response Rate	27.5%	20.6%	12.2%	11.1%	50.0%

Highlights

Changes were made to both the licensee and the Board surveys in order to obtain more constructive feedback. The licensee questions proved to be particularly insightful. Regarding the program overall, results indicate that nearly 97% of respondents understand the program's statutory monitoring requirements and 75% feel that the program treats them with dignity and respect. Of those reported non-compliant recently, 54.5% reported they thoroughly understood the process and 36.4% partially understood it. The new questions also revealed that the pool of respondents was skewed towards those more recently enrolled. Of those enrolled in the last six months, 63% rated the process "excellent" or "above average." The new in-person intake was rated quite favorably.

The positive impact of the changes to the board survey will be clearer in the next survey if there is a stronger response rate. However, services were rated well by the respondents. When reflecting on a recent licensee situation, question, or concern, responders knew who to speak with, felt the time frame was within one business day, and felt that RBH had knowledge of the licensee or situation. When reflecting on a broader question or programmatic concern, responders again knew who to speak with, felt comfortable bringing concerns forward, felt RBH provided useful and insightful data, and felt the time frame was within one business day. Finally, it was noted that the Medical Director's (Dr. Bahl's) input has been valuable.

Workplace Monitors provided strong ratings for HPSP's customer service, particularly in the case of timeliness of responses, knowledge of licensees when there is a concern in the workplace, ability to respond to questions regarding program administration, and frequency of feedback regarding licensee's compliance. Further, 93% of workplace monitor respondents this year indicated that they were either "very satisfied" or "satisfied" with the support they receive when supervising licensees. Eighty (80%) of respondents this year indicated that they rate RBH's ability to monitor the licensee to ensure safety in the workplace as "excellent" or "above average."

The majority (at least 72%) of treatment provider respondents "agreed" that their concerns were responded to promptly, that information was communicated clearly and professionally and that they had all the information needed when seeing the client. They rated the overall experience working with RBH as "above average."

It is recommended that RBH continue to outreach to each of the Professional Associations so that their support can be garnered. The Oregon Nurses Association has a particularly poor view of HPSP based on an acknowledged small number of member comments.

All responses will be reviewed by the PAC and an action plan will be put into place to address in order to provide for continued improvement.

Reliant Behavioral Health Health Professionals' Services Program (HPSP) Satisfaction of LICENSEES

Purpose

The purpose of assessing participants (Licensees) of the Health Professionals' Services Program (HPSP) is to obtain constructive feedback that can be used to improve and maintain the quality, effectiveness, and efficiency of the HPSP Program. In order to provide continuous quality services, RBH evaluates Licensees' satisfaction with the HPSP Program twice yearly.

Feedback is obtained from Licensees via a satisfaction survey that is mailed or emailed to each Licensee. When mailed, Licensees are given the option of completing the enclosed survey and mailing it back to the RBH offices in the postage-paid envelope, or going through the link to the survey and completing it online. The survey is short and can be completed in 2-3 minutes.

Changes were made to the survey this spring in order to better gauge how well RBH is serving the needs of the licensees. Feedback includes information about program administration, RBH customer service, communication, Agreement Monitors, the non-compliance process, the enrollment process, and overall services.

One method of determining the value of HPSP is through the Satisfaction Survey. One of the roles of the RBH Policy Advisory Committee (PAC) is quality management. Following review of the survey results, the PAC will identify opportunities for improvement and develop interventions if necessary. The PAC will continue to monitor performance at specified intervals following the implementation of the intervention(s).

Data Results

Response Rate

Table 1: Response Rate	This Period	Year 5	Year 4	Year 3	Year 2	Year 1
# Sent	218	455	509	915	1330	1481
# of Responses	60	125	197	246	367	342
Response Rate	27.5%	27.5%	38.7%	26.9%	27.6%	23%

The HPSP Licensee Satisfaction Survey was issued to 100% of the Licensees enrolled in the HPSP Program at the close of June 2015. The survey was emailed to 197 licensees and mailed to 21. A total of 60 responses were received, representing a response rate of 27.5%. This was consistent with the response during the first period of the year and so the response rate for the year is also 27.5%. Although this is not as high as last year (year four), it is consistent with the rates seen in years two and three.

Respondents

Question 1: 46.7% of respondents this period were representatives of the Board of Nursing. The Medical Board follows with 26.7%, then the Board of Pharmacy with 15.0% and the Board of Dentistry with 6.7% each. These figures are similar to last year: 45.6% Board of Nursing, 32.8% Medical Board, 11.2% Board of Pharmacy and 7.2% Board of Dentistry. The Medical Board percentage decreased from last year (Year Four.)

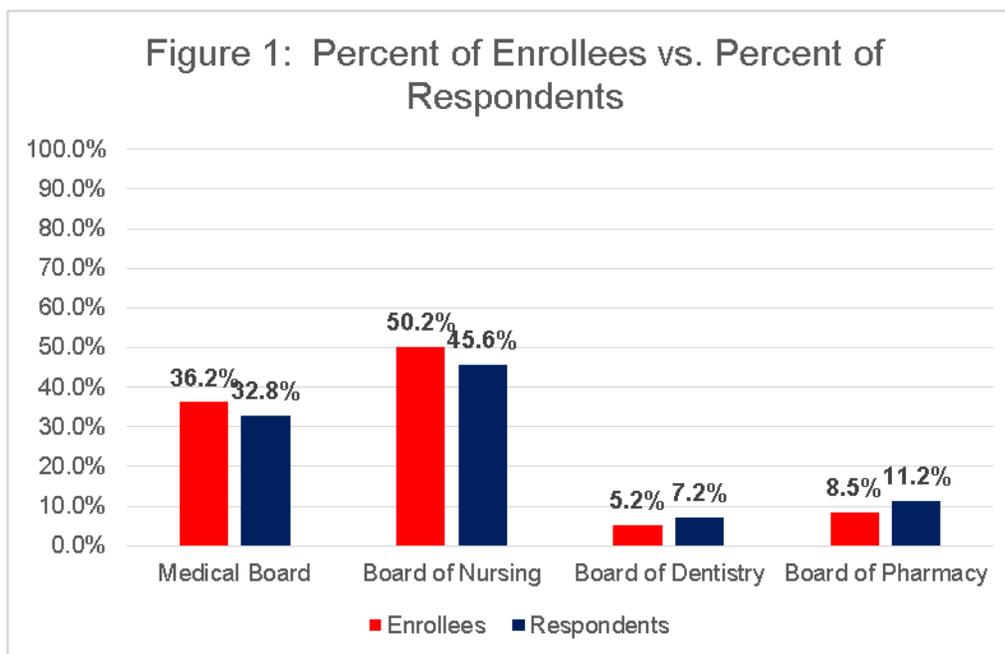
Data Table 2:

Table 2: Respondents by Board	This Period (n=60)		This Year (n=125)		Last Year (n=197)	
	#	%	#	%	#	%
Medical Board	16	26.7%	41	32.8%	81	41.1%
Board of Nursing	28	46.7%	57	45.6%	87	44.2%
Board of Dentistry	4	6.7%	9	7.2%	17	8.6%
Board of Pharmacy	9	15.0%	14	11.2%	9	4.6%
No Response	3	5.0%	4	3.2%	3	1.5%

The responses are representative of the enrolled licensee population with only a slight difference of between two and five percentage points per board.

Data Table 3 and Figure 1:

Table 3: Comparison of Enrollees to Respondents	Percent of Enrollees (7/1/15)	Percent of Respondents (This Year)
Medical Board	36.2%	32.8%
Board of Nursing	50.2%	45.6%
Board of Dentistry	5.2%	7.2%
Board of Pharmacy	8.5%	11.2%



Overall Program

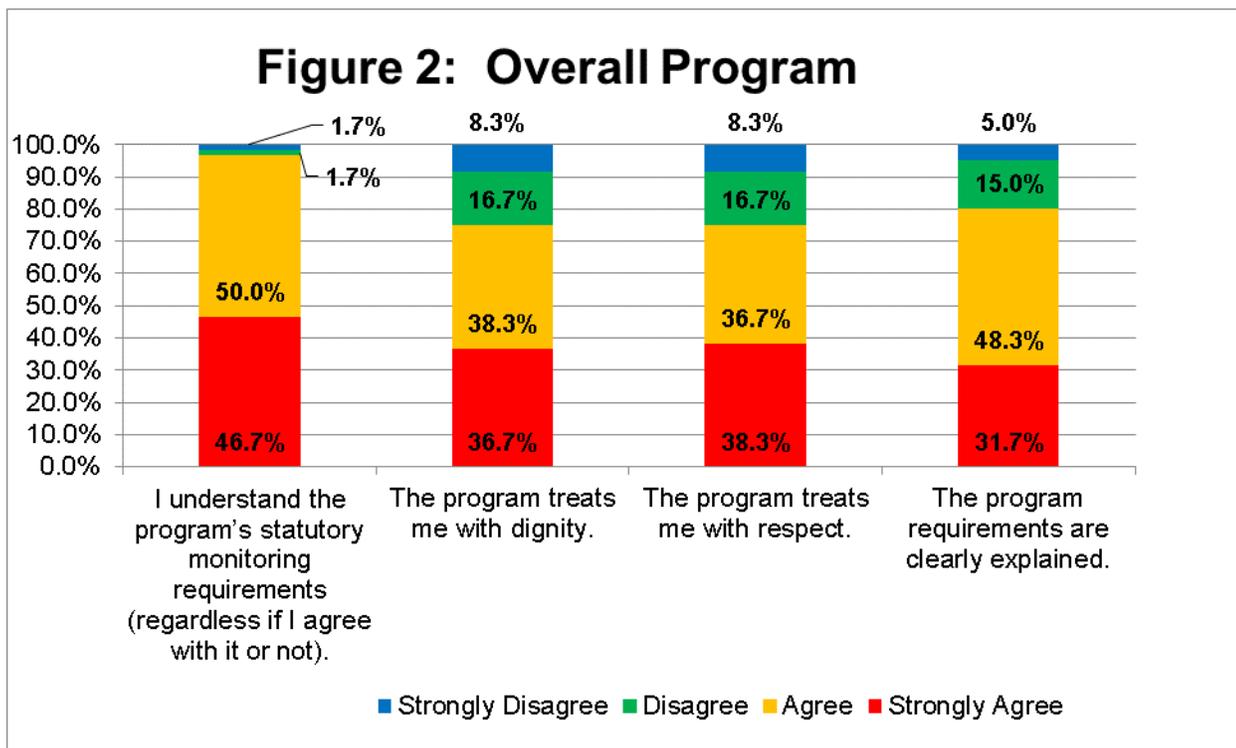
Question #2: This new question asks respondents to think about the program overall and respond to four statements:

- I understand the program’s statutory monitoring requirements (regardless if I agree with it or not).
- The program treats me with dignity.
- The program treats me with respect.
- The program requirements are clearly explained.

Nearly 97% of respondents indicate that they understand the program’s statutory monitoring requirements (50% “agree” and 46.7% “strongly agree.”) Only two (2) individuals indicated that they did not. Responses were nearly evenly split between “agree” and “strongly agree” for the statements about treatment with dignity and respect. Combined, 75% of respondents “agree” or “strongly agree” with these two statements. 31.7% of respondents “strongly agree” that the program requirements are clearly explained, while 48.3% “agree.”

Data Table 4 and Figure 2: The mode (most frequent) response is highlighted in red. Not all responses have a mode.

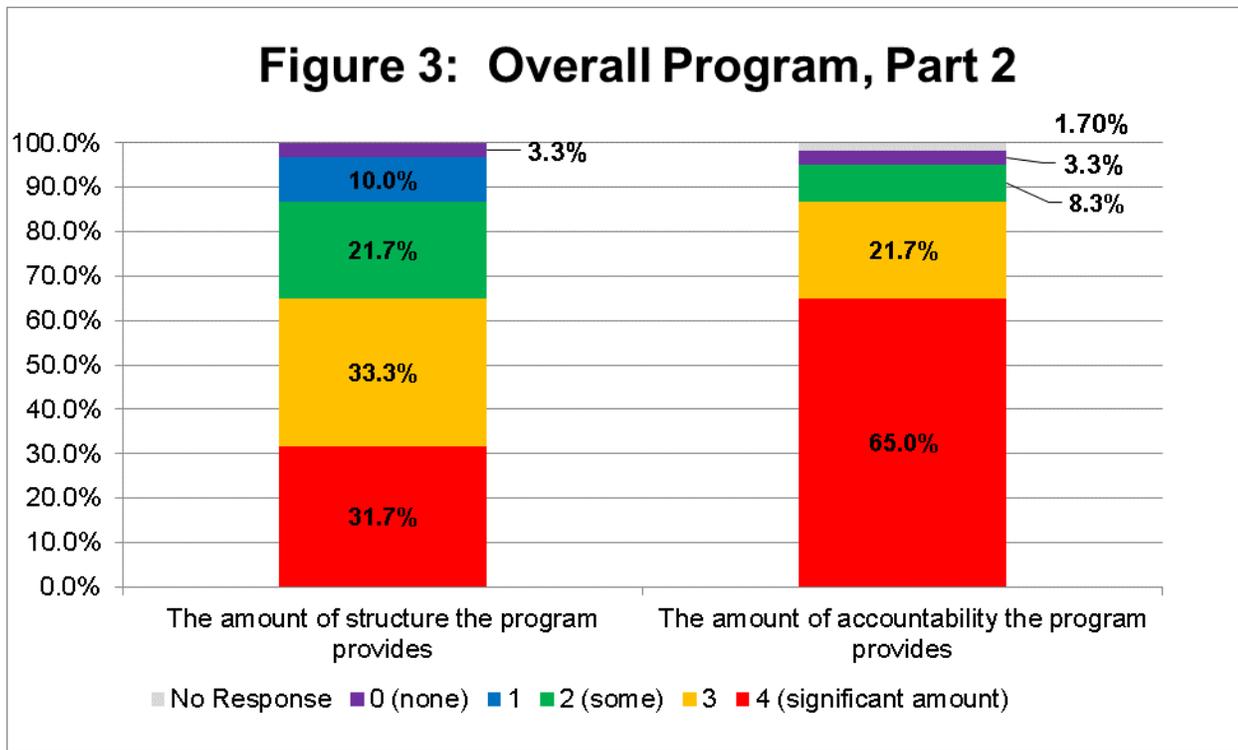
Table 4: This Period (n=60)	Strongly Agree		Agree		Disagree		Strongly Disagree		No Response	
	#	%	#	%	#	%	#	%	#	%
I understand the program’s statutory monitoring requirements (regardless if I agree with it or not).	28	46.7%	30	50.0%	1	1.7%	1	1.7%		
The program treats me with dignity.	22	36.7%	23	38.3%	10	16.7%	5	8.3%		
The program treats me with respect.	23	38.3%	22	36.7%	10	16.7%	5	8.3%		
The program requirements are clearly explained.	19	31.7%	29	48.3%	9	15.0%	3	5.0%		



Question #3: Continuing to evaluate the overall program, an additional new questions asks respondents to rate the amount of structure and the amount of accountability the program provides. The scale is 0 (none) to 4 (a significant amount) with 2 representing “some.” Notably, 65% of respondents indicated that the program provides a “significant amount” of accountability. An additional 21.7% rated this item with a “3” (more than “some” but less than a “significant amount.”) Looking at the amount of structure provided by the program, 31.7% rated it a “significant amount” and 33.3% rated it with a “3” (more than “some” but less than a “signficiant amount.”)

Data Table 5 and Figure 3: The mode (most frequent) response is highlighted in red. Not all responses have a mode.

Table 5: This Period (n=60)	4 (significant amount)		3		2 (some)		1		0 (none)		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
The amount of structure the program provides	19	31.7%	20	33.3%	13	21.7%	6	10.0%	2	3.3%		
The amount of accountability the program provides	39	65.0%	13	21.7%	5	8.3%			2	3.3%	1	1.7%



Customer Service

Question #4: This questions represents a revision of two questions on the previous survey. Response time frame, quality of response, communication style and agreement monitor knowledge are all queried. The mode response to each item was either “strongly agree” or “agree” and a minimum of 70% of respondents indicated that they either “agree” or “strongly agree” with each item.

- Response Time Frame (My questions and/or concerns are responded to within one business day): The mode response was “strongly agree” at 40% with an additional 30% “agreeing.” This however is a decrease of four to six percentage points from last period and last year’s responses. (See Tables 7a and 7b.)
- Quality of Response (My questions and/or concerns are addressed fully within the structure of the program): The mode response was “agree” at 43.3%, with an additional 36.7% who “strongly agree.” There is not a comparable question from the prior survey for this item. However, there are more positive ratings (“agree” and “strongly agree”) for this item than for that that of response time frame.
- Communication style (Information is communicated clearly and professionally): Responses were similar to those regarding the quality of the response. The mode response was “agree” at 43.3%, with an additional 38.3% who “strongly agreed.” This item was asked on prior surveys (see Tables 7a and 7b). Although the mode decreased from “strongly agree,” the total percentage of positive responses (“strongly agree” or “agree”) is consistent with last period.
- Agreement Monitor (My Agreement Monitor is knowledgeable about my case): Much like response time frame, the mode response is “strongly agree” at 40% with an additional 31.7% “agreeing.” This represents a decrease of more than ten percentage points from last period and last year. (See Tables 8a and 8b).

Data Table 6: The mode (most frequent) response is highlighted in red. Not all responses have a mode.

Table 6: This Period (n=60)	Strongly Agree		Agree		Disagree		Strongly Disagree		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%
My questions and/or concerns are responded to within one business day	24	40.0%	18	30.0%	10	16.7%	7	11.7%	1	1.7%
My questions and/or concerns are addressed fully within the structure of the program	22	36.7%	26	43.3%	4	6.7%	5	8.3%	3	5.0%
Information is communicated clearly and professionally	23	38.3%	26	43.3%	5	8.3%	5	8.3%	1	1.7%
My Agreement Monitor is knowledgeable about my case	24	40.0%	19	31.7%	7	11.7%	6	10.0%	4	6.7%

Data Tables 7a and b: The mode (most frequent) response is highlighted in red. Not all responses have a mode.

Table 7a: Last Period (n=65)	Strongly Agree		Agree		Disagree		Strongly Disagree		N/A		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
Questions and/or Concerns Were Responded to within one business day	28	43.1%	22	33.8%	4	6.2%	3	4.6%	5	7.7%	3	4.6%
Information was Communicated Clearly and Professionally	29	44.6%	24	36.9%	3	4.6%	2	3.1%	5	7.7%	2	3.1%

Table 7b: Last Year (n=197)	Strongly Agree		Agree		Disagree		Strongly Disagree		N/A		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
Questions and/or Concerns Were Responded to within one business day	77	39.1%	70	35.5%	21	10.7%	14	7.1%	11	5.6%	4	2.0%
Information was Communicated Clearly and Professionally	78	39.6%	76	38.6%	16	8.1%	8	4.1%	8	4.1%	11	5.6%

Data Table 8a and b: The mode (most frequent) response is highlighted in red. Not all responses have a mode.

Table 8a: Last Period (n=65)	Strongly Agree		Agree		Disagree		Strongly Disagree		N/A		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
My Agreement Monitor is knowledgeable about my case	28	43.1%	27	41.5%	6	9.2%	2	3.1%			2	3.1%
My needs and concerns are understood	27	41.5%	25	38.5%	5	7.7%	5	7.7%	1	1.5%	2	3.1%

Table 8b: Last Year (n=197)	Strongly Agree		Agree		Disagree		Strongly Disagree		N/A		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
My Agreement Monitor is knowledgeable about my case	84	42.6%	88	44.7%	13	6.6%	9	4.6%	1	0.5%	2	1.0%
My needs and concerns are understood	75	38.1%	69	35.0%	25	12.7%	17	8.6%	2	1.0%	9	4.6%

Non-Compliance

Question #5: This is a new item without a comparable question on prior surveys. The question asks if the respondent was reported non-compliant in the last six months and if so, how well they understood the process. Results show that 18.3% (11) of respondents indicated that they had been reported non-compliant. Of these, 54.5% reported they thoroughly understood the process and 36.4% partially understood it. Only one respondent indicated that s/he did NOT understand the process. A follow-up question requests any comments on this item, however these appear to be general comments.

Data Tables 9a and b:

Table 9a: Were you reported non-compliant in the last 6 months?	This Period (n=60)	
	#	%
No	49	81.7%
Yes	11	18.3%

Table 9b: If so, (regardless if I agreed/disagreed with the report)	This Period (n=11)	
	#	%
I thoroughly understood the process	6	54.5%
I partially understood the process	4	36.4%
I did not understand the process	1	9.1%

Actual Comments – This Period:

***Note that comments are shown as the respondent typed or wrote them. Spelling, punctuation and grammar have not been corrected.*

1. new monitor , previous left under ????????
2. Non-compliance r/t traveling and foreign testing sites and their own policies and procedures
3. never
4. Not that I know of
5. It would be much more relaxing to have vacations or long weekends without having to check if UA is up.
Maybe require UA after one of these periods. Especially after a couple years of negative results

Enrollment

Question #6: This question is also completely new with no comparable question on the prior survey. Respondents are first asked if they were enrolled in the last six months and if so, how they would rate the enrollment process overall. A follow-up question inquires if their intake was completed in-person and if that was beneficial.

Notably, 31.7% of respondents indicated that were enrolled in the last six months. (See Table 10a.) This is in comparison to 15% of the current population of licenses who were enrolled in the last six months. Thus, the pool of respondents is skewed towards the more recently enrolled.

Of those enrolled in the last six months, 36.8% rated the process “above average” and 26.3% rated it “excellent.” Only two (2 or 10.5%) respondents rated it “below average.” (See Table 10b.) Of those enrolled in the last six months, eight (8) indicated that did meet their Agreement Monitor in person and eight (8) indicated that they did not. (See Table 10c) Of the eight who did meet their Agreement Monitor in person, 50% (4) felt that it significantly improved the enrollment experience. An additional 37.5% (3) felt that it partially improved the enrollment experience. Only one respondent indicated it did not change the experience. There were not any respondents who felt it degraded the enrollment process.

Data Tables 10a, b and c:

Table 10a: Were you enrolled in the last 6 months?	This Period (n=60)	
	#	%
No	40	66.7%
Yes	19	31.7%
No Response	1	1.7%

Table 10b: Overall rating of the enrollment process:	This Period (n=19)	
	#	%
Excellent	5	26.3%
Above Average	7	36.8%
Average	3	15.8%
Below Average	2	10.5%
Poor		
No Response	2	10.5%

Table 10c: If you met your Agreement Monitor in person, do you feel this improved your enrollment experience?	This Period (n=19)	
	#	%
No Response	3	15.8%
I did NOT meet my Agreement Monitor in person.	8	42.1%
I did meet my Agreement Monitor in person.	8	42.1%
<ul style="list-style-type: none"> • <i>It significantly improved my enrollment experience.</i> 	4	50.0%
<ul style="list-style-type: none"> • <i>It partially improved my enrollment experience.</i> 	3	37.5%
<ul style="list-style-type: none"> • <i>It did not change my enrollment experience.</i> 	1	12.5%
<ul style="list-style-type: none"> • <i>It degraded my enrollment experience</i> 		
<ul style="list-style-type: none"> • <i>It significantly degraded my enrollment</i> 		

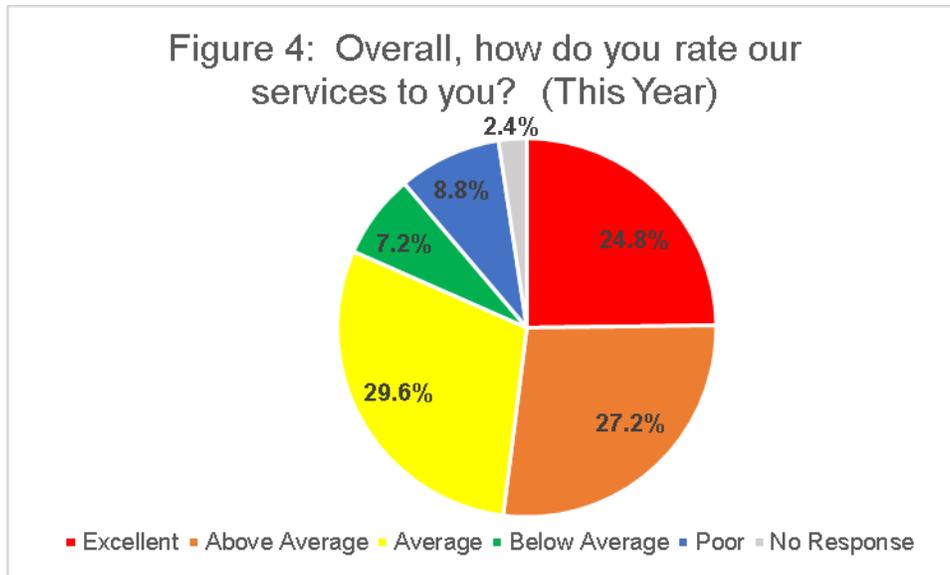
Overall Rating of Services

Question 7: Consistent with prior surveys, respondents were asked to rate the overall services. The mode response was “average” at 26.7% this period and 29.6% this year. This was also the mode last year and in year two. (The mode peaked at “above average” in year three.) The percentage of “excellent” responses has increased from year to year, starting with 14% in year two and peaking at 25% this year. Although there were more “poor” ratings this period than seen previously, the percentage this year is similar to those in prior years.

Data Table 11: The mode (most frequent) response is highlighted in red. Not all responses have a mode.

Table 11: Overall Rating	This Period (n=60)		This Year (n=125)		Year 4 (n=197)		Year 3 (n =246)		Year 2 (n=367)	
	#	%	#	%	#	%	#	%	#	%
Excellent	15	25.0%	31	24.8%	47	23.9%	42	17.1%	52	14.2%
Above Average	15	25.0%	34	27.2%	53	26.9%	81	32.9%	102	27.8%
Average	16	26.7%	37	29.6%	60	30.5%	59	24.0%	125	34.1%
Below Average	4	6.7%	9	7.2%	17	8.6%	30	12.2%	44	12.0%
Poor	9	15.0%	11	8.8%	10	5.1%	24	9.8%	40	10.9%
No Response	1	1.7%	3	2.4%	10	5.1%	10	4.1%	4	1.1%

Figure 4:



Additional Comments

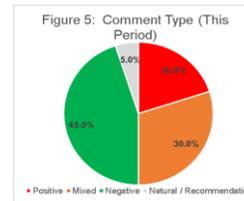
At the conclusion of the survey, respondents are asked for any additional comments. Twenty (20) comments were received, reviewed, and categorized this period. Comments were received from 33.3% of respondents.

Comments were first categorized with an overall type: positive, negative, neutral, or mixed. This period, 20% were positive, 45% were negative, 30% were a mixture of positive and negative and 5% were neutral / recommendation. (See Figure 5.) Comments were also categorized by area (see Data Table 12). Each issue within a comment was categorized to maximize the ability to capture all feedback. Staff, particularly Agreement Monitors, were the most frequently mentioned topic.

Table 12:

Categories of Comments Received (n=36)		#	%
Staff: General	Positive	1	2.8%
Staff: Agreement Monitor	Positive	4	11.1%
	Negative	6	16.7%
Toxicology: General	Positive	2	5.6%
Toxicology: Sites (availability and performance)	Positive	1	2.8%
	Negative	5	13.9%
Communication: General	Negative	3	8.3%
Communication: IVR/App	Negative	1	2.8%
	Recommendation	1	2.8%
Program Structure	Negative	4	11.1%
General	Positive	4	11.1%
	Negative	3	8.3%
Board	Negative	1	2.8%

Figure 5:



Actual Comments Received – July 2015

***Note that comments are shown as the respondent typed or wrote them. Spelling, punctuation, and grammar have not been corrected. Names and locations have been removed for confidentiality purposes.*

1. This has been a very judgmental, humiliating, and derogatory process! Not so much because of HPSP, but because of how I have been treated by the [Board]! Perhaps they should examine their own lives before they deconstruct and tear apart someone else's!
2. My agreement monitor [Name] provides enough personal attention to bring the structure and its requirements up to above average
3. I have nothing to compare my RBH experience with. The RBH staff has been very respectful to me. However, some testing sites have treated me as though I were a pariah instead of a human being suffering from a disease condition. Still MUCH work to do in educating the public in, and changing the way we look at, dealing appropriately with fellow humans with addictive disorders. Perhaps stressing to the testing sites and their staff the importance of customer service and respect in dealing with clients or not allowing non-responsive testing sites to have your business might help?
4. The only thing that I appreciate about this program is the accountability I get with the random testing. Otherwise, there is nothing positive about it for me. My monitor person calls me about once a month, otherwise I leave a voicemail, say the same thing every time. When we do talk, the conversation is over in less than 5 minutes, there is absolutely no connection. I was told that this program was supposed to help you if you were having a hard time getting a job, that was not what happened for me. This program is worthless to me. I would do the testing for the rest of my career, gladly, but the thought of dealing with RBH for the length of time I have left is painful, very painful.

5. Overall, I think RBH does a good job. I am not enrolled in the substance abuse program, so my involvement is limited to phone calls, drug testing and documentation of compliance. I would like to be released from the program, but RBH states it can not render an opinion or recommendation. Nevertheless, the [Board] states that I can be released only after both RBH and the [Board] agree. It would be helpful if RBH rendered an opinion based on the evidence it has so that licensees who do not need continued monitoring can be discharged from the program.

The number and availability of test sites within a reasonable distance from the licensee's home is suboptimal, especially on weekends. A Saturday drug test disrupts most of the day due to travel and wait time. Testing needs to be more convenient. During the week, a drug test shouldn't take more than 10 minutes, yet it usually takes up 60-120 min of my day with drive time and wait. On several occasions, both phone and on-line check-in for drug testing have been down without a mechanism to contact a person for assistance. I find this highly stressful. A person needs to be available to licensees when the system fails.

6. I understand the role of HPSP is mandated by the legislature and the various state boards involved. To me it is a useful tool to help recovery and satisfy requirements to my board so that I maintain my license.
7. I've had a difficult time getting in contact over the phone with my monitor. I have also had problems with my monitor not getting back to potential employers in a timely fashion and therefore losing precious job opportunities, which is very frustrating as I am doing everything on my end.
8. program is rigid and not very helpful in maintaining my sobriety. Only the random UDS is helpful. All else is a waste of time, money, energy
9. I have had to call my agreement monitor, [name], many times and more often than not I do not receive a call back. My email questions go unanswered. My provider, [name] reports similar problems communicating with my agreement monitor. I hate that when I call in I am asked for my case number. The whole relationship with RBH is cold and unpersonal. This is my life and my livelihood that I have on the line and I would appreciate having my emails and phone calls responded to.
10. All of my experiences with HPSP and my AM have been professional and flexible to meet my specific needs and expectations. The respect and professionalism has been greatly appreciated in this time of transition in my career and life.
11. Toxicology testing while traveling out-of-area or out-of-state is really challenging. It has led to noncompliance for me on two occasions ([Board] did not take action based on my explanation). I'm wondering if there is a way to improve the toxicology testing process while traveling.
12. not helpful for recovery. 100% punitive and intrusive. intended to check off boxes, Had to receive help with a program elsewhere and this program has done nothing to contribute to recovery process.
13. Automated phone call to advise of test date would be kind
14. Program is far too rigid. It remains the single largest stressor in my life. My recovery is solid, has been the entire duration I have been in this program. I am more likely to be found "Non compliant" because of forgetting to call in than from substance use. This program creates too many false positives.
15. i was very disappointed when [name of Agreement Monitor] left as we had a great relationship. I have had no communication with new agreement monitor when I leave voice mail for weekly check in. Also testing sites especially in [location] need to be more efficient and timely. I've had to wait over an hour there to do a UA, which I feel is unacceptable.
16. At times it feels like I am required to be more accountable to my monitor than the level of accountability I receive in return, which can be frustrating
17. not enough testing venues within reasonable distance to my location and inability to work out arrangements with collecting sites much closer to my location...especially important d/t the fact that often pharmacists have to find employment in areas that are not in urban areas
18. My agreement monitor NEVER has called to check in with me. All communication is initiated by me every week via e-mail. It was my understanding we were to talk at least once a month by phone. I have almost completed my third year with no issues. The agreement monitor has an obligation just like I do. Where is her accountability?
19. Very disappointed that [name of agreement monitor] left, or was let go.
[name of testing site] is awesome. Very accommodating and caring.
20. Going through this process has allowed me to overcome many things. Thank you for all the support. Please send a big thank you to [name of agreement monitor] for how great of a job she does. Thanks again.

Summary Analysis

The licensee survey response rate was 27.5% and the pool of respondents was representative of the licensee population in terms of board affiliation. Several new questions were asked on this survey probing enrollment, non-compliance, and program administration.

Nearly 97% of respondents this period indicate that they understand the program's statutory monitoring requirements. Combined, 75% of respondents "agree" or "strongly agree" that the program treats them with dignity and respect. 79% of respondents "strongly agree" or "agree" that the program requirements are clearly explained. Notably, 65% of respondents indicated that the program provides a "significant amount" of accountability. An additional 21.7% rated this item with a "3" (more than "some" but less than a "significant amount.") Looking at the amount of structure provided by the program, 31.7% rated it a "significant amount" and 33.3% rated it with a "3" (more than "some" but less than a "significant amount.")

Looking at customer service and communication, response time frame was rated positively by 70% of respondents. The quality of the response was rated positively by 80% of respondents. Just over 81% of respondents felt that information was communicated clearly and professionally while just over 71% felt their Agreement Monitor is knowledgeable about their case.

Eleven respondents indicated they had been reported non-compliant in the last six months. Of these, 54.5% reported they thoroughly understood the process and 36.4% partially understood it. Only one respondent indicated that s/he did NOT understand the process. Notably, 31.7% of respondents indicated that were enrolled in the last six months. This is in comparison to 15% of the current population of licenses who were enrolled in the last six months. Thus, the pool of respondents is skewed towards the more recently enrolled. Of those enrolled in the last six months, 36.8% rated the process "above average" and 26.3% rated it "excellent." Of those enrolled in the last six months, eight (8) indicated that did meet their Agreement Monitor in person. Of these, 50% (4) felt that it significantly improved the enrollment experience. An additional 37.5% (3) felt that it partially improved the enrollment experience.

Overall services were rated favorably, with 52% of respondents rating the program "excellent" or "above average" this year. One-third of respondents provided a concluding comment this period: 20% were positive, 45% were negative, 30% were a mixture of positive and negative and 5% were neutral / recommendation. Staff, particularly Agreement Monitors, were the most frequently mentioned topic.

Reliant Behavioral Health Health Professionals' Services Program (HPSP) Satisfaction of EMPLOYERS / WORKPLACE MONITORS

Purpose

The purpose of assessing the Employers, specifically the Workplace Monitors, is to obtain constructive feedback that can be used to improve the services provided by the HPSP Program. RBH strives to maintain the quality, effectiveness, and efficiency of the program, and thus evaluates Employers' / Workplace Monitors' satisfaction with the HPSP Program twice yearly.

Feedback is obtained from Employers via a satisfaction survey that is emailed or mailed to Workplace Monitors who are asked to complete the survey online. The survey is short and can be completed in 2-3 minutes.

Feedback includes information about timeliness of response, knowledge level of staff, the monthly safe practice form and their overall rating of RBH's support of their supervision of licensees. The survey also asks for any additional comments.

One method of determining the value of HPSP is through the Satisfaction Survey. One role of the RBH Policy Advisory Committee (PAC) is that of quality management. Following review of the survey results, the PAC will identify opportunities for improvement and develop interventions if necessary. The PAC will continue to monitor performance at specified intervals following the implementation of the intervention(s).

Data Results

Response Rate

Table 1: Response Rate	This Period	Year 5	Year 4	Year 3
# Sent	164	340	349	389
# Responses	34	70	89	73
Response Rate	20.7%	20.6%	25.5%	18.8%

The HPSP Employers Satisfaction Survey was distributed to Workplace Monitors through email and mail. Out of the total 164 surveys distributed this period, 34 responses were received for a response rate of 20.7%. The overall response rate for the year then is 20.6%. The response rate peaked in year four at 25.5%. This year's rate remains higher than those seen in the first three years of the program.

Type of Service Provided by Employer

Question 1: Respondents are first asked the type of services provided by their organization. The most frequent responses for the period and the year were both “medical” at over 50%. This was followed by “nursing” with another quarter of the respondents. Although the breakdown of the licensee population is heavily weighted towards nurses, it can be assumed that a number of these nurses work in “medical” offices. Thus, the response to this question does not necessarily mean that the data is inconsistent with and unrepresentative of the license population.

Data Table 2: The mode (most frequent) response is highlighted in red. Not all responses have a mode.

Table 2: Type of Services Provided	This Period (n=34)		This year (n=70)		Last Year (n=89)	
	#	%	#	%	#	%
Medical	19	55.9%	37	52.9%	35	39.3%
Nursing	8	23.5%	20	28.6%	41	46.1%
Pharmacy	5	14.7%	5	7.1%	2	2.2%
Dental	1	2.9%	4	5.7%	5	5.6%
Other	1	2.9%	2	2.9%	4	4.5%
No Response			2	2.9%	2	2.2%

Services

Question 2: Respondents are asked to rate HPSP’s services, including response timeframe; knowledge of licensee when there is a concern in the workplace; ability to respond to questions regarding program administration; and frequency of feedback from RBH. Finally, an overall rating is requested. For the period, the mode response was “excellent” for the first three items (response timeframe, knowledge of licensee when there is a concern in the workplace and ability to respond to questions regarding program administration). This was consistent with the prior period and year four. The mode response was “above average” for frequency of feedback and overall rating of services this period. However, the overall rating of services had a mode of “excellent” for the year. Both of these items had a mode response of “excellent” in year four. Figure 1 shows the comparison between year four and year five data. There were slight changes but no trends of note. Overall this year, a minimum of 54% of responses to each item was either “excellent” or “above average.” Less than 6% of responses to any item was “below average” or “poor.”

Data tables 3a, 3b, and 3c follow on the next page and Figure 1 on the following.

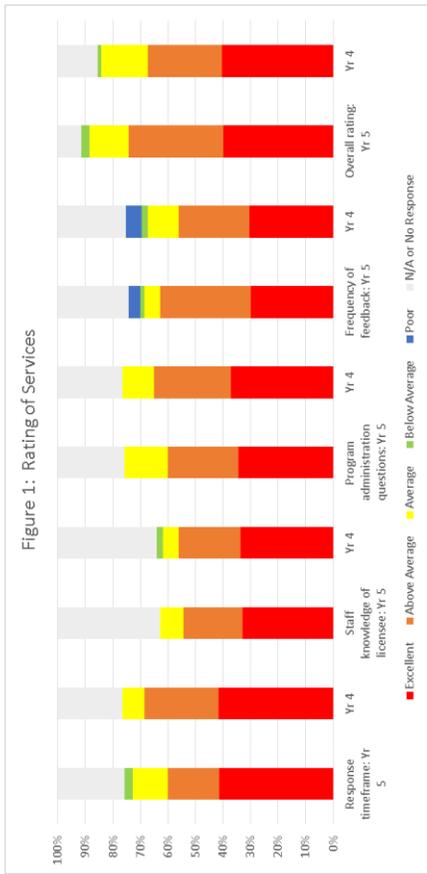
Data Tables 3a, 3b and 3c: The mode (most frequent) response is in red (not all items have a mode):

Table 3a This Period (n=36)	Excellent		Above Average		Average		Below Average		Poor		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
Response timeframe when I request information	13	38.2%	6	17.6%	3	8.8%	1	2.9%			11	32.4%
Staff knowledge of a licensee when there is concern in the workplace	8	23.5%	7	20.6%	2	5.9%					17	50.0%
Our ability to respond to questions regarding program administration	11	32.4%	7	20.6%	3	8.8%					13	38.2%
Frequency of feedback from RBH regarding Licensee's compliance	9	26.5%	10	29.4%	2	5.9%	1	2.9%			12	35.3%
Overall rating of our services	10	29.4%	15	44.1%	4	11.8%					5	14.7%

Table 3b This Year (Year 5) (n=70)	Excellent		Above Average		Average		Below Average		Poor		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
Response timeframe when I request information	29	41.4%	13	18.6%	9	12.9%	2	2.9%			17	24.3%
Staff knowledge of a licensee when there is concern in the workplace	23	32.9%	15	21.4%	6	8.6%					26	37.1%
Our ability to respond to questions regarding program administration	24	34.3%	18	25.7%	11	15.7%					17	24.3%
Frequency of feedback from RBH regarding Licensee's compliance	21	30.0%	23	32.9%	4	5.7%	1	1.4%	3	4.3%	18	25.7%
Overall rating of our services	28	40.0%	24	34.3%	10	14.3%	2	2.9%			6	8.6%

Table 3c Last Year (Year 4) (n=89)	Excellent		Above Average		Average		Below Average		Poor		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
Response timeframe when I request information	37	41.6%	24	27.0%	7	7.9%					21	23.6%
Staff knowledge of a licensee when there is concern in the workplace	30	33.7%	20	22.5%	5	5.6%	2	2.2%			32	36.0%
Our ability to respond to questions regarding program administration	33	37.1%	25	28.1%	10	11.2%					21	23.6%
Frequency of feedback from RBH regarding Licensee's compliance	27	30.3%	23	25.8%	10	11.2%	2	2.2%	5	5.6%	22	24.7%
Overall rating of our services	36	40.4%	24	27.0%	15	16.9%	1	1.1%			13	14.6%

Figure 1 – Next Page



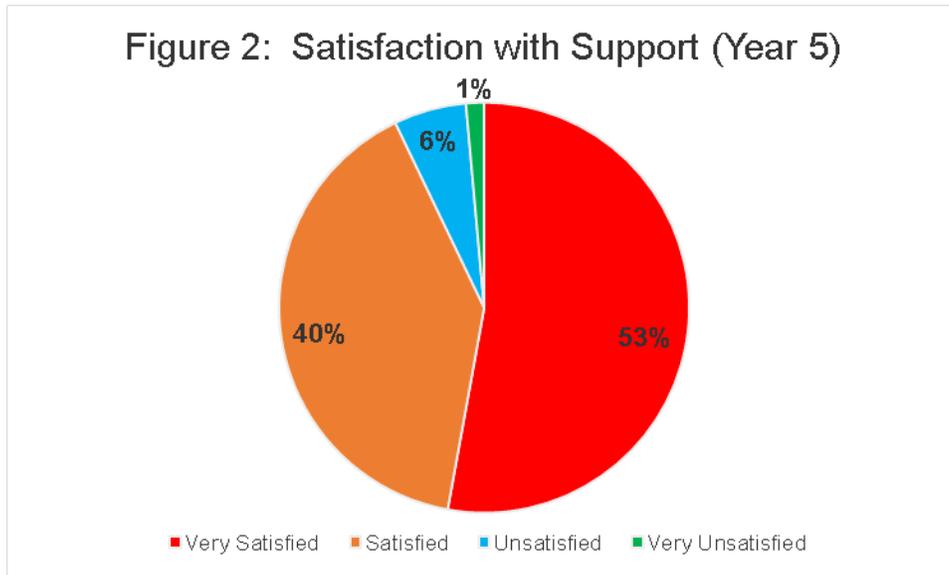
Supervision Support

Question 3: The next item reads: “RBH supports your supervision of licensees. How satisfied are you with our support?” Although there was a slight decrease in the “very satisfied” responses this quarter, the mode response for the year remained “very satisfied” with nearly 53%, similar to last year. An additional 40% this year indicated they were satisfied. Only 7% of the respondents this year were not satisfied.

Data Table 4: The mode (most frequent) response is in red (not all items have a mode):

Table 4: Supervision Support	This Period (n=34)		This Year (n=70)		Last Year (n=89)	
	#	%	#	%	#	%
Very Satisfied	16	47.1%	37	52.9%	50	56.2%
Satisfied	17	50.0%	28	40.0%	35	39.3%
Unsatisfied			4	5.7%	3	3.4%
Very Unsatisfied	1	2.9%	1	1.4%		
No Response					1	1.1%

Figure 2:



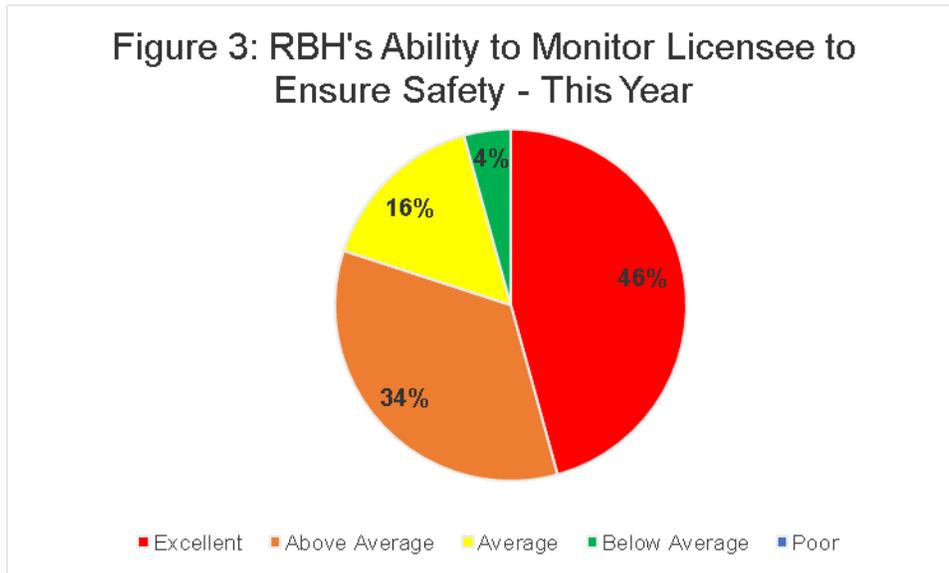
Workplace Safety

Question 4: RBH's ability to monitor the licensee to ensure safety in the workplace is queried in the next item. There was an increase in "excellent" ratings this period to 50% (17). Overall for the year, we see that 45.7% of respondents rated this item "excellent" and 34.3% rated it "above average." This is a slight improvement from last year. Only 20% of respondents this year rated this item "average" or "below average."

Data Table 5: The mode (most frequent) response is highlighted in red:

Table 5: Workplace Safety	This Period (n=34)		This Year (n=70)		Last Year (n=89)	
	#	%	#	%	#	%
Excellent	17	50.0%	32	45.7%	35	39.3%
Above Average	10	29.4%	24	34.3%	33	37.1%
Average	7	20.6%	11	15.7%	19	21.3%
Below Average			3	4.3%		
Poor						
No Response					2	2.2%

Figure 3:



A follow-up question requests any suggested changes or recommendations.

Actual Comments – This Period:

***Note that comments are shown as the respondent typed or wrote them. Spelling, punctuation and grammar have not been corrected.*

1. No
2. No....we have never needed your help.

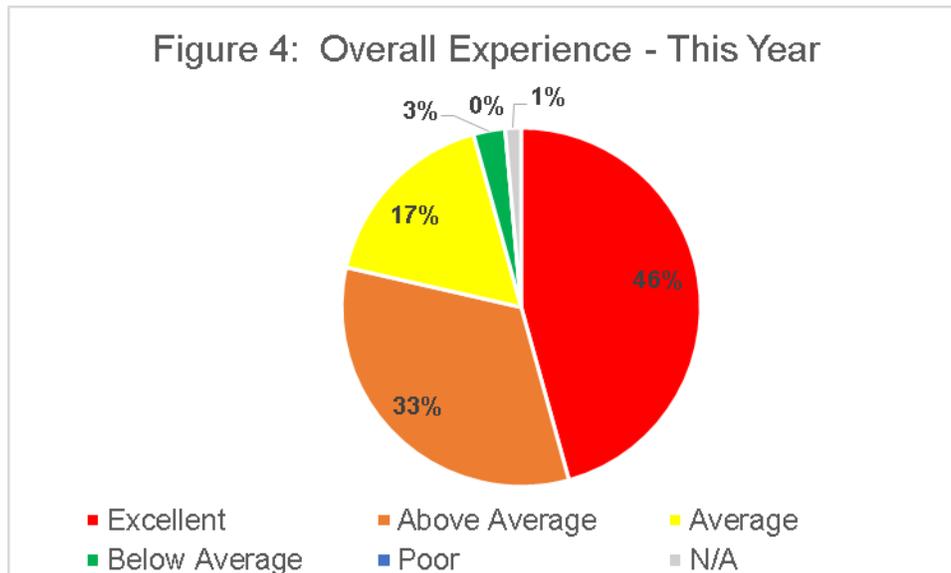
Overall Experience

Question 5: Respondents are asked to rate their overall experience working with RBH. More than 78% of responses were either “above average” or “excellent” this year. The mode responses was “excellent” for the year (45.7%) and the period (41.2%). There continue to be no “poor” responses. There were also no “below average” responses this period.

Data Table 6: The mode (most frequent) response is highlighted in red:

Table 6: Overall Experience	This Period (n=34)		This Year (n=70)		Last Year (n=89)	
	#	%	#	%	#	%
Excellent	14	41.2%	32	45.7%	37	41.6%
Above Average	12	35.3%	23	32.9%	30	33.7%
Average	7	20.6%	12	17.1%	18	20.2%
Below Average			2	2.9%	2	2.2%
Poor						
N/A or No Response	1	2.9%	1	1.4%	2	2.2%

Figure 4:



Additional Comments

Actual Comments – This Period

***Note that comments are shown as the respondent typed or wrote them. Spelling, punctuation, and grammar have not been corrected.*

1. none
2. The only concern would be related to response I've called three times and left messages to ask if the person I'm monitoring is allowed to train into a management position, as of this writing I still have not received a call back. Before this question came up I have placed calls regarding other things and gotten calls back, so this is a concern.
3. None at this point

Summary Analysis

The HPSP Employers' / Workplace Monitor's Satisfaction Survey had a response rate of 20.6% for the year (20.7% for the period). Primarily, respondents indicated that their organizations provide either medical services (53% this year) or nursing services (29% this year).

Strong ratings were provided for HPSP's customer service, particularly in the case of timeliness of responses, knowledge of licensees when there is a concern in the workplace, ability to respond to questions regarding program administration and frequency of feedback regarding licensee's compliance. With only one exception this year the mode response to these items was "excellent." The exception was for "frequency of feedback" which had a mode rating of "above average." Overall this year, a minimum of 54% of responses to each item was either "excellent" or "above average." Less than 6% of responses to any item was "below average" or "poor."

Ninety-three percent (93%) of respondents this year indicated that they were either "very satisfied" or "satisfied" with the support they receive when supervising licensees. Eighty (80%) of respondents this year indicated that they rate RBH's ability to monitor the licensee to ensure safety in the workplace as "excellent" or "above average." Finally, just over 78% rate their overall experience working with RBH HPSP as "excellent" or "above average."

A total of five comments were provided but four of these indicated there were no concerns or no comments. Thus, there was only one comment of substance. This respondent indicated s/he was waiting for a call back after leaving three messages.

Reliant Behavioral Health

Health Professionals' Services Program (HPSP)

Satisfaction of PROFESSIONAL ASSOCIATIONS

Purpose

The purpose of assessing representatives from the Oregon Medical Association, Oregon Nursing Association, Oregon Pharmacy Association, and the Oregon Dental Association is to obtain constructive feedback that can be used to improve and maintain the quality, effectiveness, and efficiency of the HPSP Program. In order to provide continuous quality services, RBH evaluates this stakeholder group's satisfaction with the HPSP Program twice yearly.

Feedback is obtained from Association representatives via a satisfaction survey that is emailed to representatives who are asked to complete the survey online. The survey is short and can be completed in 2-3 minutes.

Feedback includes information about the timeliness of response, knowledge level of staff, ability to enroll licensees and an overall rating of RBH services. Also, the survey asks about the value of the HPSP Program to their membership and asks for any additional comments.

One method of determining the value of HPSP is through the Satisfaction Survey. One of the roles of the RBH Policy Advisory Committee (PAC) is that of quality management. Following review of the survey results, the PAC will identify opportunities for improvement and develop interventions if necessary. The PAC will continue to monitor performance at specified intervals following the implementation of the intervention(s).

Data Results

Response Rate

Table 1: Response Rate	This Period	Year 5	Year 4	Year 3
# Sent	9	18	14	5
# Responses	1	2	2	0
Response Rate	11.1%	11.1%	14.3%	0%

The HPSP Satisfaction survey was distributed to representatives of each Professional Association as follows:

- Oregon Nursing Association: 2
- Oregon Medical Association: 4
- Oregon Dental Association: 2
- Oregon Pharmacy Association: 1

A total of nine surveys were emailed. One response was received for a response rate of 11.1%. This was the same for the first period of Year 5. Thus, the average response rate for the year is also 11.1%

Membership of Respondent

The first question asks respondents of which professional association they are members. The respondent this period and both respondents for the year were from the Oregon Nursing Association.

Table 2: Role of Respondent	This Period (n=1)		This Year (n=2)		Last Year (n=2)	
			#	%	#	%
Oregon Nursing Association	1	100%	2	100%	1	50%
Oregon Medical Association					1	50%
Oregon Dental Association						
Oregon Pharmacy Association						

Customer Service and Communication

Question 2: Survey respondents are asked to rate three different statements relating to customer service, particularly timeliness and knowledge level. Neither of the respondents this year provided a rating for these 3 statements.

Data Table 3a, 3b and 3c:

Table 3: This Period (n=1)	Excellent		Above Average		Average		Below Average		Poor		N/A	
	#	%	#	%	#	%	#	%	#	%	#	%
The timeliness of our response to your inquiries											1	100%
The knowledge level of our staff											1	100%
Overall rating of our services											1	100%

Table 3b: This Year (n=2)	Excellent		Above Average		Average		Below Average		Poor		N/A	
	#	%	#	%	#	%	#	%	#	%	#	%
The timeliness of our response to your inquiries											2	100%
The knowledge level of our staff											2	100%
Overall rating of our services											2	100%

Table 3c: Last Year (n=2)	Excellent		Above Average		Average		Below Average		Poor		N/A	
	#	%	#	%	#	%	#	%	#	%	#	%
The timeliness of our response to your inquiries					1	50%					1	50%
The knowledge level of our staff					1	50%					1	50%
Overall rating of our services					1	50%					1	50%

Value to Members

Question 3: Respondents are then asked “How valuable is the Health Professionals' Services Program to your membership?” The respondent for the period and the year replied “unvaluable.”

Data Table 4:

Table 4: Value to Membership	This Period		This Year		Last Year	
	#	%	#	%	#	%
Extremely Valuable						
Valuable					1	50%
Unvaluable	1	100%	2	100%	1	50%
Extremely Unvaluable						

Feedback from Membership

Question 4: Feedback received from membership is then queried. This period that feedback was rated as “poor.”

Data Table 5:

Table 5: Value to Membership	This Period		This Year		Last Year	
	#	#	#	%	#	%
Excellent						
Above Average						
Average						
Below Average					2	100%
Poor	1	100%	2	100%		
N/A						

Additional Comments

Actual Comments – July 2015:

***Note that comments are shown as the respondent typed or wrote them. Spelling, punctuation and grammar have not been corrected.*

1. Although the number of members who have commented on your services is small, I have consistently heard that there is a lack of timely response, that testing is more frequent than it should be and concerns about conflicts of interest.

Summary Analysis

There was one (1) response to this survey for the period and two (2) for the year both representing an 11.1% response. It is recommended that RBH continue to outreach to each of the Professional Associations so that the associations support can be garnered and a broader response base can be obtained.

Both responses were from the Oregon Nurses Association. The value of the HPSP services to membership was rated “unvaluable.” The feedback received from membership was rated “poor.” The comment received was negative although the respondent did indicate that it was based on a small number of member comments.

Reliant Behavioral Health

Health Professionals' Services Program (HPSP)

Satisfaction of TREATMENT PROVIDERS

Purpose

The purpose of assessing representatives from Treatment Providers is to solicit feedback that can be used to improve the services provided through the HPSP Program. RBH strives to maintain the quality, effectiveness, and efficiency of the program, and evaluates the Treatment Providers' satisfaction with the HPSP Program on a twice yearly basis.

Feedback is obtained from Treatment Providers representatives via a satisfaction survey that is emailed or mailed to representatives who are asked to complete the survey online. The survey is short and can be completed in 2-3 minutes.

Feedback includes information about RBH's communication, responsiveness of staff, overall rating of experience, and any additional comments.

One method of determining the value of HPSP is through the Satisfaction Survey. One of the roles of the RBH Policy Advisory Committee (PAC) is that of quality management. Following review of the survey results, the PAC will identify opportunities for improvement and develop interventions if necessary. The PAC will continue to monitor performance at specified intervals following the implementation of the intervention(s).

Data Results

Response Rate

Table 1: Response Rate	This Period	Year 5	Year 4	Year 3
# Sent	163	343	387	294
# Responses	18	42	28	27
Response Rate	11.0%	12.2%	7.2%	9.2%

This Satisfaction Survey was distributed to those individuals and programs that provide various treatment services to Licensees enrolled in HPSP. A total of 163 surveys were sent by mail or email this period and 18 responses were received. The response rate this period was 11.0%, bringing the average response rate for the year to 12.2%. This is an improvement over prior years although still lower than desired.

Role of Respondent

The first question asks the respondents the capacity in which they have provided services to HPSP licensees. They are able to provide more than one response. The 18 respondents this period provided a total of 27 responses. As a result, percentages total more than 100%. This is also the case for the other two periods of data presented. For the year, more than half (57.1%) of the respondents indicated that one of their roles is mental health therapist. This was closely followed by the role of Monitor (e.g. PMC, GMC or Quarterly Monitor) with 45.2% of the responses. Last year the majority of respondents indicated that they were Monitors at 46.4%.

Data Table 2: The mode (most frequent) response is highlighted in red.

Table 2: Role of Respondent	This Period (n=18)		This Year (n=42)		Last Year (n=28)	
	#	%	#	%	#	%
Chemical Dependency Counselor	4	22.2%	11	26.2%	4	14.3%
Evaluator	2	11.1%	3	7.1%	2	7.1%
Mental Health Therapist	12	66.7%	24	57.1%	6	21.4%
Monitor (PMC / GMC / Quarterly Monitor)	8	44.4%	19	45.2%	13	46.4%
Pain Management					1	3.6%
Psychiatrist			1	2.4%	2	7.1%
Treating physician	1	5.6%	2	4.8%	1	3.6%
Other					2	7.1%
Unspecified					2	7.1%

Customer Service and Communication

Question 2: Survey respondents are asked to rate three different statements relating to customer service, particularly communication between HPSP and the provider. For the period and the year, the majority of respondents “Agreed” that their concerns were responded to promptly, that information was communicated clearly and professionally and that they had all the information needed when seeing the client. An additional 22-33% of respondents “strongly agreed” with each of the three statements. This is consistent with responses last year and continues to represent an improvement from year three. In summary, a minimum of 72% agreed or strongly agreed with each statement both this period and this year. The lowest rated of the three statements was that the provider had all the information needed when seeing the licensee.

Data Tables 3 a, b, and c: The mode (most frequent) response is highlighted in red. Not all responses have a mode.

Table 3a: This Period (n=18)	Strongly Agree		Agree		Disagree		Strongly Disagree		N/A		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
My questions and/or concerns were responded to promptly	6	33.3%	10	55.6%					2	11.1%	6	33.3%
Information was communicated clearly and professionally	5	27.8%	10	55.6%	1	5.6%			2	11.1%	5	27.8%
I had all the information I needed when I saw the licensee	4	22.2%	9	50.0%	3	16.7%	1	5.6%	1	5.6%	4	22.2%

Table 3b: This Year (n=42)	Strongly Agree		Agree		Disagree		Strongly Disagree		N/A		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
My questions and/or concerns were responded to promptly	12	28.6%	22	52.4%	2	4.8%	1	2.4%	5	11.9%		
Information was communicated clearly and professionally	11	26.2%	23	54.8%	3	7.1%	1	2.4%	4	9.5%		
I had all the information I needed when I saw the licensee	11	26.2%	21	50.0%	6	14.3%	3	7.1%	1	2.4%		

Table 3c: Last Year (n=28)	Strongly Agree		Agree		Disagree		Strongly Disagree		N/A		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
My questions and/or concerns were responded to promptly	7	25.0%	19	67.9%	1	3.6%			1	3.6%		
Information was communicated clearly and professionally	8	28.6%	15	53.6%	4	14.3%	1	3.6%				
I had all the information I needed when I saw the licensee	9	32.1%	10	35.7%	7	25.0%	1	3.6%	1	3.6%		

Overall Experience

Question 3: Respondents are next asked “Overall, how would you rate your experience working with RBH staff of the HPSP program?” The mode response was “above average” for this period with an equal number of respondents each indicating “excellent,” “above average,” and “average” for the year.

Data Table 4: The mode (most frequent) response is highlighted in red. Not all responses have a mode.

Table 4: Overall Rating	This Period (n=18)		This Year (n=42)		Last Year (n=28)	
	#	%	#	%	#	%
Excellent	4	22.2%	12	28.6%	7	25.0%
Above Average	7	38.9%	12	28.6%	10	35.7%
Average	5	27.8%	12	28.6%	8	28.6%
Below Average			3	7.1%	3	10.7%
Poor						
N/A or No Response	2	11.1%	3	7.1%		

Additional Comments

Actual Comments – This Period:

***Note that comments are shown as the respondent typed or wrote them. Spelling, punctuation, and grammar have not been corrected.*

1. Communication and working with agreement monitors has been great. Communication with administrative staff is limited and when it's occurred not clear and concise.
2. As client was referred to me through a third party and my treatment wasn't mandated, things were a bit unclear about my relationship to HPSP
3. I don't get any updates from RBH before my PMC meetings with licensees.
4. I would prefer to get all vouchers at the start
5. I have one participant remaining. There are no requests for discussion of him. It seems to be an accounting process, not a program.

Summary Analysis

The response rate to the HPSP Treatment Provider Satisfaction Survey for the period was 11.0%. This brings the average response rate for the year to 12.2% and represents a substantial improvement over prior years. Continued efforts to partner with the providers should allow for further increases. Respondents varied in their relationship to the licensee. More than half (57.1%) of respondents indicated that in one of their roles they serve as a Mental Health Therapist while 45.2% described one of their roles as a monitor (e.g GMC,PMC).

For both the period and the year, the majority of respondents "agreed" that their concerns were responded to promptly, that information was communicated clearly and professionally and that they had all the information needed when seeing the client. A minimum of 72% respondents this year "agreed" or "strongly agreed" with each statement.

"Above Average" was the most common response to the overall experience working with RBH this period. Responses were evenly split between "excellent," "above average" and "average" for the year.

Five comments were received and were a mix of positive, negative and neutral recommendations for improvement. The PAC will review each comment individually and develop an appropriate action plan. A collaborative relationship with the treatment providers is beneficial to the support of the licensees in their recovery and will improve monitoring.

Reliant Behavioral Health

Health Professionals' Services Program (HPSP)

Satisfaction of BOARDS

Purpose

The purpose of assessing representatives from the Medical Board, Board of Nursing, Board of Dentistry, and the Board of Pharmacy, is to obtain constructive feedback that can be used to improve and maintain the quality, effectiveness, and efficiency of the HPSP Program. In order to provide continuous quality services, RBH evaluates satisfaction with the HPSP Program twice yearly.

Feedback is obtained from the Boards via a satisfaction survey that is emailed to representatives who are asked to complete the survey online. The survey is short and can be completed in 2-3 minutes.

Changes were made to the survey this spring in order to better gauge how well RBH is serving the needs of the Boards and their representatives. The revised survey requests feedback on the overall program, timeliness of responses to inquiries, the knowledge level of staff and the quality of information provided.

One method of determining the value of HPSP is through the Satisfaction Survey. One of the roles of the RBH Policy Advisory Committee (PAC) is that of quality management. Following review of the survey results, the PAC will identify opportunities for improvement and develop interventions if necessary. The PAC will continue to monitor performance at specified intervals following the implementation of the intervention(s).

Data Results

Response Rate

Table 1: Response Rate	This Period	Year 5	Year 4	Year 3
# Sent	7	14	13	17
# Returned	2	7	8	8
Response Rate	28.6%	50.0%	61.5%	47.1%

The HPSP Boards Satisfaction Survey was emailed to representatives at 100% of the participating Boards. The response rate was 28.6% for the period with two (2) responses to the seven (7) surveys sent. The average response rate for the year was 50%. This falls between the response rates seen in year four and year three.

Respondents

Question 1: There were not any changes to this question which asks which Board the respondent represents. Respondents this period were from the Board of Nursing (1) and the Board of Pharmacy (1). Surveys were sent to three representatives from the Medical Board, two from the Board of Pharmacy and one each from the other two boards. For the year, there is representation in the responses from all four boards.

Table 2: Respondents by Board	This Period (n=2)		Year 4 (n=7)		Year 4 (n=8)		Year 3 (n=8)	
	#	%	#	%	#	%	#	%
Medical Board			2	28.6%	4	50.0%	5	62.5%
Board of Nursing	1	50.0%	2	28.6%	1	12.5%	1	12.5%
Board of Dentistry			1	14.3%	2	25.0%		
Board of Pharmacy	1	50.0%	2	28.6%	1	12.5%	2	25%

Communication and Service

Question 2 was new this period: Respondents were asked to reflect on a recent licensee situation, question, or concern and rate three elements. Responders knew who to speak with (mode response of “agree”), the time frame was within one business day (mode response of “agree”) and RBH had knowledge of the licensee or situation (one “strongly agree” and one “agree” response each).

Data Table 3: The mode (most frequent) response is highlighted in red. Not all responses have a mode:

Table 3 – This Period (n=2)	Strongly Agree		Agree		Undecided		Disagree		Strongly Disagree		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
I knew who I should speak with			2	100%								
Staff had knowledge of the licensee or situation	1	50%	1	50%								
The response time frame was within one (1) business day			2	100%								

Question 3 was also new and was similar to the above. Respondents were asked to reflect on a broader question or programmatic concern, and rate four elements. Again, responses were positive with either “agree” or “strongly agree” values as seen in Table 4: responders again knew who to speak with (one “strongly agree” and one “agree” response each), felt comfortable bringing concerns forward (one “agree” and one “N/A” response each), felt RBH provided useful and insightful data (one “strongly agree” and one “agree” response each) and felt the time frame was within one business day (mode response of “agree.”) Past surveys have also asked about staff knowledge, time frame of responses and ability to address programmatic concerns. A summary of these responses is located on the next page (Data Tables 5a and 5b.)

Data Table 4: The mode (most frequent) response is highlighted in red. Not all responses have a mode:

Table 4 – This Period (n=2)	Strongly Agree		Agree		Undecided		Disagree		Strongly Disagree		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
I knew who I should speak with	1	50%	1	50%								
I felt comfortable bringing my concerns about the program forward			1	50%							1	50%
RBH provided useful and insightful data to address my questions	1	50%	1	50%								
The response time frame was within one (1) business day			2	100%								

Data Tables 5a and 5b: The mode (most frequent) response is highlighted in red. Not all responses have a mode:

Table 5a – Last Period (n=5)	Excellent		Above Average		Average		Below Average		Poor		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
Staff knowledge of the case when I need to discuss a board referred licensee	3	60%	1	20%			1	20%				
Response timeframe when I request information	3	60%	2	40%								
Our ability to respond to Board concerns regarding program administration	4	80%	1	20%								

Table 5b – Last Year (n=8)	Excellent		Above Average		Average		Below Average		Poor		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
Staff knowledge of the case when I need to discuss a board referred licensee	1	25%	3	75%								
Response timeframe when I request information	1	25%	3	75%								
Our ability to respond to Board concerns regarding program administration			4	100%								

Overall Experience

Question 4 had been asked on previous surveys. It asked respondents to rate the services overall. This period there was one “excellent” response and one “average” response. Overall for the year, the mode response was “excellent” at 57.1% followed by “above average” at 28.6%. This is an improvement from last year.

Table 6: Overall Rating	This Period (n=2)		This Year (n=7)		Last Year (n=8)	
	#	%	#	%	#	%
Excellent	1	50%	4	57.1%	1	25.0%
Above Average			2	28.6%	3	75.0%
Average	1	50%	1	14.3%		
Below Average						
Poor						
N/A or No Response						

What Should We Improve?

Actual Comments – July 2015:

***Note that comments are shown as the respondent typed or wrote them. Spelling, punctuation, and grammar have not been corrected.*

1. I would prefer if more often a live person answered the phone opposed to a voice mail.

Additional Comments

Actual Comments – July 2015:

***Note that comments are shown as the respondent typed or wrote them. Spelling, punctuation, and grammar have not been corrected.*

1. Dr. Bahl's input has been a valuable tool for the Board.

Summary Analysis

The response rate this year was 50% with responses from all four Boards. Changes were made to the survey this period. When reflecting on a recent licensee situation, question, or concern responders knew who to speak with (mode response of “agree”), felt the time frame was within one business day (mode response of “agree”) and felt that RBH had knowledge of the licensee or situation (one “strongly agree” and one “agree” response each). When reflecting on a broader question or programmatic concern, responders again knew who to speak with (one “strongly agree” and one “agree” response each), felt comfortable bringing concerns forward (one “agree” and one “N/A” response each), felt RBH provided useful and insightful data (one “strongly agree” and one “agree” response each) and felt the time frame was within one business day (mode response of “agree.”)

Overall services were rated well. This period there was one “excellent” response and one “average” response. Overall for the year, the mode response was “excellent” at 57.1% followed by “above average” at 28.6%. This is an improvement from year four. It was however recommended to have more live answers to phone calls. Finally, it was noted that the Medical Director’s (Dr. Bahl’s) input has been valuable. The PAC will review the result of the survey including the comments carefully.

**Health Professionals' Services Program Summary Annual Report
Highlights of Year Five 7/1/14-6/30/15**

The purpose of this report is to provide the Oregon Health Authority and the representatives of the participating health licensing boards with a summary of the highlights of year five of the Health Professionals' Services Program (HPSP). HPSP began provision of monitoring services to the Oregon Board of Dentistry, Oregon Board of Nursing, Oregon Medical Board, and the Oregon Board of Pharmacy on July 1, 2010. The following data tables were developed to give an overview of the HPSP program during the period from July 1, 2014 through June 30, 2015.

Table 1: Enrollment Overview: Year 5

Enrollment Overview: Year 5 (7/1/14 - 6/30/15)	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Total Enrolled End of Year 4 (6/30/14)	18	122	14	88	242
Enrolled: Board Referral	3	35	6	6	50
Enrolled: Self-Referral	0	5	0	9	14
Successfully Completed	7	34	2	23	66
Terminations	3	21	0	3	27
Total Enrolled End of Year 5 (6/30/15)	11	107	18	77	213
Referred but Not Enrolled/Inquiry Only	2	8	2	8	20

Table 1 provides a summary of year five enrollment, beginning with the number of licensees enrolled at the end of year four and reviewing the changes in enrollment during the year. In particular, it displays: the number of licensees referred by board to the program, the number of self-referrals to the program, the number of licensees who successfully completed the program, and the number of licensees who were terminated from the program by the licensing boards. The total enrollees at the end of year five follows from this data. Table 1 also displays the number of licensees who were referred but never enrolled or those who called about the program but did not enroll. Table 2 provides the same information but for year four enrollment (see next page.)

At the end of year five, the program had 213 participants, representing a 12% decline from year four. This is a smaller percentage decline than that from year three to year four (16%). Enrollment this year, with 64 new enrollees, was up slightly from last year's 60 enrollees. As a further point of reference, enrollment in year three was 69 licensees. It appears the number of new referrals is stabilizing. The percentage of licensees who successfully completed the program and those who were terminated stayed stable: Last year 26% of those enrolled at the beginning of the year completed and this year 27% did so. Similarly, last year 10% of those enrolled at the beginning of the year were terminated and this year 11% did so. If these percentages continue into next year, we can anticipate that approximately 58 licensees will successfully complete and 24 will be terminated for a total of 82 cases closed.

The Board of Pharmacy was the only board to end the year with more enrolled licensees than it started with: there were 14 enrolled as of July 2014 and as of June 2015 there were 18. There were not any terminations for the Board of Pharmacy this year. As should be anticipated, the Oregon Board of Nursing had the largest number of licensees referred to the program, as well as the largest number of successful completions and terminations. Successful completions exceeded terminations for each board. The Board of Nursing and the Medical Board both had self-referrals into the program this year.

Table 2: Enrollment Overview: Year 4

Enrollment Overview: Year 4 (7/1/13 - 6/30/14)	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Total Enrolled End of Year 3 (6/30/13)	17	149	17	106	289
Enrolled: Board Referral*	4	31	3	6	44
Enrolled: Self-Referral*	1	4	0	11	16
Successfully Completed	2	41	6	27	76
Terminations	2	21	0	8	31
Total Enrolled End of Year 4 (6/30/14)	18	122	14	88	242
Referred but Not Enrolled/Inquiry Only	0	5	0	4	9*

*Data in this row was updated to reflect cases that enrolled subsequently to last year's report.

Table 3: Program Termination Reasons

Termination Reasons: Year 5	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Deceased	0	2	0	0	2
Inappropriate Referral (Determined after Enrollment)	0	2	0	0	2
License Inactivated	0	1	0	0	1
License Retired	3	0	0	2	5
License Revoked	0	2	0	0	2
License Surrendered	0	12	0	1	13
License Suspended	0	1	0	0	1
Probation	0	1	0	0	1
TOTAL	3	21	0	3	27

Table 3 reviews the reasons for terminations from the HPSP program this year. Please note that a licensee has to be enrolled in order to be terminated from the program. The Board of Pharmacy did not have any participants terminated from the program this year. The primary reason for program termination was the licensee surrendered his/ her license; this is consistent with the last four years of the program. This is primarily driven by the Board of Nursing (12). The second most common reason this year was that the participant's license was retired. Both the Board of Dentistry and the Medical Board had licensees terminated from the program for this reason this year.

Table 4: Suspensions During Year Five

Suspensions (At Any Time During Year 5)	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Expired License	0	1	0	0	1
Health: Severe Issues	0	0	0	0	0
Non-Compliance: Financial	1	4	0	0	5
Per Board, Open HPSP But Not Participating	0	0	0	1	1
TOTAL	1	5	0	1	7

Table 4 details the number of licensees who were suspended at any time during year four. A total of seven licensees were suspended from the program during the year: five from the Board of Nursing and one each from the Board of Dentistry and the Medical Board. The most common reason for suspension was due to financial non-compliance. One licensee was also suspended due to an expired license. A new suspension reason was added this year “Per Board, Open HPSP but Not Participating.” This reason was created due to a licensee who had ceased participating in HPSP but the Board requested that the licensee’s case be kept open until a decision could be made. (The licensee was terminated from the program at the beginning of year six.)

By the close of the fifth program year, there was only one licensee suspended (see Table 5). This licensee was a representative of the Medical Board.

Table 5: Suspensions at the End of Year Five

Suspensions (At End of Year 5)	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Expired License	0	0	0	0	0
Health: Severe Issues	0	0	0	0	0
Non-Compliance: Financial	0	0	0	0	0
Per Board, Open HPSP But Not Participating	0	0	0	1	1
TOTAL	0	0	0	1	1

Table 6: Non-Compliance Reports by Licensee

Non-Compliance Reports by Licensee: Year 5	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Total Non-Compliance Reports	14	115	1	24	154
Total Non-Compliance Reports as a Percentage of Average # of Licensees Enrolled in Year 5	96.6%	100.4%	6.3%	29.1%	67.7%
# of Licensees with NC Reports	6	53	1	14	74
# of Licensees with >1 NC report	4	28	0	5	37
# of Licensees with >3 NC report	1	11	0	2	14

Table 6 gives the total number of non-compliance reports by board and then reports this number as a percentage of the average number of licensees enrolled during the year. A break-down of these reports is then listed, showing the number of licensees who received reports, the number with more than one report throughout the year and the number with more than three reports throughout the year. There were a total of 74 licensees with non-compliant reports this year. This is down from 84 last year, representing a 12% reduction in licensees with any non-compliant events during the year. However, the number of licensees with a non-compliance report as a percentage of the average number of licensees enrolled during the year was stable from last year to this year at 31-32%.

The 11 Board of Nursing licensees who had more than three non-compliance reports received a combined total of 115 non-compliance reports, 45% of the total reports from this board. The Board of Nursing had the highest percentage of reports to licensees at 100.4%, although this is continuing to trend down from prior years in the program (see chart below). This is compared to 96.6% for the Board of Dentistry, 29.1% for the Medical Board, and 6.3% for the Board of Pharmacy. The Board of Dentistry's percentage of reports to licensees has increased for the last three years, the Medical Board's percentages have stayed relatively stable for the last three years. The Board of Pharmacy has maintained a low 6% for the last two years.

	Year Two	Year Three	Year Four	Year Five
Board of Dentistry	218%	33.3%	45.7%	96.6%
Board of Nursing	211%	142.6%	104.8%	100.4
Board of Pharmacy	76%	118.9%	6.5%	6.3%
Medical Board	36%	30.4%	25.8%	29.1%

Table 7: Self-Referrals Known to Board After Report of Non-Compliance

Self-Referrals Known to Board After Report of Non-Compliance	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Year 1 (7/1/10 - 6/30/11)	0	0	0	11	11
Year 2 (7/1/11 - 6/30/12)	0	1	0	8	9
Year 3 (7/1/12 - 6/30/13)	1	0	0	5	6
Year 4 (7/1/13 - 6/30/14)	0	0	0	4	4
Year 5 (7/1/14 - 6/30/15)	0	4	0	7	11
TOTAL	1	5	0	35	41

Table 7 shows the number of Self-Referral licensees who were reported non-compliant and are thus now known to the board. This year, the Medical Board had seven self-referrals who are now board known and the Board of Nursing had four.

Table 8: Non-Compliance Reasons

Non-Compliance Reasons*: Year 5	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Failure to Enroll	0	3	0	1	4
Failure to Participate: Missed AM Check-in	1	9	0	3	13
Failure to Participate: Missed IVR Call	2	25	0	9	36
Failure to Participate: Missed Test (includes failure to provide specimen)	8	48	0	16	72
Failure to Participate: Non-Payment	1	1	0	0	2
Failure to Participate: Other	5	26	1	4	36
Hospitalization	0	0	0	0	0
Violated Restriction on Practice	0	0	0	0	0
Positive Non-RBH Test	0	1	0	1	2
Positive Toxicology Test	4	41	0	1	46
Impaired in a Health Care Setting in the Course of Employment (including admitted substance use & diversion of medications)	0	1	0	0	1
Impaired Outside of Employment (including admitted substance use & diversion of medications)	0	1	0	3	4
Public Endangerment	0	0	0	0	0
Criminal Behavior (including DUI)	0	0	0	0	0
Unapproved Use of Prescription Medication	0	4	0	0	4
TOTAL	21	160	1	38	220

* May have more than 1 reason per report

Table 8 shows the reasons why a non-compliance report was submitted to the appropriate board. The most common reason for non-compliance was the licensee failing to test as scheduled with 72 reports. This has been the most frequent reason for a non-compliance report for the past two years. Positive toxicology tests, "Failure to participate: other" and missed IVR calls were the next most common reasons just like last year, although the order has changed slightly. Missed IVR calls were the second most common last year; this change is likely due to the use of "periodic" non-compliance reports rather than one report for each missed IVR call. The only notable difference between the boards is in the category of "impaired outside of employment." The Medical Board accounted for 75% (three of the four) of these although they only account for 17% of the total non-compliance reports.

Table 9: Non-Negative Tests

Non-Negative Tests: Year 5	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Invalid Tests	11	6	0	0	17
Positive Tests (non-negative results)	7	55	0	2	64
Positive Tests as a Percentage of Average # of Licensees Enrolled in Year 5	48.3%	48.0%	n/a	2.4%	28.1%
TOTAL	18	61	0	2	81

Table 9 shows the number of invalid test results and non-negative tests per board. Examples of problems that would cause an invalid test result include a specimen bottle leaking, a broken seal, identification numbers of the specimen and chain of custody form do not match, and insufficient volume of specimen (this should have been caught at the collection site). The positive tests (non-negative results) also include re-test results. During year five, there were a total of two positive retests. Both of these tests was also positive on the original toxicology panel so they are only counted once each.

Table 9 also reflects the number of positive tests (non-negative results) as a percentage of the average number of licensees enrolled in the program during year five. Overall the non-negative tests are 28.1% of the average number of enrolled licensees. This is an increase from last year's 18.8% and the third year's 15.8%. The rate was the highest for the Board of Nursing and the Board of Dentistry both at 48%. The Board of Nursing percentage has increased the last two years (from 30% in year four and 22% in year three.) The Board of Dentistry's percentage is skewed as six of the seven positives were from one licensee. The Medical Boards number of positive tests (2) is down from seven last year and it's percentage of positive tests to average number of licensees was down from 7% to 2%. The Board of Pharmacy did not have any positive tests this year, as it did not last year.

The total number of positive (non-negative) tests can be compared to the number of Non-Compliance reports submitted due to a positive toxicology test result. There were 46 non-compliance reports submitted with a reason listed as "positive toxicology test." There were 17 positive tests for which a non-compliance report was not required due to the program's ETG guideline. This is increase from last year when eight tests met this criteria. The one additional positive test's non-compliance report is in process.

Table 10: Drugs Resulting in Positive Tests

Drugs Resulting in Positive Tests: Year 5**	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
amphetamines / methamphetamines	0	3	0	0	3
anti-depressants	0	1	0	0	1
antihistamines	1	1	0	0	2
benzodiazepines	0	4	0	0	4
cocaine metabolite	0	2	0	0	2
ethyl glucuronide (ETG)	6	33	0	2	41
ethyl glucuronide (ETG) – PETH	0	1	0	0	1
marijuana metabolite (THC)	0	2	0	0	2
methadone	0	3	0	0	3
opiates (narcotics/opiates)	0	1	0	0	1
oxycodone	0	4	0	0	4
tramadol	0	3	0	0	3
TOTAL	7	58	0	2	67

*May have more than one drug per test.

Table 10 shows the various drugs that resulted in a positive test result. In prior years, this table included any substances found in a sample that was resulted as positive. This meant that if a sample had multiple drugs found and the MRO excused one or more due to a valid prescription, but reported the test positive overall, all the identified drugs were listed in the table, including those that were excused. This year, advancements in our information systems have allowed this data to be further clarified. **Only** the drugs resulting in the positive test are listed; any excused by the MRO are not included. Similar to the last three years, the largest number of positive tests was for alcohol (ethyl glucuronide (ETG)). This year positive ETG tests accounted for approximately two-thirds (61%) of the positive tests. No other category accounted for more than 6% of the positive tests.

Table 11: Missed Test Details – Breakdown by Reason

Missed Test Breakdown by Reason: Year 5	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
No Call/No Show	2	39	0	25	66
No Show	5	27	0	9	41
Refused	1	2	0	1	4
TOTAL	8	68	0	35	111

Table 11 gives detail on licensees who failed to take a scheduled toxicology test. No call/no show refers to licensees who failed to call the IVR and did not test as scheduled. No Show refers to situations when the licensee did not go to the collection site to give a specimen but did check to see if a test was required by either calling the IVR or looking at the website or iPhone app. Refused refers to licensees who went to the collection site but did not provide an adequate specimen. This is considered a refusal to test which is treated like a positive test unless the licensee can provide a medical explanation from a physician, verifying that the licensee has a medical condition which prevents the licensee from providing an adequate sample.

There were four “refusals to test” this year compared to one last year. As we have seen in the past, the number of no call/no shows (66) exceeds the number of no shows (41), with apparent knowledge of the requirement to test, by approximately 50%. It is substantial that 41 times a licensee checked the system to see if a test was required, learned that they were scheduled to test but still failed to go to the collection site. Notably, the Board of Pharmacy did not have any missed tests this year.

Table 12: Missed Test Details – By Licensees

Missed Test Details: Year 5	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Total Number of Missed Tests	8	68	0	35	111
Number of Licensees with a Missed Test	5	35	0	9	49
Licensees with a Missed Test as a Percentage of Average # of Licensees Enrolled in Year 5	34.5%	30.6%	0.0%	10.9%	21.5%

Table 12 shows the total number of missed tests (also reported in Table 11) as compared to the number of licensees who missed a scheduled toxicology test. If these numbers were identical, it would mean that each licensee was only responsible for one missed test. The larger the difference in these numbers, the more times a single licensee is responsible for multiple missed tests. On average, a Board of Dentistry and a Board of Nursing licensee with a missed test actually missed two during the year. For the Medical Board, a licensee with a missed test actually missed four during the year. This is a significant difference between boards. Table 12 also shows the number of missed tests as a percentage of the average number of licensees enrolled in year four. On average, this percentage was 21.5% but was highest for the Board of Dentistry at 34.5% followed by the Board of Nursing at 30.6% and the Medical Board at 10.9%.

Table 13: Workplace Safe Practice Reports

Workplace Safe Practice Reports: Year 5	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Number of Licensees who had Reports Submitted	12	124	13	76	225
Number of Reports Received / Reviewed	104	870	102	656	1732
Percentage of Required Reports Received	87.4%	86.4%	91.1%	90.9%	88.4%
Number of Reports Received with Concerns Noted	0	23	0	4	27
Percentage of Reports with Concerns Noted	0.0%	2.6%	0.0%	0.6%	1.6%
Percentage of Reports in which Noted Concerns were Addressed	n/a	100.0%	n/a	100.0%	100.0%
Number of Licensees with a Report with Concerns Noted	n/a	16	n/a	3	19
Number of Licensees with Concerns Reported who also had a NC report	n/a	12	n/a	1	13
Above as a Percentage of the Total Licensees with NC Reports	0.0%	22.6%	0.0%	7.1%	17.6%

Table 13 displays details on the workplace safe practice reports received from workplace monitors during the year, including the number of licensees who had reports submitted, the total number of reports received and reviewed and the percentage of the required reports that were actually received. It is important to note that for any board this number was a minimum of 86% up from 80% last year. A goal for RBH during year five was to increase the percentage of required reports received, particularly for the Medical Board. RBH did increase the percentage for the Medical Board from 80% to nearly 91%. Overall across the four boards, the percentage stayed the same as last year at 88% however. This is due to a slight decline in the percentage for the Board of Nursing from 94% to 86%. RBH will continue to focus on Workplace Safe Practice Reports during year six.

Table 13 additionally displays the number and percentage of reports in which the workplace monitor noted concerns about the licensee in the workplace. The Board of Nursing had the most such reports at 23, which was 2.6% of all the reports received for the Board of Nursing licensees. This is down from 3.8% last year. It is important to note that 100% of the reports with a concern noted had an appropriate plan developed and put into place to address the concerns. Table 13 further displays the number of licensees with a report indicating concerns who also had a non-compliance report. In fact, 13 of the 19 licensees with a workplace concern noted *did* have a non-compliance report on record.

Table 13 then displays the number of licensees with a workplace safe practice report noting concerns *and* a non-compliance report as a percentage of the total number of licensees with a non-compliance report. One in five Board of Nursing licensees with a non-compliance report displayed concerning behavior in the workplace.

Year Six

During Year Six, the HPSP team will focus on:

- Outreach to increase enrollment to overcome discharge rates.
- Data analysis to determine the attributes of licensees who successfully complete HPSP.
- Continue to focus on the timely receipt of Workplace Safe Practice Reports.

Christopher J. Hamilton, PhD
Monitoring Programs Director
July, 2015

**Summary of Agency Head Financial Transactions
July 1, 2014 to June 30, 2015**

<u>SPOTS Card Purchases</u>	<u>Total</u>
Registrations	\$3,113.00
Office Equipment	\$279.64
Publications/Subscriptions	\$363.30
Board Meeting Food	<u>\$2,474.86</u>
	<u>\$6,230.80</u>

<u>AT&T</u>	<u>\$212.94</u>
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<u>Travel Expenses- Patrick Braatz</u>	
Instate Travel	2,857.96
Out of State Travel	<u>1,817.04</u>
Reimbursed to employee:	<u>\$4,675.00</u>

<u>Travel Expenses - Stephen Prisby</u>	
Instate Travel	431.55
Out of State Travel	<u>0.00</u>
Reimbursed to employee:	<u>\$431.55</u>

Total - Agency Head Travel Expenses	<u><u>\$5,106.55</u></u>
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<u>PATRICK BRAATZ Leave Taken (resigned 2/6)</u>	<u>Hours</u>
Vacation	53.75
Sick leave	73.50
Personal Business	24.00
Discretionary Leave	40.00
Furlough Leave	<u>0.00</u>
	<u><u>191.25</u></u>

<u>STEPHEN PRISBY Leave Taken (Since 2/7)</u>	<u>Hours</u>
Vacation	0.00
Sick leave	2.00
Personal Business	0.00
Discretionary Leave	14.00
Furlough Leave	<u>0.00</u>
	<u><u>16.00</u></u>

AGENCY HEAD FINANCIAL TRANSACTIONS
SPOTS Card and Travel Reimbursement
Fiscal Year 2015 by Quarter

SPOTS Card Purchases:	<u>sub-total</u>	<u>Total</u>
(Agency credit card-paid directly by State)		
<u>July - September</u>		1,170.74
DOJ-Publications	65.00	
Kremeworks-Donuts August Board Meeting	9.99	
Bridecity Café -August Board Meeting	380.29	
Proforum Subscription	198.00	
DOJ Client-Legal Training	180.00	
Bellagios Pizza- Jurisprudence Exam Workgroup meeting	133.46	
Survey Monkey Subscription	204.00	
<u>October - December</u>		1701.89
Kremeworks-Donuts December Board Meeting	15.95	
Paradise Bakery-Coffee October Board Meeting	62.90	
Kremeworks-Donuts October Board Meeting	15.95	
Paradise Bakery-Coffee December Board Meeting	62.90	
Subway - New Board Member Orientation	45.45	
CPR Lifeline - Staff Training	420.00	
Amazon - New Voice Recorder	184.00	
Bridecity Café -October Board Meeting	250.00	
Safeway - Beverages October Board Meeting	4.88	
AED Superstore - New Battery	69.99	
Safeway - Beverages December Board Meeting	4.49	
Bridecity Café -December Board Meeting	312.70	
ADA - CDT Book	44.18	
Paradise Bakery-Lunch December Board Meeting	208.50	
<u>January - March</u>		2592.99
Fedex	13.17	
FARB Registration	725.00	
Safeway - Oral and Maxillofacial Exam	17.97	
PDR - Reference Book	59.95	
Subway - February Board Meeting	168.10	
Bridecity Café -February Board Meeting	146.80	
AADA Agency Annual Dues	1420.00	
Secretary of State- OARs	42.00	
<u>April - June</u>		765.18
Subway - New Board Member Orientation	51.30	
ODC Internet/Electric	105.00	
Bridecity Café -April Board Meeting	162.05	
A-Z Stamping and Engraving	25.65	
Elephants Catering - Interview Committee Mtg	114.70	
Pizza Hut - Interview Committee Mtg	66.48	
Qdoba - April Board Meeting	240.00	
Total SPOTS Card Purchases:		<u><u>6230.80</u></u>

	<u>Sub-total</u>	<u>Total</u>
Travel Reimbursements - Patrick Braatz:		
<u>July - February</u>		
Instate Travel		2,857.96
Out of State Travel		1,817.04
Oct 2014 AADB/AADA Annual Meetings San Antonio TX	1,817.04	
Travel Reimbursements - Stephen Prisby:		
<u>February - June</u>		
Instate Travel		431.55
Out of State Travel	0.00	0.00
<i>Instate Travel</i>		3,289.51
<i>Out of State Travel</i>		1,817.04
<i>Total Reimbursable Travel Expenses:</i>		<u>\$5,106.55</u>
<i>Total SPOTS Card Purchases:</i>		<u>\$6,230.80</u>
<u>Total Reimbursable Travel Expenses & SPOTS Card Expenses</u>		<u>\$11,337.35</u>

**AGENCY HEAD FINANCIAL TRANSACTIONS
AT & T**

AT& T Phone	
Patrick Braatz	
Jul-14	\$30.42
Aug-14	\$30.42
Sep-14	\$30.42
Oct-14	\$30.42
Nov-14	\$30.42
Dec-14	\$30.42
Jan-15	\$30.42
Stephen Prisby	
Feb-15	\$0.00
Mar-15	\$0.00
Apr-15	\$0.00
May-15	\$0.00
Jun-15	<u>\$0.00</u>
TOTAL	\$212.94

AGENCY HEAD FINANCIAL TRANSACTIONS
Annual Leave Report - Fiscal Year 2015

Paid Leave Report	Sick Leave	Vacation	Disc.	Pers. Bus.	Furlough	Total
Patrick Braatz -Beginning Balance	386.62	117.92	40	24	0	568.54
Jul-14	3.25	30.00	0.00	0.00	0.00	33.25
Aug-14	9.25	12.75	0.00	0.00	0.00	22.00
Sep-14	0.00	0.00	0.00	0.00	0.00	0.00
Oct-14	0.00	0.00	0.00	0.00	0.00	0.00
Nov-14	0.00	22.75	0.00	24.00	0.00	46.75
Dec-14	23.25	0.00	8.00	0.00	0.00	31.25
Jan-15	0.00	24.00	32.00	0.00	0.00	32.00
Total paid leave taken (hours)	53.75	73.50	40.00	24.00	0.0	191.25
Leave Accumulation **	66.00	96.72	0	0	0	162.72
Ending Balance	398.87	141.14	0	0	0	540.01

Sick Leave ending balance moved to Clearing Account for two years.
 Vacation ending balance paid out upon separation to Mr. Braatz.

Paid Leave Report	Sick Leave	Vacation	Disc.	Pers. Bus.	Furlough	Total
Stephen Prisby - Beginning Balance (2/7/15)	206.68	161.73	14.00	0.00	0.00	382.41
Feb-15	0.00	0.00	0.00	0.00	0.00	0.00
Mar-15	2.00	0.00	14.00	0.00	0.00	16.00
Apr-15	0.00	0.00	0.00	0.00	0.00	0.00
May-15	0.00	0.00	0.00	0.00	0.00	0.00
Jun-15	0.00	0.00	0.00	0.00	0.00	0.00
Total paid leave taken (hours)	2.00	0	14.00	0	0	16.00
Leave Accumulation **	48.00	60.00	0	0	0	108.00
Ending Balance	252.68	221.73	0	0	0	474.41

**** Leave Accumulations:**

Personal Business -

Full time employees receive 24 hrs. leave to be used for "personal business" each Fiscal Year. This leave must be used during the fiscal year and does not carry over or accumulate.

This leave must be used during the fiscal year and does not carry over or accumulate.

Sick Leave - Full time employees receive 8 hours per month to be used for sick leave. This accumulates indefinitely.

Vacation Leave - The executive director receives 11.34 hours per month based on employment level. This leave accumulates up to 350 hours.

Up to 250 hours can be cashed out at termination from service.

Up to 40 hours may be paid out (called a "vacation payout").

Best Practices Self-Assessment Guide: Information in Support of Best Practices

Best Practices Criteria
<p>1. Executive Director's performance expectations are current.</p> <ul style="list-style-type: none"> • Goals and expectations for the Executive Director are reviewed annually.
<p>2. Executive Director receives annual performance feedback.</p> <ul style="list-style-type: none"> • The Administrative Workgroup reviews the Executive Director's performance annually and makes recommendations to the Board
<p>3. The agency's mission and high-level goals are current and applicable.</p> <ul style="list-style-type: none"> • The OBD's strategic plan is reviewed each biennium as the budget document is developed. Agency performance measures, as well as short and long term goals, are reviewed annually.
<p>4. The Board reviews the Annual Performance Progress Report.</p> <ul style="list-style-type: none"> • Performance measures are reviewed as a part of the budget.
<p>5. The Board is appropriately involved in review of agency's key communications.</p> <ul style="list-style-type: none"> • Board members prepare articles for inclusion in the newsletter
<p>6. The Board is appropriately involved in policy-making activities.</p> <ul style="list-style-type: none"> • The Board's committees review policy making issues. • The Board reviews all legislative proposals that could impact the Board.
<p>7. The agency's policy option budget packages are aligned with their mission and goals.</p> <ul style="list-style-type: none"> • The Board reviews agency's proposed policy option packages. • The Board reviews the Agency Request Budget.
<p>8. The Board reviews all proposed budgets.</p> <ul style="list-style-type: none"> • The Board reviews the Agency Request Budget.
<p>9. The Board periodically reviews key financial information and audit findings.</p> <ul style="list-style-type: none"> • The Board reviews agency head financial and payroll transactions annually at a Board Meeting. • The Board reviews agency performance audits.
<p>10. The Board is appropriately accounting for resources.</p> <ul style="list-style-type: none"> • All Board revenue and expenditures are reviewed by the Board. • All Board expenditures are reviewed and approved by the Executive Director and Office Manager. • Physical inventory of all agency property is conducted annually.
<p>11. The agency adheres to accounting rules and other relevant financial controls.</p> <ul style="list-style-type: none"> • Board staff prepares all transaction entries in accordance with Oregon Statute, Oregon Administrative Rules, Oregon Accounting Manual and Generally Accepted Accounting principles. • The Board has annually received the Department of Administrative Services Comprehensive Annual Financial Report Gold Star Award for timely and complete financial data.

12. Board members act in accordance with their roles as public representatives.

- Board members appropriately recuse themselves from cases which create an actual or potential conflict of interest.
- The Board follows public meetings and records laws.
- The Board uses good judgment in upholding the Board's Mission Statement of Protecting the Citizens of Oregon.

13. The Board coordinates with others where responsibilities and interest overlap.

- Board members and staff participate in appropriate professional associations.
- The OBD works with the OHSU School of Dentistry on certain issues.
- The OBD works with the ODA, ODHA and ODAA and DBIC to present important practice related issues to members.
- The OBD is actively involved in the American Association of Dental Board (AADB) and regional testing agencies.

14. The Board members identify and attend appropriate training sessions.

- New Board members attend new Board member orientation presented by OBD Staff.
- Board members utilize the Governor's Board Training.
- Board Members attend AADE training workshops.

15. The Board reviews its management practices to ensure best practices are utilized.

- On an annual basis.

Best Practices Self-Assessment

Annually, Board members are to self-evaluate their adherence to a set of best practices and report the percent total best practices met by the Board (percent of yes responses in the table below) in the Annual Performance Progress Report as specified in the agency Budget instructions.

Best Practices Assessment Score Card

Best Practices Criteria	Yes	No
1. Executive Director's performance expectations are current.		
2. Executive Director receives annual performance feedback.		
3. The agency's mission and high-level goals are current and applicable.		
4. The Board reviews the Annual Performance Progress Report.		
5. The Board is appropriately involved in review of agency's key communications.		
6. The Board is appropriately involved in policy-making activities.		
7. The agency's policy option budget packages are aligned with their mission and goals.		
8. The Board reviews all proposed budgets.		
9. The Board periodically reviews key financial information and audit findings.		
10. The Board is appropriately accounting for resources.		
11. The agency adheres to accounting rules and other relevant financial controls.		
12. Board members act in accordance with their roles as public representatives.		
13. The Board coordinates with others where responsibilities and interest overlap.		
14. The Board members identify and attend appropriate training sessions.		
15. The Board reviews its management practices to ensure best practices are utilized.		
Total Number		
Percentage of total:		



**TRI-COUNTY METROPOLITAN TRANSPORTATION
DISTRICT OF OREGON**

**EMPLOYER CONTRACT
FOR**

TRIMET UNIVERSAL ANNUAL PASS FARE PROGRAM

This Contract is entered into September 1st, 2015 by and between the Tri-County Metropolitan Transportation District of Oregon ("TriMet") and **OREGON BOARD OF DENTISTRY** ("Employer") located at 1500 SW 1st Avenue, Suite 770, Portland, OR 97201.

1. Universal Annual Pass Program
Employer shall implement the Universal Annual Pass Program at Employer's work site(s) in accordance with the Administrative Program Requirements, attached and incorporated as Exhibit A, which may be amended by TriMet. By signature hereto, Employer certifies that it has read and agrees to be bound by all of the Administrative Program Requirements set forth in Exhibit A, including but not limited to the Requirements initialed by Employer.

2. Term
This Contract shall be in effect from the date listed above through August 31st, 2016, unless terminated sooner by TriMet as provided in the Program Requirements. TriMet also may terminate this Contract upon 30 days advance written notice to Employer, and in such event where Employer is in compliance with this Contract, TriMet will reimburse Employer for all returned Universal Annual Pass validation stickers based on the number of days remaining in the Contract term.

3. Employer Payment
Employer's total payment due under this Contract is **\$1,564.65**. Refer to Exhibit C for calculation of Universal Annual Pass price. Employer's Universal Annual Pass price per employee per year under this Contract is **\$521.55**. Additional stickers purchased during the contract year will be prorated based on this price, as set forth in section E.2) of Exhibit A of this contract.

4. Universal Annual Pass Qualified Employees
The total number of Employer's qualified employees, as defined in Exhibit A, Paragraph B, is **3**. The Employee Commute Options survey was performed **June 1, 2014**, the results of which are contained in the attached and incorporated Exhibit B.

5. Correspondence/Communications
TriMet's Marketing Representative and Employer's Transportation Coordinator shall be responsible for routine, day-to-day correspondence regarding Employer's implementation of the Universal Annual Pass program. Upon commencement of this Contract, TriMet and Employer shall provide written notice to each other of the name and address of their respective designated

Marketing Representative and Transportation Coordinator, and shall provide prompt written notice of any change thereto. All other correspondence and communications pertaining to this Contract shall be provided to the individuals signing on behalf of the parties at the addresses indicated below the signature line.

6. No Third Party Beneficiary

Employer and TriMet are the only parties to this Contract and as such are the only parties entitled to enforce its terms. Nothing in this Agreement gives or shall be construed to create or provide any legal right or benefit, direct, indirect or otherwise to any other party unless that party is individually identified by name herein with the express and stated designation as an intended beneficiary of the terms of this Agreement.

7. Authority

Employer agrees to comply with the requirements set forth in this Contract. The representatives signing on behalf of the parties certify that they are duly authorized by the party for which they sign to make this Contract.

8. Execution of Contract

This Contract and any written modifications thereto, may be executed in two or more counterparts, each of which together shall be deemed an original, but all of which together shall constitute one and the same instrument. In the event that any signature is delivered by facsimile transmission or by e-mail delivery of a "pdf" format date file, such signature shall create a valid and binding obligation of the party executing (or on whose behalf such signature is executed) with the same force and effect as if such facsimile or "pdf" signature page were an original thereof.

OREGON BOARD OF DENTISTRY

**THE TRI-COUNTY METROPOLITAN
TRANSPORTATION DISTRICT OF OREGON**

By: _____
signature

By: _____
signature

Date: _____

Date: _____

Name: _____
please print

Name: Bernie Bottomly

Title: _____

Title: Executive Director of Public Affairs

Address: _____

Telephone Number: _____

Federal Employer ID Number: _____

TriMet Universal Annual Pass Fare Program
ADMINISTRATIVE PROGRAM REQUIREMENTS
Effective September 1, 2015

As part of a regional employer transportation program, TriMet offers the Universal Annual Pass Program (Program) to employers within the TriMet service district. Employers shall implement and maintain the Program at their worksite(s) according to the following program requirements:

A. Definition Of A Worksite

- 1) A “worksite” is a building or group of buildings located at one physical location within the TriMet service district and under the control of an employer.
- 2) An employer with multiple worksites in the district may include out-of-district worksites, provided that the out-of-district worksite represents less than 25% of the employer’s total number of enrolled employees within the TriMet district.

B. Definition Of A Qualified Employee

- initial here*
- 1) Participating employers must purchase a pass (validation sticker) for each qualified employee (100% participation) at each participating worksite regardless of whether the employee uses transit at the time of purchase.
 - 2) For the purposes of the Program, a “qualified” employee is defined as any person on, or expected to be on, the employer’s payroll, full or part-time, for at least six consecutive months, including business owners, associates, partners, and partners classified as professional corporations. Part-time is defined as 80 or more hours per 28-day period.
 - 3) An employee who works at multiple worksites is considered a qualified employee at the worksite of his/her cost center. A cost center is the department through which the employee’s salary is paid.
 - 4) Contract employees, per-diem employees, and/or temporary employees are considered qualified employees only if they are covered under the employer’s benefits package and have been included in the employee commute options survey.
 - 5) Exempted from the Program are:
 - Part-time volunteers (defined as less than 80 hours per 28-day period);
 - Full-time volunteers (defined as 80 or more hours per 28-day period);
 - Employees working less than part-time (less than 80 hours per 28-day period);
 - Field personnel required to use their personal vehicle as a condition of their job;
 - Employees whose regular work commute has either a start or an end time outside of TriMet’s service hours (service hours are 5:00 A.M through 1:00 A.M.);
 - Residents of the State of Washington;
 - Independent contractors;
 - Temporary or seasonal employees hired for a term of less than six (6) months;
 - Employees exempted by the Department of Environmental Quality (DEQ) for Employee Commute Option (ECO) rule purposes;
 - Regularly sworn officers of local law enforcement agencies within the TriMet boundaries, including the Oregon State Police; and
 - Employees who have an annual transit pass from another source (i.e., employee is a TriMet dependent or works for two employers and has received a validation sticker through the other employer).
 - 6) Subject to the following subparagraph (7), categories of employees and volunteers who are exempted from the Program, as defined in B.5) above, also must be excluded from the employee commute options survey. The total number of employee exemptions shall not exceed 50% of the employer’s total employee population.
 - 7) If an employer wishes to include categories of exempted employees and/or volunteers in the Program, as defined in B.5) above, the exempted personnel to be included must have photo identification issued by the contracting employer and must be included in the employee commute options survey.
 - An employer must purchase a validation sticker for 100% of the category(s) of exempted personnel.
 - The exempted personnel must be surveyed prior to receiving validation stickers.

C. Definition of Transit Mode Split

- 1) The transit mode split is defined as follows:
(Total number of transit trips to the worksite by qualified employees) divided by (Total number of trips to the worksite by qualified employees).
- 2) If more than one commute mode is used to travel to a worksite, the commute mode for the longest portion of the trip constitutes the commute mode for the purposes of the Program.

D. Survey Requirements

- 1) The Program's pricing structure is dependent on an accurate determination of the employer's transit mode split. To determine the transit mode split, employers must survey their qualified employees (and categories of exempted employees, if included in the Program) at each worksite separately using an employee commute options survey or similar survey approved by TriMet (hereinafter "survey").
- 2) Surveys must be conducted for each participating worksite on the following schedule:
 - a. For the first year of participation:
 - i. A pre-program survey, within twelve months prior to the start date of the first year contract, of all qualified employees to determine transit mode split and first year contract pricing; and
 - ii. A follow-up survey before the date on which the next year's contract will take effect, to determine the next year's contract pricing and the effectiveness of the program; and
 - b. For all subsequent years:
 - i. A follow-up survey at least every other year after the first follow-up survey. Each subsequent follow-up survey must be conducted within twelve months prior to the date on which the next contract will take effect.
 - ii. The most recent survey data available will be used to determine the pass price, even if the survey conducted is for reasons other than to meet the minimum survey requirements for the Program, provided that it is performed in accordance with these Program Requirements.
 - c. Surveys shall not be conducted more than once within the period of three months, without prior approval from TriMet.
- 3) The survey instrument must be approved by TriMet; and
 - a. The survey must be distributed to all qualified employees and achieve a return rate of a minimum of 75%; or
 - b. Companies with 400 or more employees at a worksite may use a statistically valid sampling methodology approved by TriMet with the prior approval of DEQ or TriMet and achieve a return rate of a minimum of 75%.
 - c. Companies with 15 employees or less must survey 100% of their eligible employees.
- 4) Surveys must be distributed during the week following a typical workweek for the worksite and not bordering on a holiday.
- 5) If an employer moves a worksite to a different location during a contract year, the original contract price remains valid until the expiration of the contract. In the event that the new location results in a significant change in transit service from the previous location, the employer must re-survey its qualified employees before the date on which the next contract will take effect to identify the transit mode split at the new worksite. The next contract price will be calculated according to the transit mode split at the new worksite location. The survey schedule for subsequent contract years will be determined as set forth above in D.2)b. Employers that move to a new location with a significant decrease in transit service shall not be subject to a limit to a maximum annual price decrease.
- 6) An employer may participate at individual worksites, or all worksites. If an employer wishes to participate in the Program at more than one worksite, the employer must survey qualified employees at each worksite separately to determine the transit mode split at each worksite. Each worksite's price per pass is based on the transit mode split at that site.
 - a. If an employer adds a worksite(s) during the term of a contract, additional validation stickers may be purchased for all qualifying employees at the new worksite(s) at the existing price per pass dictated by this contract for the term of this contract. After the first full contract term, a survey must be performed at the new worksite(s) to determine the transit mode split to be used for the calculation of the following

contract year's price per pass, after which the survey schedule for the new worksite(s) will follow according to the schedule established by the contract that is in effect.

- b. If an employer wishes to purchase the Program for employees at an out-of-district worksite, it is not necessary to survey those employees and if they are surveyed, the resulting information cannot be used to determine overall transit mode split. The out-of-district worksite(s)'s price per pass shall be that dictated by this contract.

E. Fare Requirements; General

- 1) The price of the fare shall be calculated based on an annual contract term of September 1 through August 31 in accordance with Paragraph F below. For employers joining the Program mid-year, the price of the fare shall be prorated based on the number of months remaining in the annual term (September 1 through August 31).
- 2) TriMet will issue validation stickers for all qualified employees at the employer's contract price. If the employer hires additional qualified employees during the contract term, the employer shall purchase additional validation stickers, at a prorated cost based on the number of months remaining in the contract term (September 1 through August 31) for these additional new hires.
- 3) TriMet does not prohibit employers from re-selling the validation stickers to their employees; however, the validation sticker price shall not exceed the employer's per employee sticker purchase price.
- 4) TriMet will not provide refunds for terminated employees. Replacement validation stickers will be provided for replacement employees only in accordance with paragraph G.8) below.

F. Contract Pricing

- 1) Employer's per pass (validation sticker) pricing calculation formula is based on the fare in effect during the contract period as set forth at TriMet Code Sections 19.15(C)(8)(a), (c) and (d) (*a copy of TMC Section 19.15(C)(8)(a), (c) and (d) is available at www.TriMet.org or on request from TriMet*).
- 2) Employer's Total Contract Pricing shall be calculated as follows:
 - a. (# of qualified employees) x (per pass price) = total contract amount.
 - b. The minimum annual contract price shall be the amount of the Annual Adult pass price in effect at the beginning of the contract year. This amount is subject to pro-rating for less than a contract term year, as outlined in these Program Requirements.

G. Fare Instrument; Use of Stickers; Remedies

- 1) Employer shall provide qualified employees with a photo identification (ID) card which shall be affixed with the validation sticker provided by TriMet. Only the employer's designated program administrator, or the program administrator's designee, may affix the validation sticker to employee photo ID cards. The sticker must be placed on the ID card near the employee's photo. The employee's ID card with the affixed sticker shall constitute the fare instrument and must be carried by the employee as proof of fare payment. The validation sticker remains the property of TriMet, the use of which is subject to the terms of the contract between employer and TriMet. Employer shall keep validation stickers in secure locked storage, accessible only to the employer's designated program administrator(s).
initial here

- 2) The employer shall verify qualified employee status before providing an employee with a validation sticker. Only one validation sticker may be distributed per qualified employee.
initial here

- 3) The fare instrument may not be provided to or used by anyone other than the qualified employee to whom it is issued, and is a valid fare instrument only for the person whose name and photo appear on the identification card. Any alteration of the validation sticker, including removal of the serial number, shall render the fare instrument invalid. Use of the fare instrument is subject to all provisions in the TriMet Code, violation of which may result in fines, exclusion, or other penalty as provided by the Code.
initial here

- 4) At the request of employer, TriMet may create a standard photo ID card template for the purpose of creating photo ID cards for the Program. TriMet may charge a reasonable administrative fee for this service.
- 5) Employee photo ID cards already provided by the employer, may be used as the fare instrument when affixed with a validation sticker if approved by TriMet as an acceptable fare instrument prior to use. The ID card must display the following:
 - a. A photo of the employee;

- b. The employee's name; and
 - c. The company's name.
- 6) The employee's photo ID card with an affixed validation sticker is valid as the fare instrument through the month and year shown on the validation sticker, and shall allow travel for TriMet services within the TriMet service district, including regular bus and MAX service, Streetcar and LIFT service.
 - 7) TriMet does not replace lost or stolen validation stickers. TriMet, in its sole discretion, may replace damaged or destroyed validation stickers; TriMet reserves the right to require employers to provide adequate documentation of the damaged or destroyed stickers(s). If the employer cannot provide documentation of damaged or destroyed sticker(s), the employer may purchase additional stickers at a prorated price based on the number of months remaining in the contract year (September 1 through August 31).
 - 8) TriMet may provide replacement stickers for replacement employees. Employer must collect employee validation sticker upon an employee's separation from employment. TriMet reserves the right, in its sole discretion, to require employer to provide upon request the separated employee's validation sticker or other written documentation approved by TriMet evidencing that employer has disabled the effectiveness of the separated employee's fare instrument. Replacement stickers shall be provided only in accordance with the requirements set forth in this paragraph G.8).
 - 9) In the event that TriMet reasonably believes that any of an employer's employees has duplicated, altered, or otherwise used the validation sticker in a manner not authorized by the contract, upon notice from TriMet, employer shall conduct a reasonable investigation of the matter, including notice to the employee and an opportunity for the employee to respond. Employer shall submit written findings of its investigation to TriMet. TriMet reserves the right to make its own independent investigation and determinations as to whether the misuse occurred. If, based on the results of an investigation, TriMet determines that the misuse occurred, TriMet reserves the right to require employer to return the employee's validation sticker or provide written assurance to TriMet that employer has disabled the effectiveness of the employee's fare instrument. Employer shall not forward any employer-generated photo ID cards to TriMet. In addition, TriMet reserves all rights and remedies available under law.
 - 10) If TriMet reasonably determines that employer has provided falsified information, intentionally provided validation stickers to non-qualified employees or other ineligible persons, or that employer is otherwise in breach of the contract including but not limited to failure to make a contract payment when due, TriMet reserves the right in its sole discretion to demand within the timelines specified by TriMet, that employer return any or all validation stickers, or that employer provide other written assurance that employer has disabled the effectiveness of any fare instruments, and may also immediately terminate the contract. In addition, TriMet reserves all rights and remedies available under law. In the event of termination by TriMet, employer's sole remedy shall be reimbursement for any undistributed validation stickers returned to TriMet so long as employer's failure to distribute the stickers did not constitute a breach of the contract and employer is otherwise not in default of the contract terms; any reimbursement to employer may be prorated by TriMet based on the number of days remaining in the contract term.
 - 11) In any action or suit based upon any of the rights and obligations of the parties contained in the contract where TriMet is the prevailing party, employer shall be liable for TriMet's reasonable attorneys fees and its costs and disbursements.
 - 12) In no event shall TriMet be liable for any consequential, special, incidental or punitive damages, whether under theory of tort, contract, statute or otherwise.
 - 13) The terms and conditions of the Oregon Tort Claims Act, ORS 30.260 through ORS 30.300, and to the extent applicable, Article XI, Section 7, of the Oregon Constitution shall apply to employer's and TriMet's performance of this Agreement.

H. Payment Options; Issuance of Validation Stickers; and Contract Remedies

- 1) The employer shall be required to enter into a written contract based on the annual term of September 1 through August 31, in a minimum annual amount of the Annual Adult pass. The contract amount may be prorated for less than one year, as provided for in these program requirements. An employer signed contract must be received by TriMet before the contract start date.
- 2) Subject to (a) and (b) below, Employers with a total contract amount of \$6,050 or greater may elect to submit the total payment amount in full, or shall pay the total payment in equal quarterly installments.

Employers with a total contract amount of less than \$6,050 must submit payment in full.

- a. Payment in Full: All Employers new to the Program must submit full payment prior to receiving validation stickers, in which case a discount of 3% off the entire contract balance may be taken. Employers renewing their participation in the Program by executing a new contract, with prior credit approval from TriMet, will be invoiced with payment due net 30 days from the invoice date or the contract start date, whichever is later, in which case a discount of 3% off the entire contract balance may be taken. If full payment is not received by TriMet within the time allotted by this contract, the 3% discount will be void.
 - b. Quarterly Payments: Employers new to the Program that are eligible to elect to make quarterly payments are required to submit payment for the first quarter prior to receiving validation stickers, with subsequent quarterly payments due net 30 days from the invoice date. Employers renewing their participation in the Program by executing a new contract, with prior credit approval from TriMet, will be invoiced for the first quarter with payment due net 30 days from the invoice date or the contract start date, whichever is later. Employers who elect to make quarterly payments are ineligible for the 3% discount.
- 3) Payment for additional validation stickers purchased throughout the contract year must be paid in one lump sum, and will not be calculated into remaining quarterly payments. Payment for additional validation stickers is due net 30 days from the date of the invoice. If employer is an entity for which applicable law specifies a maximum time period for payment, that maximum time period shall apply.
 - 4) Payments not received by the due date will accrue interest at an annual rate of 18%. If employer is an entity for which applicable law specifies a maximum interest rate that the entity may pay, that maximum interest rate shall apply.
 - 5) In the event an employer fails to make a payment as scheduled in the contract, TriMet reserves all its rights and remedies under law, including but not limited to the right to suspend future issuance of validation stickers and as otherwise provided in Paragraph G above.
 - 6) Invoices past due over 90 days will be forwarded to TriMet's Legal Department for further action.
 - 7) Payment(s) shall be made by either ACH or submitted to TriMet's Finance Department, Attn: Accounts Receivable at TriMet M/S 02, PO Box 4300, Portland, OR 97208.
 - 8) Validation stickers will be provided to the employer, normally within ten (10) business days of TriMet's receipt of an employer's total payment or first quarterly installment due as described above. For employers renewing their participation in the Program by executing a new contract, and with prior credit approval from TriMet, validation stickers will be provided normally within ten (10) business days of receipt of an employer's signed contract. TriMet is not responsible for late deliveries. A designated representative of the employer must sign for receipt of the validation stickers. TriMet reserves the right to limit the number of validation stickers provided at any one time, or to determine the distribution schedule thereof.

I. Employer Designated Agents

- 1) Employer may elect to participate in the Program through their designated agent ("Employer Designated Agent"). Employer Designated Agent will enter into a contract with TriMet for implementation of the Program in accordance with these Program requirements, including the purchase of and payment for validation stickers.
- 2) Employer Designated Agent must be an incorporated entity, established for the purpose of providing administrative services to facilitate employer transportation options or other employer related services, including commercial or industrial property management and/or other transportation related services.
- 3) Upon TriMet's request, Employer Designated Agent shall provide TriMet with written authorization from employer on employer's official letterhead evidencing employer's designation of Employer Designated Agent.

J. Information Required of Employers

- 1) Prior to contract approval, TriMet must receive the survey data form, or an equivalent document with the following information:
 - a. the total number of employees, in all work groups;
 - b. the total number of qualified employees, according to these Program requirements;
 - c. the total number of employees in other employee work groups included in the Program; and a copy of the employer's survey results and data. A participating employer must conduct follow-up surveys as

defined above, with results and data provided to TriMet. The survey instruments must be in conformance with the survey requirements as described in these program requirements.

d. TriMet shall not be bound and assumes no obligation in any respect with regard to the Program until TriMet's authorized signator executes the contract.

- 2) TriMet, at its sole discretion, may require an employer to verify the number of qualified employees and to confirm employee status at any time during the term of the contract. TriMet may also require an employer to demonstrate that validation stickers are kept in secure locked storage, accessible only to the employer's designated program administrator(s).
- 3) Employees must sign a statement (Employee Agreement Form) verifying receipt of a validation sticker. The statement includes a signed acknowledgement by the employee that the validation sticker and the photo ID card affixed with the validation sticker (fare instrument) are non-transferable and may only be used by the employee to whom it was issued, and that the sticker must be returned to the employer upon separation from employment. Employees determined to knowingly violate these terms may face criminal prosecution for theft of services.
- 4) Each validation sticker includes a unique serial number for the purposes of tracking and control. For each employee that receives a validation sticker, the employer's designated program administrator, or the program administrator's designee, shall record the validation sticker's serial number on the Employee Agreement Form, along with the employees' signed statement agreeing to the terms and conditions of receiving the fare instrument.
- 5) All fields of the Employee Agreement Form must be completed in full. The employer must return a copy of the Employee Agreement Form to TriMet by October 1st, and make the form available for TriMet's review upon request by TriMet. The employer shall retain a copy of the Employee Agreement Form through the end of the contract period.

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UNFINISHED
BUSINESS
&
RULES

Secretary of State
Certificate and Order for Filing
TEMPORARY ADMINISTRATIVE RULES
A Statement of Need and Justification accompanies this form.

FILED
4-17-15 2:34 PM
ARCHIVES DIVISION
SECRETARY OF STATE

I certify that the attached copies are true, full and correct copies of the TEMPORARY Rule(s) adopted on Upon filing, by the
Oregon Board of Dentistry 818

Agency and Division

Administrative Rules Chapter Number

Stephen Prisby

(971) 673-3200

Rules Coordinator

Telephone

1500 SW 1st Ave., Suite 770, Portland, OR 97201

Address

To become effective 04/17/2015 through 10/13/2015.

RULE CAPTION

Temporary Rules to amend Dental Hygiene Rules on prescriptive authority.

Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

RULEMAKING ACTION

Secure approval of new rule numbers with the Administrative Rules Unit prior to filing.

ADOPT:

AMEND:

818-035-0025, 818-035-0030

SUSPEND:

Statutory Authority:

ORS 679 and 680

Other Authority:

Statutes Implemented:

ORS 293.445, ORS 679.020(1), 679.025(2)(j), 679.060, 679.115, 679.120, 679.250, 680.050, 680.075, 680.200 and 680.205

RULE SUMMARY

Amends OAR 818-035-0025 to add prescriptive authority for dental hygienists for certain drugs related to dentistry.

Amends OAR 818-035-0030 to add prescriptive authority for dental hygienists for certain drugs related to dentistry.

Stephen Prisby

stephen.prisby@state.or.us

Rules Coordinator Name

Email Address

Secretary of State
STATEMENT OF NEED AND JUSTIFICATION
A Certificate and Order for Filing Temporary Administrative Rules
accompanies this form

FILED
4-17-15 2:34 PM
ARCHIVES DIVISION
SECRETARY OF STATE

Oregon Board of Dentistry
Agency and Division

818
Administrative Rules Chapter Number

Temporary Rules to amend Dental Hygiene Rules on prescriptive authority.

Rule Caption (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

In the Matter of:

OAR 818-035-0025
OAR 818-035-0030

Statutory Authority:

ORS 679 and 680

Other Authority:

Statutes Implemented:

ORS 293.445, ORS 679.020(1), 679.025(2)(l), 679.060, 679.115, 679.120, 679.250, 680.050, 680.075, 680.200 and 680.205

Need for the Temporary Rule(s):

These temporary rules are needed until the Board can schedule a public rulemaking hearing and promulgate permanent rules on this and future rules changes. The Oregon Legislature has information regarding all legislation on their website. The OBD will post the Temporary rules also on our website. www.oregon.gov/dentistry

Documents Relied Upon, and where they are available:

Need for the Temporary Rule(s):

The amendments to OAR 818-035-0025 and OAR 818-035-0030 are to be consistent with the passage of Senate Bill 302, which outlines the type of prescriptive authority dental hygienists will have effective with the implementation of this rule.

These temporary rules are needed until the Board can schedule a public rulemaking hearing and promulgate permanent rules on this and future rules changes. The Oregon Legislature has information regarding all legislation on their website. The OBD will post the amended rules also on our website. www.oregon.gov/dentistry

Justification of Temporary Rule(s):

Without these temporary rules regarding dental hygiene prescriptive authority, the current OARs would not be consistent with SB 302 which clarifies that dental hygienists have specific prescriptive authority and would cause licensees and the public confusion regarding the rules.

Stephen Prisby

stephen.prisby@state.or.us

Printed Name

Email Address

1 **DIVISION 35**

2 **818-035-0025**

3 **Prohibitions**

4 A dental hygienist may not:

- 5 (1) Diagnose and treatment plan other than for dental hygiene services;
- 6 (2) Cut hard or soft tissue with the exception of root planing;
- 7 (3) Extract any tooth;
- 8 (4) Fit or adjust any correctional or prosthetic appliance except as provided by OAR 818-035-
- 9 0030(1)(h);
- 10 (5) **Prescribe, Administer** or dispense any drugs except as provided by OAR 818-035-0030,
- 11 818-035-0040, 818-026-0060(11) and 818-026-0070(11);
- 12 (6) Place, condense, carve or cement permanent restorations except as provided in OAR 818-
- 13 035-0072, or operatively prepare teeth;
- 14 (7) Irrigate or medicate canals; try in cones, or ream, file or fill canals;
- 15 (8) Use the behavior management techniques of Hand Over Mouth (HOM) or Hand Over Mouth
- 16 Airway Restriction (HOMAR) on any patient.
- 17 (9) Place or remove healing caps or healing abutments, except under direct supervision.
- 18 (10) Place implant impression copings, except under direct supervision.

19 Stat. Auth.: ORS 679 & 680

20 Stats. Implemented: ORS 679.020(1)

21

22 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-

23 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-

24 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,

25 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-

26 08; OBD 4-2011, f. & cert. ef. 11-15-11; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14

1 **DIVISION 35**

2 **818-035-0030**

3 **Additional Functions of Dental Hygienists**

4 (1) In addition to functions set forth in ORS 679.010, a dental hygienist may perform the
5 following functions under the general supervision of a licensed dentist:

- 6 (a) Make preliminary intra-oral and extra-oral examinations and record findings;
- 7 (b) Place periodontal dressings;
- 8 (c) Remove periodontal dressings or direct a dental assistant to remove periodontal dressings;
- 9 (d) Perform all functions delegable to dental assistants and expanded function dental assistants
10 providing that the dental hygienist is appropriately trained;
- 11 (e) Administer and dispense antimicrobial solutions or other antimicrobial agents in the
12 performance of dental hygiene functions.
- 13 (f) **Prescribe, A**administer and dispense fluoride, fluoride varnish, antimicrobial solutions for
14 mouth rinsing or other non-systemic antimicrobial agents.
- 15 (g) Use high-speed handpieces to polish restorations and to remove cement and adhesive
16 material.
- 17 (h) Apply temporary soft relines to complete dentures for the purpose of tissue conditioning.
- 18 (i) Perform all aspects of teeth whitening procedures.

19 (2) A dental hygienist may perform the following functions at the locations and for the persons
20 described in ORS 680.205(1) and (2) without the supervision of a dentist:

- 21 (a) Determine the need for and appropriateness of sealants or fluoride; and
- 22 (b) Apply sealants or fluoride.

23

24 Stat. Auth.: ORS 679 & 680

25 Stats. Implemented: ORS 679.025(2)(j)

26 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;
27 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-
28 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.
29 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-
30 2009, f. 10-21-09, cert. ef. 11-1-09; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14

**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

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

.....
Peter Courtney, President of Senate

Passed by House March 16, 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

Secretary of State
Certificate and Order for Filing
TEMPORARY ADMINISTRATIVE RULES
A Statement of Need and Justification accompanies this form.

FILED
6-26-15 4:23 PM
ARCHIVES DIVISION
SECRETARY OF STATE

I certify that the attached copies are true, full and correct copies of the TEMPORARY Rule(s) adopted on Upon filing, by the
Oregon Board of Dentistry 818

Agency and Division

Administrative Rules Chapter Number

Stephen Prisby

(971) 673-3200

Rules Coordinator

Telephone

1500 SW 1st Ave., Suite 770, Portland, OR 97201

Address

To become effective 06/26/2015 through 12/22/2015.

RULE CAPTION

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

Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

RULEMAKING ACTION

Secure approval of new rule numbers with the Administrative Rules Unit prior to filing.

ADOPT:

AMEND:

818-001-0087

SUSPEND:

Statutory Authority:

Stat. Auth.: ORS 679 & 680

Other Authority:

Statutes 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.

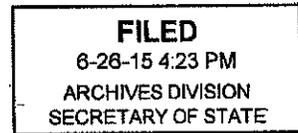
Stephen Prisby

stephen.prisby@state.or.us

Rules Coordinator Name

Email Address

Secretary of State
STATEMENT OF NEED AND JUSTIFICATION
A Certificate and Order for Filing Temporary Administrative Rules
accompanies this form



Oregon Board of Dentistry
Agency and Division

818
Administrative Rules Chapter Number

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

Rule Caption (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

In the Matter of:

OAR 818-001-0087

Statutory Authority:

Stat. Auth.: ORS-679 & 680

Other Authority:

Statutes Implemented:

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

Need for the Temporary Rule(s):

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, Dental Faculty License Fees will be increased from \$260.00 to \$335.00 and Dental Hygiene License Fees will be increased from \$155.00 to \$230.00

Documents Relied Upon, and where they are available:

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

Justification of 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.

Stephen Prisby

Printed Name

stephen.prisby@state.or.us

Email Address

1 **Division 1**

2 **Procedures**

3 **818-001-0087**

4 **Fees**

5 (1) The Board adopts the following fees:

6 (a) Biennial License Fees:

7 (A) Dental — ~~\$315~~ **390**;

8 (B) Dental — retired — \$0;

9 (C) Dental Faculty — ~~\$260~~ **335**;

10 (D) Volunteer Dentist — \$0;

11 (E) Dental Hygiene — ~~\$155~~ **230**;

12 (F) Dental Hygiene — retired — \$0;

13 (G) Volunteer Dental Hygienist — \$0.

14 (b) Biennial Permits, Endorsements or Certificates:

15 (A) Nitrous Oxide Permit — \$40;

16 (B) Minimal Sedation Permit — \$75;

17 (C) Moderate Sedation Permit — \$75;

18 (D) Deep Sedation Permit — \$75;

19 (E) General Anesthesia Permit — \$140;

20 (F) Radiology — \$75;

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

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

23 (I) Instructor Permits — \$40;

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

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

26 (L) Anesthesia Dental Assistant — \$50;

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

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

29 (c) Applications for Licensure:

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

31 (B) Dental Faculty — \$305;

32 (C) Dental Hygiene — \$180;

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

34 (d) Examinations:

- 35 (A) Jurisprudence — \$0;
- 36 (B) Dental Specialty:
- 37 (i) If only one candidate applies for the exam, a fee of \$2,000.00 will be required at the time of
- 38 application; and
- 39 (ii) If two candidates apply for the exam, a fee of \$1,000.00 will be required at the time of
- 40 application; and
- 41 (iii) If three or more candidates apply for the exam, a fee of \$750.00 will be required at the time
- 42 of application.
- 43 (e) Duplicate Wall Certificates — \$50.
- 44 (2) Fees must be paid at the time of application and are not refundable.
- 45 (3) The Board shall not refund moneys under \$5.01 received in excess of amounts due or to
- 46 which the
- 47 Board has no legal interest unless the person who made the payment or the person's legal
- 48 representative requests a refund in writing within one year of payment to the Board.

49
50

51 Stat. Auth.: ORS 679 & 680

52 Stats. Implemented: ORS 293.445, 679.060, 679.115, 679.120, 679.250, 680.050, 680.075,
53 680.200 & 680.205

54 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-
55 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;
56 Renumbered from 818-001-0085; DE 2-1989(Temp), f. & cert. ef. 11-30-89; DE 1-1990, f. 3-19-
57 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-
58 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.
59 & cert. ef. 6-8-98; OBD 3-1999, f. 6-25-99, cert. ef. 7-1-99; Administrative correction, 8-2-99;
60 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-
61 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;
62 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.
63 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-
64 11 thru 12-27-11; OBD 4-2011, f. & cert. ef. 11-15-11; OBD 1-2012, f. & cert. ef. 1-27-12; OBD
65 1-2013, f. 5-15-13, cert. ef. 7-1-13; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14

**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

Memorandum

To: Attendees of OBD public rulemaking hearing on August 27, 2015 @ 6:30 p.m.

From: Stephen Prisby, Executive Director

Re: Oregon Medical Board Conference Room - Suite 620 access

The Crown Plaza closes the 1st floor lobby/access at 6:00 p.m.

The building must be accessed on the 2nd floor. There is a security desk/guard that may require you to sign in with and show I.D.

The parking garage is directly across the street from our building (The Crown Plaza).

The access is via two walkways on the 2nd floor. If you walk up to the building there are stairs that take you to the second floor.

The rulemaking hearing is being held in the Oregon Medical Board's Conference room on the 6th floor.

Please contact the OBD if you have any questions. Thank you.

Secretary of State
NOTICE OF PROPOSED RULEMAKING HEARING*
A Statement of Need and Fiscal Impact accompanies this form

FILED 7-9-15 11:35 AM ARCHIVES DIVISION SECRETARY OF STATE
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Oregon Board of Dentistry Agency and Division	818 Administrative Rules Chapter Number
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Stephen Prisby Rules Coordinator	(971) 673-3200 Telephone
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Oregon Board of Dentistry, 1500 SW 1st Ave., Suite 770, Portland, OR 97201 Address

RULE CAPTION

Amending 22 Rules regarding practice, definitions, fees, anesthesia, education, hygiene, assistants and continuing education rules.

Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

Hearing Date	Time	Location	Hearings Officer
8-27-15	6:30 p.m.	Crown Plaza in the Oregon Medical Board's Conference Room @ 6:30	OBD President

RULEMAKING ACTION

Secure approval of rule numbers with the Administrative Rules Unit prior to filing.

ADOPT:

AMEND:

- OAR 818-001-0002 Definitions
- OAR 818-001-0087 Fees
- OAR 818-012-0030 Unprofessional Conduct
- OAR 818-021-0060 Continuing Education - Dentists
- OAR 818-021-0070 Continuing Education - Dental Hygienists
- OAR 818-026-0010 Definitions
- OAR 818-026-0020 Presumption of Degree of Central Nervous System Depression
- OAR 818-026-0030 Requirement for Anesthesia Permit, Standards and Qualifications of an Anesthesia Monitor
- OAR 818-026-0040 Qualifications, Standards Applicable, and Continuing Education Requirements for Anesthesia Permits: Nitrous Oxide Permit
- OAR 818-026-0050 Minimal Sedation Permit
- OAR 818-026-0060 Moderate Sedation Permit
- OAR 818-026-0065 Deep Sedation
- OAR 818-026-0070 General Anesthesia Permit
- OAR 818-026-0080 Standards Applicable When a Dentist Performs Dental Procedures and a Qualified Provider Induces Anesthesia
- OAR 818-026-0110 Office Evaluations
- OAR 818-035-0025 Prohibitions
- OAR 818-035-0030 Additional Functions of Dental Hygienists
- OAR 818-035-0065 Expanded Practice Dental Hygiene Permit
- OAR 818-042-0040 Prohibited Acts
- OAR 818-042-0050 Taking of X-Rays - Exposing of Radiographs
- OAR 818-042-0070 Expanded Function Dental Assistants (EFDA)
- OAR 818-042-0090 Additional Functions of EFDAs

REPEAL:

- OAR 818-001-0087 Temporary Rule that will now be permanent
- OAR 818-035-0025 Temporary Rule that will now be permanent
- OAR 818-035-0030 Temporary Rule that will now be permanent

RENUMBER: Secure approval of new rule numbers with the Administrative Rules Unit prior to filing.

AMEND AND RENUMBER: Secure approval of new rule numbers with the Administrative Rules Unit prior to filing.

Statutory Authority:

ORS 183.325-183.355, 183.400, 679.250, 679.255, 680.150, 680.200, 680.205.

Other Authority:

Statutes Implemented:

670.260, 676.185, 676.190, 676.195, 676.200, 679.010, 679.020, 679.025, 679.060, 679.090, 679.115, 679.120, 679.140, 679.160, 679.170, 679.250, 680.050, 680.072, 680.075, 680.082, 680.100, 680.150, 680.200, 680.205.

RULE SUMMARY

The Board is amending 818-001-0002 Definitions. The amendment to 818-001-0002 is to define what a dental study group is.

The Board is repealing Temporary Rule 818-001-0087 Fees which was effective July 1, 2015, to make it permanent. The amendment to 818-001-0087 is to raise the biennial license fee by \$75.

The Board is amending 818-012-0030 Unprofessional Conduct. The amendment to 818-012-0030 is to clarify the lettering of the level of healthcare provider training needed.

The Board is amending 818-021-0060 Continuing Education - Dentists. The amendment to 818-021-0060 is to add attendance at dental study groups as included in counting towards continuing education credit.

The Board is amending 818-021-0070 Continuing Education - Hygienists. The amendment to 818-021-0070 is to add attendance at dental study groups as included in counting towards continuing education credit.

The Board 818-026-0010 Definitions. The amendment to 818-026-0010 is to allow the use of non-intravenous pharmacological methods to induce minimal sedation and define maximum recommended dose (MRD), incremental dosing, supplemental dosing, enteral route and parenteral route.

The Board is amending 818-026-0020 Presumption of Degree of Central Nervous System Depression. The amendment to 818-026-0020 is to delete reference to rapidly acting steroids in the rule.

The Board is amending 818-026-0030 Requirements for Anesthesia Permits, Standards and Qualification of an Anesthesia Monitor. The amendment to 818-026-0030 is to define BLS, PALS and ACLS requirements for different levels of sedation and the ages of patients.

The Board is amending 818-026-0040 Qualifications, Standards Applicable, and Continuing Education Requirements for Anesthesia Permits: Nitrous Oxide Permits. The amendment to 818-026-0040 is to clarify the level of permit needed if a higher level of sedation is possible.

The Board is amending 818-026-0050 Minimal Sedation Permit. The amendment to 818-026-0050 is to clarify the level of health care provider training needed and define how a patient shall be monitored.

The Board is amending 818-026-0060 Moderate Sedation Permit. The amendment to 818-026-0060 is to clarify the level of health care provider training needed and define how a patient shall be monitored.

The Board is amending 818-026-0065 Deep Sedation. The amendment to 818-026-0065 is to clarify the level of health care provider training needed.

The Board is amending 818-026-0070 General Anesthesia Permit. The amendment to 818-026-0070 is to clarify the level of health care provider training needed.

The Board is amending 818-026-0080 Standards Applicable When a Dentist Performs Dental Procedures and a Qualified Provider Induces Anesthesia. The amendment to 818-026-0080 is to clarify the scheduling protocols when treating patients under sedation.

The Board is amending 818-026-0110 Office Evaluations. The amendment to 818-026-0110 is to clarify the criteria for in office evaluations.

The Board is repealing Temporary Rule 818-035-0025 Prohibitions which was effective April 17, 2015, to make it permanent. The amendment to 818-035-0025 is to add prescriptive authority back in the rule.

The Board is repealing Temporary Rule 818-035-0030 Additional Functions of Dental Hygienists which was effective April 17, 2015, to make it permanent. The amendment to 818-035-0030 is to add prescriptive authority back in the rule.

The Board is amending 818-035-0065 Expanded Practice Dental Hygiene Permit. The amendment to 818-026-0065 is to clarify the level of health care provider training needed.

The Board is amending 818-042-0040 Prohibited Acts. The amendment to 818-042-0040 is to delete the word dispense from the rule, add reference to another rule and correct a numbering mistake.

The Board is amending 818-042-0050 Taking of X-Rays - Exposing of Radiographs. The amendment to 818-042-0050 is to clarify that a dental hygienist may authorize the dental assistant regarding films referenced in rule.

The Board is amending 818-042-0070 Expanded Function Dental Assistants (EFDA). The amendment to 818-042-0070 is to clarify the duties of a dental assistant.

The Board is amending 818-042-0090 Additional Functions of EDDAs. The amendment to 818-042-0090 is to allow EFDAs to place cord subgingivally.

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

<u>08-27-2015 4:00 p.m.</u>	<u>Stephen Prisby</u>	<u>stephen.prisby@state.or.us</u>
Last Day (m/d/yyyy) and Time for public comment	Rules Coordinator Name	Email Address

*The Oregon Bulletin is published on the 1st of each month and updates the rule text found in the Oregon Administrative Rules Compilation.

Secretary of State
STATEMENT OF NEED AND FISCAL IMPACT
A Notice of Proposed Rulemaking Hearing accompanies this form.

FILED
7-9-15 11:35 AM
ARCHIVES DIVISION
SECRETARY OF STATE

Oregon Board of Dentistry
Agency and Division

818
Administrative Rules Chapter Number

Amending 22 Rules regarding practice, definitions, fees, anesthesia, education, hygiene, assistants and continuing education rules.

Rule Caption (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

In the Matter of:

The amendment of OARs

- 818-001-0002
- 818-001-0087
- 818-012-0030
- 818-021-0060
- 818-021-0070
- 818-026-0010
- 818-026-0020
- 818-026-0030
- 818-026-0040
- 818-026-0050
- 818-026-0060
- 818-026-0065
- 818-026-0070
- 818-026-0080
- 818-026-0110
- 818-035-0025
- 818-035-0030
- 818-035-0065
- 818-042-0040
- 818-042-0050
- 818-042-0070
- 818-042-0090

Statutory Authority:

ORS 183.325-183.355, 183.400, 679.250, 679.255, 680.150, 680.200, 680.205.

Other Authority:

Statutes Implemented:

670.260, 676.185, 676.190, 676.195, 676.200, 679.010, 679.020, 679.025, 679.060, 679.090, 679.115, 679.120, 679.140, 679.160, 679.170, 679.250, 680.050, 680.072, 680.075, 680.082, 680.100, 680.150, 680.200, 680.205.

Need for the Rule(s):

- The amendment to 818-001-0002 is to define what a dental study group is.
- The amendment to 818-001-0087 is to raise the biennial license fee by \$75.
- The amendment to 818-012-0030 is to clarify the lettering of the level of healthcare provider training needed.
- The amendment to 818-021-0060 is to add attendance at dental study groups as included in counting towards continuing education credit.
- The amendment to 818-021-0070 is to add attendance at dental study groups as included in counting towards continuing education credit.
- The amendment to 818-026-0010 is to allow the use of non-intravenous pharmacological methods to induce minimal sedation and define maximum recommended dose (MRD), incremental dosing, supplemental dosing, enteral route and parenteral route.
- The amendment to 818-026-0020 is to delete reference to rapidly acting steroids in the rule.
- The amendment to 818-026-0030 is to define BLS,PALS and ACLS requirements for different levels of sedation and the ages of patients.
- The amendment to 818-026-0040 is to clarify the level of permit needed if a higher level of sedation is possible.
- The amendment to 818-026-0050 is to clarify the level of health care provider training needed and define how a patient shall be monitored.
- The amendment to 818-026-0060 is to clarify the level of health care provider training needed and define how a patient shall be monitored.

The amendment to 818-026-0065 is to clarify the level of health care provider training needed.
 The amendment to 818-026-0070 is to clarify the level of health care provider training needed.
 The amendment to 818-026-0080 is to clarify the scheduling protocols when treating patients under sedation.
 The amendment to 818-026-0110 is to clarify the criteria for in office evaluations.
 The amendment to 818-035-0025 is to add prescriptive authority back in the rule.
 The amendment to 818-035-0030 is to add prescriptive authority back in the rule.
 The amendment to 818-035-0065 is to delete reference to overall dental risk assessment in the rule.
 The amendment to 818-042-0040 is to delete the word dispense from the rule, add reference to another rule and correct a numbering mistake.
 The amendment to 818-042-0050 is to clarify that a dental hygienist may authorize the dental assistant regarding films referenced in rule.
 The amendment to 818-042-0070 is to clarify the duties of a dental assistant.
 The amendment to 818-042-0090 is to allow EFDAs to place cord subgingivally.

Documents Relied Upon, and where they are available:

The Oregon Board of Dentistry has a website at www.Oregon.gov/dentistry where all documents are available and posted.

Fiscal and Economic Impact:

It is not possible to estimate the exact number of small businesses, as the majority of dental practices are considered small businesses. Some licensees may see a small increase in costs to be in compliance with rule change

Statement of Cost of Compliance:

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)):

It is not possible to estimate the exact number of small businesses, as the majority of dental practices are considered small businesses. Some licensees may see a small increase in costs to be in compliance with rule change

2. Cost of compliance effect on small business (ORS 183.336):

a. Estimate the number of small business and types of businesses and industries with small businesses subject to the rule:

It is not possible to estimate the exact number of small businesses, as the majority of dental practices are considered small businesses. Some licensees may see a small increase in costs to be in compliance with rule change

b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services:

It is not possible to estimate the exact number of small businesses, as the majority of dental practices are considered small businesses. Some licensees may see a small increase in costs to be in compliance with rule change

c. Equipment, supplies, labor and increased administration required for compliance:

It is not possible to estimate the exact number of small businesses, as the majority of dental practices are considered small businesses. Some licensees may see a small increase in costs to be in compliance with rule change

How were small businesses involved in the development of this rule?

Dentists who are owners of dental practices assisted in the review and writing of the rules as members of the Oregon Board of Dentistry (OBD) Rules Oversight Committee and the Anesthesia Committee. Professional association representatives are also members of the OBD Rules Oversight Committee and participated in the drafting of the proposed rules and amendments.

**Administrative Rule Advisory Committee consulted?: Yes
 If not, why?:**

08-27-2015 4:00 p.m.	Stephen Prisby	stephen.prisby@state.or.us
Last Day (m/d/yyyy) and Time for public comment	Printed Name	Email Address

**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.

35 (a) "Dental Public Health" is the science and art of preventing and controlling dental diseases
36 and promoting dental health through organized community efforts. It is that form of dental
37 practice which serves the community as a patient rather than the individual. It is concerned with
38 the dental health education of the public, with applied dental research, and with the
39 administration of group dental care programs as well as the prevention and control of dental
40 diseases on a community basis.

41 (b) "Endodontics" is the branch of dentistry which is concerned with the morphology, physiology
42 and pathology of the human dental pulp and periradicular tissues. Its study and practice
43 encompass the basic and clinical sciences including biology of the normal pulp, the etiology,
44 diagnosis, prevention and treatment of diseases and injuries of the pulp and associated
45 periradicular conditions.

46 (c) "Oral and Maxillofacial Pathology" is the specialty of dentistry and discipline of pathology that
47 deals with the nature, identification, and management of diseases affecting the oral and
48 maxillofacial regions. It is a science that investigates the causes, processes, and effects of
49 these diseases. The practice of oral pathology includes research and diagnosis of diseases
50 using clinical, radiographic, microscopic, biochemical, or other examinations.

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

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

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

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

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

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

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

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

86 (14) "Dental Study Group" as used in ORS 679.050, OAR 818-021-0060 and OAR 818-021-
87 0070 is defined as a group of licensees who come together for clinical and non-clinical
88 educational study for the purpose of maintaining or increasing their competence. This is
89 not meant to be a replacement for residency requirements.

90
91 Stat. Auth.: ORS 679 & 680

92 Stats. Implemented: ORS 679.010 & 680.010

93 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-
94 89, cert. ef. 2-1-89; Renumbered from 818-001-0001; DE 3-1997, f. & cert. ef. 8-27-97; OBD 7-
95 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.
96 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
97 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:

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

43 (e) Duplicate Wall Certificates — \$50.

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

45 (3) The Board shall not refund moneys under \$5.01 received in excess of amounts due or to
46 which the
47 Board has no legal interest unless the person who made the payment or the person's legal
48 representative requests a refund in writing within one year of payment to the Board.

49

50 Stat. Auth.: ORS 679 & 680

51 Stats. Implemented: ORS 293.445, 679.060, 679.115, 679.120, 679.250, 680.050, 680.075,
52 680.200 & 680.205

53 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-
54 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;
55 Renumbered from 818-001-0085; DE 2-1989(Temp), f. & cert. ef. 11-30-89; DE 1-1990, f. 3-19-
56 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-
57 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.
58 & cert. ef. 6-8-98; OBD 3-1999, f. 6-25-99, cert. ef. 7-1-99; Administrative correction, 8-2-99;
59 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-
60 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;
61 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.
62 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-
63 11 thru 12-27-11; OBD 4-2011, f. & cert. ef. 11-15-11; OBD 1-2012, f. & cert. ef. 1-27-12; OBD
64 1-2013, f. 5-15-13, cert. ef. 7-1-13; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14

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

35 (B) Duplicates of study models and radiographs, photographs or legible copies thereof if the
36 radiographs, photographs or study models have been paid for.

37 (b) The dentist may require the patient or guardian to pay in advance a fee reasonably
38 calculated to cover the costs of making the copies or duplicates. The dentist may charge a fee
39 not to exceed \$30 for copying 10 or fewer pages of written material and no more than \$0.50 per
40 page for pages 11 through 50 and no more than \$0.25 for each additional page (including
41 records copied from microfilm), plus any postage costs to mail copies requested and actual
42 costs of preparing an explanation or summary of information, if requested. The actual cost of
43 duplicating x-rays may also be charged to the patient. Patient records or summaries may not be
44 withheld from the patient because of any prior unpaid bills, except as provided in (9)(a)(B) of this
45 rule.

46 (10) Fail to identify to a patient, patient's guardian, or the Board the name of an employee,
47 employer, contractor, or agent who renders services.

48 (11) Use prescription forms pre-printed with any Drug Enforcement Administration number,
49 name of controlled substances, or facsimile of a signature.

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

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

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

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

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

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

65 (18) Fail to maintain at a minimum a current [BLS](#) Health Care Provider ~~Basic Life Support~~
66 ~~(BLS)~~ /Cardio Pulmonary Resuscitation (CPR) training or its equivalent. (Effective January 1,
67 2015)

68

69 [Publications: Publications referenced are available from the agency.]
70 Stat. Auth.: ORS 679 & 680
71 Stats. Implemented: ORS 679.140(1)(c), 679.140(2), 679.170(6) & 680.100
72 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;
73 DE 2-1982, f. & ef. 3-19-82; DE 5-1982, f. & ef. 5-26-82; DE 9-1984, f. & ef. 5-17-84;
74 Renumbered from 818-010-0080; DE 3-1986, f. & ef. 3-31-86; DE 1-1988, f. 12-28-88, cert. ef.
75 2-1-89; DE 1-1989, f. 1-27-89, cert. ef. 2-1-89; Renumbered from 818-011-0020; DE 1-1990, f.
76 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-
77 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. &
78 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.
79 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.

35 (6) At least 2 hours of continuing education must be related to infection control. (Effective
36 January 1, 2015.)

37

38 Stat. Auth.: ORS 679

39 Stats. Implemented: ORS 679.250(9)

40 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,
41 cert. ef. 2-1-89; DE 1-1989, f. 1-27-89, cert. ef. 2-1-89; Renumbered from 818-020-0072; DE 1-
42 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,
43 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;
44 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-
45 11; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14

DRAFT

1 **DIVISION 21**

2 **EXAMINATION AND LICENSING**

3 **818-021-0070**

4 **Continuing Education — Dental Hygienists**

5 (1) Each dental hygienist must complete 24 hours of continuing education every two years. An
6 Expanded Practice Permit Dental Hygienist shall complete a total of 36 hours of continuing
7 education every two years. Continuing education (C.E.) must be directly related to clinical
8 patient care or the practice of dental public health.

9 (2) Dental hygienists must maintain records of successful completion of continuing education for
10 at least four licensure years consistent with the licensee's licensure cycle. (A licensure year for
11 dental hygienists is October 1 through September 30.) The licensee, upon request by the Board,
12 shall provide proof of successful completion of continuing education courses.

13 (3) Continuing education includes:

14 (a) Attendance at lectures, [dental](#) study ~~clubs~~ [groups](#), college post-graduate courses, or
15 scientific sessions at conventions.

16 (b) Research, graduate study, teaching or preparation and presentation of scientific sessions.
17 No more than six hours may be in teaching or scientific sessions. (Scientific sessions are
18 defined as scientific presentations, table clinics, poster sessions and lectures.)

19 (c) Correspondence courses, videotapes, distance learning courses or similar self-study course,
20 provided that the course includes an examination and the dental hygienist passes the
21 examination.

22 (d) Continuing education credit can be given for volunteer pro bono dental hygiene services
23 provided in the state of Oregon; community oral health instruction at a public health facility
24 located in the state of Oregon; authorship of a publication, book, chapter of a book, article or
25 paper published in a professional journal; participation on a state dental board, peer review, or
26 quality of care review procedures; successful completion of the National Board Dental Hygiene
27 Examination, taken after initial licensure; or test development for clinical dental hygiene
28 examinations. No more than 6 hours of credit may be in these areas.

29 (4) At least three hours of continuing education must be related to medical emergencies in a
30 dental office. No more than two hours of Practice Management and Patient Relations may be
31 counted toward the C.E. requirement in any renewal period.

32 (5) Dental hygienists who hold a Nitrous Oxide Permit must meet the requirements contained in
33 OAR 818-026-0040(9) for renewal of the Nitrous Oxide Permit.

34 (6) At least 2 hours of continuing education must be related to infection control. (Effective
35 January 1, 2015.)

36

37 Stat. Auth.: ORS 679

38 Stats. Implemented: ORS 279.250(9)

39 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-
40 89, cert. ef. 2-1-89; Renumbered from 818-020-0073; DE 1-1990, f. 3-19-90, cert. ef. 4-2-90;
41 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-
42 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.
43 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-
44 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

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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

34 the ability to independently and continuously maintain an airway and to respond purposefully to
35 physical stimulation and to verbal command.

36 (8) “Maximum recommended dose” (MRD) means ~~maximum Food and Drug Administration-~~
37 ~~recommended dose of a drug, as printed in Food and Drug Administration-Approved~~
38 ~~labeling for unmonitored dose~~ maximum Food and Drug Administration (FDA)
39 recommended dose of a drug, as printed in FDA approved labeling for unmonitored
40 home use.

41 (9) “Incremental Dosing” means during minimal sedation, administration of multiple
42 doses of a drug until a desired effect is reached, but not to exceed the maximum
43 recommended dose (MRD).

44 (10) “Supplemental Dosing” means during minimal sedation, supplemental dosing is a
45 single additional dose of the initial drug that is necessary for prolonged procedures. The
46 supplemental dose should not exceed one-half of the initial dose and should not be
47 administered until the dentist has determined the clinical half-life of the initial dosing has
48 passed. The total aggregate dose must not exceed 1.5x the MRD on the day of treatment.

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

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

55
56 Stat. Auth.: ORS 679

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

58 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-
59 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-
60 10, cert. ef. 7-1-10

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

35 (e) Demonstration of current competency to the satisfaction of the Board that the applicant
36 possesses adequate sedation or general anesthesia skill to safely deliver sedation or general
37 anesthesia services to the public.

38 (4) Persons serving as anesthesia monitors in a dental office shall maintain current certification
39 in Health Care Provider Basic Life Support (BLS)/Cardio Pulmonary Resuscitation (CPR)
40 training, or its equivalent, shall be trained in monitoring patient vital signs, and be competent in
41 the use of monitoring and emergency equipment appropriate for the level of sedation utilized.
42 (The term "competent" as used in these rules means displaying special skill or knowledge
43 derived from training and experience.)

44 ~~(5) A licensee holding an anesthesia permit shall at all times hold a current Health Care
45 Provider BLS/CPR level certificate or its equivalent, or a current Advanced Cardiac Life
46 Support (ACLS) Certificate or Pediatric Advanced Life Support (PALS) Certificate,
47 whichever is appropriate for the patient being sedated.~~

48 (5) A licensee holding a nitrous or minimal sedation permit, shall at all times maintain a
49 current BLS for Healthcare Providers certificate or its equivalent. A licensee holding an
50 anesthesia permit for moderate sedation, at all times maintains a current BLS for
51 Healthcare Providers certificate or its equivalent, and a current Advanced Cardiac Life
52 Support (ACLS) Certificate or Pediatric Advanced Life Support (PALS) Certificate,
53 whichever is appropriate for the patient being sedated. If a licensee sedates only patients
54 under the age of 12, only PALS is required. If a licensee sedates only patients age 12 and
55 older, only ACLS is required. If a licensee sedates patients younger than 12 years of age
56 as well as older than 12 years of age, both ACLS and PALS are required. For licensees
57 with a moderate sedation permit only, successful completion of the American Dental
58 Association's course "Recognition and Management of Complications during Minimal
59 and Moderate Sedation" at least every two years may be substituted for ACLS, but not
60 for PALS.

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

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

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

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

68

69 Stat. Auth.: ORS 679 & 680
70 Stats. Implemented: ORS 679.250
71 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
72 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-
73 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,
74 cert. ef. 7-1-10; OBD 2-2012, f. 6-14-12, cert. ef. 7-1-12

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DIVISION 26
ANESTHESIA

818-026-0040

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;

35 (c) Certify that the patient is an appropriate candidate for nitrous oxide sedation; and
36 (d) Obtain informed consent from the patient or patient's guardian for the anesthesia. The
37 obtaining of the informed consent shall be documented in the patient's record.

38 (4) If a patient chronically takes a medication which can have sedative side effects,
39 including, but not limited to, a narcotic or benzodiazepine, the practitioner shall
40 determine if the additive sedative effect of nitrous oxide would put the patient into a level
41 of sedation deeper than nitrous oxide. If the practitioner determines it is possible that
42 providing nitrous oxide to such a patient would result in minimal sedation, a minimal
43 sedation permit would be required.

44 ~~(4)~~ (5) A patient under nitrous oxide sedation shall be visually monitored by the permit holder or
45 by an anesthesia monitor at all times. The patient shall be monitored as to response to verbal
46 stimulation, oral mucosal color and preoperative and postoperative vital signs.

47 ~~(5)~~ (6) The permit holder or anesthesia monitor shall record the patient's condition. The record
48 must include documentation of all medications administered with dosages, time intervals and
49 route of administration.

50 ~~(6)~~ (7) The person administering the nitrous oxide sedation may leave the immediate area after
51 initiating the administration of nitrous oxide sedation only if a qualified anesthesia monitor is
52 continuously observing the patient.

53 ~~(7)~~ (8) The permit holder shall assess the patient's responsiveness using preoperative values as
54 normal guidelines and discharge the patient only when the following criteria are met:

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

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

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

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

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

61 (8) (9) The permit holder shall make a discharge entry in the patient's record indicating the
62 patient's condition upon discharge.

63 ~~(9)~~ (10) Permit renewal. In order to renew a Nitrous Oxide Permit, the permit holder must
64 provide proof of having a current Health Care Provider BLS/CPR level certificate, or its
65 equivalent. In addition, Nitrous Oxide Permit holders must also complete four (4) hours of
66 continuing education in one or more of the following areas every two years: sedation, nitrous
67 oxide, physical evaluation, medical emergencies, monitoring and the use of monitoring
68 equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain

69 current Health Care Provider BLS/CPR level certification, or its equivalent, may not be counted
70 toward this requirement. Continuing education hours may be counted toward fulfilling the
71 continuing education requirement set forth in OAR 818-021-0060 and 818-021-0070.

72

73 Stat. Auth.: ORS 679 & 680

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

75 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

76 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

818-026-0050

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;

- 35 (g) Sphygmomanometer, stethoscope, pulse oximeter, and/or automatic blood pressure cuff;
36 and
- 37 (h) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the
38 drugs used, vasopressors, corticosteroids, bronchodilators, antihistamines, antihypertensives
39 and anticonvulsants.
- 40 (3) Before inducing minimal sedation, a dentist who induces minimal sedation shall:
- 41 (a) Evaluate the patient;
- 42 (b) Give written preoperative and postoperative instructions to the patient or, when appropriate
43 due to age or psychological status of the patient, the patient's guardian;
- 44 (c) Certify that the patient is an appropriate candidate for minimal sedation; and
- 45 (d) Obtain written informed consent from the patient or patient's guardian for the anesthesia.
46 The obtaining of the informed consent shall be documented in the patient's record.
- 47 (4) No permit holder shall have more than one person under minimal sedation at the same time.
- 48 (5) While the patient is being treated under minimal sedation, an anesthesia monitor shall be
49 present in the room in addition to the treatment provider. The anesthesia monitor may be the
50 dental assistant.
- 51 (a) After training, a dental assistant, when directed by a dentist, may administer oral sedative
52 agents or anxiolysis agents calculated and dispensed by a dentist under the direct supervision
53 of a dentist.
- 54 (6) A patient under minimal sedation shall be visually monitored at all times, including recovery
55 phase. The dentist or anesthesia monitor shall monitor and record the patient's condition.
- 56 (7) The patient shall be monitored as follows:
- 57 (a) Color of mucosa, skin or blood must be evaluated continually. Patients must have
58 continuous monitoring using pulse oximetry. The patient's response to verbal stimuli, blood
59 pressure, heart rate, and respiration shall be monitored and documented if they can
60 reasonably be obtained.
- 61 (b) A discharge entry shall be made by the dentist in the patient's record indicating the patient's
62 condition upon discharge and the name of the responsible party to whom the patient was
63 discharged.
- 64 (8) The dentist shall assess the patient's responsiveness using preoperative values as normal
65 guidelines and discharge the patient only when the following criteria are met:
- 66 (a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;
- 67 (b) The patient is alert and oriented to person, place and time as appropriate to age and
68 preoperative psychological status;

- 69 (c) The patient can talk and respond coherently to verbal questioning;
70 (d) The patient can sit up unaided;
71 (e) The patient can ambulate with minimal assistance; and
72 (f) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.
73 (g) A dentist shall not release a patient who has undergone minimal sedation except to the care
74 of a responsible third party.

75 (9) Permit renewal. In order to renew a Minimal Sedation Permit, the permit holder must provide
76 documentation of having a current ~~Health-Care-Provider~~ BLS/CPR-level Health Care
77 Providers certificate, or its equivalent. In addition, Minimal Sedation Permit holders must also
78 complete four (4) hours of continuing education in one or more of the following areas every two
79 years: sedation, physical evaluation, medical emergencies, monitoring and the use of
80 monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to
81 maintain current ~~Health-Care-Provider~~ BLS/CPR-level Health Care Providers certification, or
82 its equivalent, may not be counted toward this requirement. Continuing education hours may be
83 counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060.

84

85 Stat. Auth.: ORS 679

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

87 Hist.: OBD 6-1999, f. 6-25-99, cert. ef. 7-1-99; Administrative correction 8-12-99; OBD 3-2003, f.
88 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.
89 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;

- 33 (b) An operating table or chair which permits the patient to be positioned so the operating team
34 can maintain the patient's airway, quickly alter the patient's position in an emergency, and
35 provide a firm platform for the administration of basic life support;
- 36 (c) A lighting system which permits evaluation of the patient's skin and mucosal color and a
37 backup lighting system of sufficient intensity to permit completion of any operation underway in
38 the event of a general power failure;
- 39 (d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a
40 backup suction device which will function in the event of a general power failure;
- 41 (e) An oxygen delivery system with adequate full face mask and appropriate connectors that is
42 capable of delivering high flow oxygen to the patient under positive pressure, together with an
43 adequate backup system;
- 44 (f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate
45 continuous oxygen delivery and a scavenger system;
- 46 (g) A recovery area that has available oxygen, adequate lighting, suction and electrical outlets.
47 The recovery area can be the operating room;
- 48 (h) Sphygmomanometer, precordial/pretracheal stethoscope, capnograph, pulse oximeter, oral
49 and nasopharyngeal airways, laryngeal mask airways, intravenous fluid administration
50 equipment, automated external defibrillator (AED); and
- 51 (i) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the
52 drugs used, vasopressors, corticosteroids, bronchodilators, antihistamines, antihypertensives
53 and anticonvulsants.
- 54 (3) No permit holder shall have more than one person under moderate sedation, minimal
55 sedation, or nitrous oxide sedation at the same time.
- 56 (4) During the administration of moderate sedation, and at all times while the patient is under
57 moderate sedation, an anesthesia monitor, and one other person holding a **Health Care**
58 **Provider BLS/CPR certificate or its equivalent** Health Care Provider certification or its
59 equivalent, shall be present in the operatory, in addition to the dentist performing the dental
60 procedures.
- 61 (5) Before inducing moderate sedation, a dentist who induces moderate sedation shall:
- 62 (a) Evaluate the patient and document, using the American Society of Anesthesiologists Patient
63 Physical Status Classifications, that the patient is an appropriate candidate for moderate
64 sedation;
- 65 (b) Give written preoperative and postoperative instructions to the patient or, when appropriate
66 due to age or psychological status of the patient, the patient's guardian; and

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

68 (6) A patient under moderate sedation shall be visually monitored at all times, including the

69 recovery phase. The dentist or anesthesia monitor shall monitor and record the patient's

70 condition.

71 (7) The patient shall be monitored as follows:

72 (a) Patients must have continuous monitoring using pulse oximetry, and End-tidal CO2

73 monitors. Patients with cardio vascular disease shall have continuous ECG monitoring.

74 The patient's blood pressure, heart rate, and respiration shall be recorded at regular intervals

75 but at least every 15 minutes, and these recordings shall be documented in the patient record.

76 The record must also include documentation of preoperative and postoperative vital signs, all

77 medications administered with dosages, time intervals and route of administration. If this

78 information cannot be obtained, the reasons shall be documented in the patient's record. A

79 patient under moderate sedation shall be continuously monitored and shall not be left alone

80 while under sedation;

81 (b) During the recovery phase, the patient must be monitored by an individual trained to monitor

82 patients recovering from moderate sedation.

83 (8) A dentist shall not release a patient who has undergone moderate sedation except to the

84 care of a responsible third party.

85 (a) When a reversal agent is administered, the doctor shall document justification for its

86 use and how the recovery plan was altered.

87 (9) The dentist shall assess the patient's responsiveness using preoperative values as normal

88 guidelines and discharge the patient only when the following criteria are met:

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

90 (b) The patient is alert and oriented to person, place and time as appropriate to age and

91 preoperative psychological status;

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

93 (d) The patient can sit up unaided;

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

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

96 (10) A discharge entry shall be made by the dentist in the patient's record indicating the patient's

97 condition upon discharge and the name of the responsible party to whom the patient was

98 discharged.

99 (11) After adequate training, an assistant, when directed by a dentist, may dispense oral

100 medications that have been prepared by the dentist permit holder for oral administration to a

101 patient under direct supervision or introduce additional anesthetic agents into an infusion line
102 under the direct visual supervision of a dentist.
103 (12) Permit renewal. In order to renew a Moderate Sedation Permit, the permit holder must
104 provide documentation of having current [BLS for Health Care Providers certification or its](#)
105 [equivalent and](#) ACLS [and/or](#) PALS certification or current certification of successful completion
106 of the American Dental Association’s course “Recognition and Management of Complications
107 during Minimal and Moderate Sedation” and must complete 14 hours of continuing education in
108 one or more of the following areas every two years: sedation, physical evaluation, medical
109 emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and
110 agents used in sedation. Training taken to maintain current ACLS or PALS certification or
111 successful completion of the American Dental Association’s course “Recognition and
112 Management of Complications during Minimal and Moderate Sedation” may be counted toward
113 this requirement. Continuing education hours may be counted toward fulfilling the continuing
114 education requirement set forth in OAR 818-021-0060.

115

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

117 Stat. Auth.: ORS 679

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

119 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-
120 1999, f. 6-25-99, cert. ef. 7-1-99; Administrative correction 8-12-99; OBD 2-2000(Temp), f. 5-22-
121 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,
122 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-
123 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
124 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-
125 2013, f. 10-24-13, cert. ef. 1-1-14; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14

1 **DIVISION 26**
2 **ANESTHESIA**

3 **818-026-0065**

4 **Deep Sedation**

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

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

8 (a) Is a licensed dentist in Oregon; and

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

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

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

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

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

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

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

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

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

32 (h) Sphygmomanometer, precordial/pretracheal stethoscope, capnograph, pulse oximeter,
33 electrocardiograph monitor (ECG), automated external defibrillator (AED), oral and

34 nasopharyngeal airways, laryngeal mask airways, intravenous fluid administration equipment;
35 and
36 (i) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the
37 drugs used, vasopressors, corticosteroids, bronchodilators, antihistamines, antihypertensives
38 and anticonvulsants.

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

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

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

46 (a) Evaluate the patient and document, using the American Society of Anesthesiologists Patient
47 Physical Status Classifications, that the patient is an appropriate candidate for deep sedation;
48 (b) Give written preoperative and postoperative instructions to the patient or, when appropriate
49 due to age or psychological status of the patient, the patient's guardian; and
50 (c) Obtain written informed consent from the patient or patient's guardian for the anesthesia.

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

53 (7) The patient shall be monitored as follows:

54 (a) Patients must have continuous monitoring using pulse oximetry, electrocardiograph monitors
55 (ECG) and End-tidal CO₂ monitors. The patient's heart rhythm shall be continuously monitored
56 and the patient's blood pressure, heart rate, and respiration shall be recorded at regular
57 intervals but at least every 5 minutes, and these recordings shall be documented in the patient
58 record. The record must also include documentation of preoperative and postoperative vital
59 signs, all medications administered with dosages, time intervals and route of administration. If
60 this information cannot be obtained, the reasons shall be documented in the patient's record. A
61 patient under deep sedation shall be continuously monitored;

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

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

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

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

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

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

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

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

76 (d) The patient can sit up unaided;

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

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

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

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

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

93

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

95 Stat. Auth.: ORS 679

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

97 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

98 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

99 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;

- 34 (d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a
35 backup suction device which will function in the event of a general power failure;
- 36 (e) An oxygen delivery system with adequate full face mask and appropriate connectors that is
37 capable of delivering high flow oxygen to the patient under positive pressure, together with an
38 adequate backup system;
- 39 (f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate
40 continuous oxygen delivery and a scavenger system;
- 41 (g) A recovery area that has available oxygen, adequate lighting, suction and electrical outlets.
42 The recovery area can be the operating room;
- 43 (h) Sphygmomanometer, precordial/pretracheal stethoscope, capnograph, pulse oximeter,
44 electrocardiograph monitor (ECG), automated external defibrillator (AED), oral and
45 nasopharyngeal airways, laryngeal mask airways, intravenous fluid administration equipment;
46 and
- 47 (i) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the
48 drugs used, vasopressors, corticosteroids, bronchodilators, intravenous medications for
49 treatment of cardiac arrest, narcotic antagonist, antihistaminic, antiarrhythmics,
50 antihypertensives and anticonvulsants.
- 51 (3) No permit holder shall have more than one person under general anesthesia, deep sedation,
52 moderate sedation, minimal sedation or nitrous oxide sedation at the same time.
- 53 (4) During the administration of deep sedation or general anesthesia, and at all times while the
54 patient is under deep sedation or general anesthesia, an anesthesia monitor, and one other
55 person holding a ~~Health Care Provider BLS/CPR certificate or its equivalent~~ Health Care
56 Provider certification or its equivalent, shall be present in the operatory in addition to the
57 dentist performing the dental procedures.
- 58 (5) Before inducing deep sedation or general anesthesia the dentist who induces deep sedation
59 or general anesthesia shall:
- 60 (a) Evaluate the patient and document, using the American Society of Anesthesiologists Patient
61 Physical Status Classifications, that the patient is an appropriate candidate for general
62 anesthesia or deep sedation;
- 63 (b) Give written preoperative and postoperative instructions to the patient or, when appropriate
64 due to age or psychological status of the patient, the patient's guardian; and
- 65 (c) Obtain written informed consent from the patient or patient's guardian for the anesthesia.
- 66 (6) A patient under deep sedation or general anesthesia shall be visually monitored at all times,
67 including recovery phase. A dentist who induces deep sedation or general anesthesia or

68 anesthesia monitor trained in monitoring patients under deep sedation or general anesthesia
69 shall monitor and record the patient's condition on a contemporaneous record.

70 (7) The patient shall be monitored as follows:

71 (a) Patients must have continuous monitoring of their heart rate, heart rhythm, oxygen
72 saturation levels and respiration using pulse oximetry, electrocardiograph monitors (ECG) and
73 End-tidal CO2 monitors. The patient's blood pressure, heart rate and oxygen saturation shall be
74 assessed every five minutes, and shall be contemporaneously documented in the patient
75 record. The record must also include documentation of preoperative and postoperative vital
76 signs, all medications administered with dosages, time intervals and route of administration. The
77 person administering the anesthesia and the person monitoring the patient may not leave the
78 patient while the patient is under deep sedation or general anesthesia;

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

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

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

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

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

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

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

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

93 (d) The patient can sit up unaided;

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

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

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

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

101 (12) Permit renewal. In order to renew a General Anesthesia Permit, the permit holder must
102 provide documentation of having current [BLS Health Care Provider certification or its](#)
103 [equivalent and](#) ACLS [and](#)/or PALS certification and complete 14 hours of continuing education
104 in one or more of the following areas every two years: deep sedation and/or general anesthesia,
105 physical evaluation, medical emergencies, monitoring and the use of monitoring equipment,
106 pharmacology of drugs and agents used in anesthesia. Training taken to maintain current ACLS
107 or PALS certification may be counted toward this requirement. Continuing education hours may
108 be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-
109 0060.

110
111 [Publications: Publications referenced are available from the agency.]

112 Stat. Auth.: ORS 679

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

114 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;

115 Administrative correction 8-12-99; OBD 2-2000(Temp), f. 5-22-00, cert. ef. 5-22-00 thru 11-18-

116 00; Administrative correction 6-21-01; OBD 3-2003, f. 9-15-03, cert. ef. 10-1-03; OBD 1-2005, f.

117 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,

118 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.

119 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.

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36 Stat. Auth.: ORS 679

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

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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

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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

35 Stats. Implemented: ORS 680.200
36 Hist.: OBD 1-1998, f. & cert. ef. 6-8-98; OBD 3-2001, f. & cert. ef. 1-8-01; OBD 3-2007, f. & cert.
37 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
38 2-2012, f. 6-14-12, cert. ef. 7-1-12

DRAFT

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.

35 (18) Place any type of cord subgingivally. except as provided by in OAR 818-042-
36 0090.

37 (19) Take jaw registrations or oral impressions for supplying artificial teeth as
38 substitutes for natural teeth, except diagnostic or opposing models or for the
39 fabrication of temporary or provisional restorations or appliances.

40 (20) Apply denture relines except as provided in OAR 818-042-0090(2).

41 (21) Expose radiographs without holding a current Certificate of Radiologic
42 Proficiency issued by the Board (818-042-0050 and 818-042-0060) except while
43 taking a course of instruction approved by the Oregon Health Authority, Oregon
44 Public Health Division, Office of Environmental Public Health, Radiation Protection
45 Services, or the Oregon Board of Dentistry.

46 (22) Use the behavior management techniques known as Hand Over Mouth (HOM) or
47 Hand Over Mouth Airway Restriction (HOMAR) on any patient.

48 (23) Perform periodontal probing.

49 (24) Place or remove healing caps or healing abutments, except under direct
50 supervision.

51 (25) Place implant impression copings, except under direct supervision.

52 (26) Any act in violation of Board statute or rules.

53

54 Stat. Auth.: ORS 679 & 680

55 Stats. Implemented: ORS 679.020, 679.025 & 679.250

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)

1 **DIVISION 42**
2 **DENTAL ASSISTING**

3 **818-042-0090**

4 **Additional Functions of EFDAs**

5 Upon successful completion of a course of instruction in a program accredited by the
6 Commission on Dental Accreditation of the American Dental Association, or other course of
7 instruction approved by the Board, a certified Expanded Function Dental Assistant may perform
8 the following functions under the indirect supervision of a dentist or dental hygienist providing
9 that the procedure is checked by the dentist or dental hygienist prior to the patient being
10 dismissed:

11 (1) Apply pit and fissure sealants provided the patient is examined before the sealants are
12 placed. The sealants must be placed within 45 days of the procedure being authorized by a
13 dentist or dental hygienist.

14 (2) Apply temporary soft relines to complete dentures for the purpose of tissue conditioning.

15 **(3) Place cord subgingivally.**

16
17 Stat. Auth.: ORS 679

18 Stats. Implemented: ORS 679.025(2)(j) & 679.250(7)

CORRESPONDENCE

RECEIVED

JUL 07 2015

Oregon Board
of Dentistry

To: Oregon Board of Dentistry
1500 SW 1st Ave., Ste. 770
Portland, OR 97207

Re: Paul Kleinstub, DMD, MS

Mr. Prisby:

I am writing this letter regarding the June 2015 Board Meeting Public Packet. I am specifically referring to the dentist who wrote a letter regarding being "dinged" by the Board of Dentistry. I was informed of this letter by a colleague of mine who practices in Oregon. I am licensed in Oregon, however, my practice is in Washington State. My specific concern has to deal with whom this individual addressed the letter to. He addressed his letter to Dr. Kleinstub. I do not know who this individual is however I went to your website and found out that he is the dental director and chief investigator. Thanks to your website I looked up his name to verify a state license. What I found is absolutely shocking. Dr. Kleinstub does not possess an Oregon license of any kind! I reviewed the bylaws of the state practice act and it states that anyone engaged in the making of any diagnosis or care in dentistry in Oregon is required to have a license in Oregon. If Dr. Kleinstub is reading chart notes, X-rays and making findings, he is then practicing without a license. My brother is an attorney in the state of Oregon and I asked him his opinion of this. His response was that Dr. Kleinstub cannot make any legal assertions of any kind against another dentist without an active license in Oregon. Furthermore the Board is complacent in its duty by having someone in that position without a dental license.

Our profession needs accountability. I can't practice dentistry without a license and I am sure you would not allow me to consult on cases if I did not have a license. Why should someone who oversees the disciplinary review of dentists be held to a different account?

Would you please post this letter and a response online in your next Public Packet information?

Thanks,

DDS in WA

RECEIVED

JUL 23 2015

Oregon Board
of Dentistry

To the Oregon Board of Dentistry,

I am a board certified pediatric dentist in southern Oregon and am writing to express an interest in having a certificate for expanded function for a pediatric dental assistants much like the expanded functions for the general and orthodontic assistants.

I have found as I am continually searching for great dental assistants, that I am often in a frustrating position. I need assistants who are certified in coronal polishing which requires the general EFDA certification. One of my employees, when she was hired a year and a half ago, was still working to complete her general EFDA requirements. I worked with her in my office to try to help her finish all the requirements that I could, but, as a pediatric dentist, there are only 4 of the 9 requirements that are done in a pediatric dental office. I was able to make arrangements with other general dentists to allow her to come into their office and sign off for the rest of the procedures so she could complete all of her certification. I just recently hired another employee who also still needs to complete her EFDA requirements as well, and I'm back in the same position of having to impose upon other general dentists to find an office where she can go to do the other half of her requirements.

I've become frustrated that because I work in a pediatric dental office and we simply do not perform five of the nine procedures required for the general EFDA certificate, I am left with very limited choices of whom I can hire. If I don't hire assistants that already have their general EFDA, I am forced into a position where I have to rely on other dentists to allow my assistants to get the experiences with the procedures that no pediatric dental offices provide. This, honestly, is something I hate to ask because it is a significant time investment by the other doctor in an employee who is not their own and will have zero return for them.

General dentists can help assistants obtain a general EFDA because all of the procedure experiences required by DANB are performed in their offices. Orthodontists can help assistants obtain an EFODA certificate for the same reason. Pediatric dentists cannot help assistants obtain a general EFDA without imposing on other general dentists to allow their assistants to gain experience in procedures that are not performed in a pediatric dental office.

It is my hope that the board would consider adding a certificate for expanded functions pediatric dental assistant (EFPDA). This would allow pediatric dental offices the opportunity to have fully trained assistants without relying and imposing on the generosity and schedules of our general dentist colleagues.

Thank you for your consideration,

Bren Dixon, DMD

OTHER ISSUES

818-012-0005

Scope of Practice

(1) No dentist may perform any of the procedures listed below:

- (a) Rhinoplasty;
- (b) Blepharoplasty;
- (c) Rhytidectomy;
- (d) Submental liposuction;
- (e) Laser resurfacing;
- (f) Browlift, either open or endoscopic technique;
- (g) Platysmal muscle plication;
- (h) Otoplasty;
- (i) Dermabrasion;
- (j) Lip augmentation;
- (k) Hair transplantation, not as an isolated procedure for male pattern baldness; and
- (l) Harvesting bone extra orally for dental procedures, including oral and maxillofacial procedures.

(2) Unless the dentist:

(a) Has successfully completed a residency in Oral and Maxillofacial Surgery accredited by the American Dental Association, Commission on Dental Accreditation (CODA), and

(b) Has successfully completed a clinical fellowship, of at least one continuous year in duration, in esthetic (cosmetic) surgery recognized by the American Association of Oral and Maxillofacial Surgeons or by the American Dental Association Commission on Dental Accreditation, or

(c) Holds privileges either:

(A) Issued by a credentialing committee of a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to perform these procedures in a hospital setting; or

(B) Issued by a credentialing committee for an ambulatory surgical center licensed by the State of Oregon and accredited by either the JCAHO or the Accreditation Association for Ambulatory Health Care (AAAHC).

(3) A dentist may utilize Botulinum Toxin Type A to treat a condition that is within the scope of the practice of dentistry after completing a minimum of 16 hours in a hands on clinical course(s) in which the provider is approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) or by the American Dental Association Continuing Education Recognition Program (ADA CERP).

Stat. Auth.: ORS 679 & 680

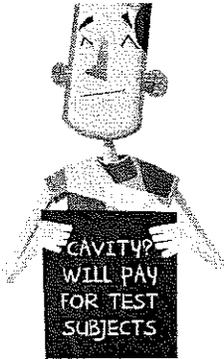
Stats. Implemented: ORS 679.010(2), 679.140(1)(c), 679.140(2), 679.170(6) & 680.100

Hist.: OBD 6-2001, f. & cert. ef. 1-8-01; 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

NEWSLETTERS
&
ARTICLES OF
INTEREST

Editorial: Ban use of live patients in licensing test

The Register's editorial 3:47 p.m. CDT August 9, 2015



(Photo: Mark Marturello/Register Illustration)

Students who graduate from the University of Iowa's College of Dentistry spent four years intensely preparing for their future careers. They each treated nearly 500 patients, performed about 1,700 dental procedures, and passed numerous tests, including National Board exams. They have met all the requirements imposed by a top-notch, accredited institution and they're ready to be practicing dentists.

But that apparently does not satisfy the Iowa Dental Board, composed of mostly private-sector dental workers appointed by the governor. Obtaining a license to work from this board is where the pursuit to become a dentist in Iowa takes a turn to the ridiculous.

The board requires the graduating students to pass an additional exam — one facilitated by a Kansas-based testing service. (State dental board members can receive a per diem to act as an "examiner.") After paying \$2,000 for the exam, students must find and even pay people to undergo predetermined dental procedures. Some look for volunteers by advertising on Craigslist or posting fliers around town.

More than a decade ago the American Dental Association passed a resolution opposing the use of human subjects in clinical examinations. For nearly a decade, leaders at UI have asked the dental board to nix the requirement. Now they're asking again.

The exam is unethical, of questionable validity, and does not contribute to public safety or the education of a future dentist, said Michael Kanellis, associate dean for patient care at the dental school. He points to California, which grants a license based on the completion of a portfolio of work done. To maintain accreditation, the UI dental school must already ensure every student can successfully perform every dental procedure.

The Iowa Dental Board should finally nix the requirement. If it won't, the University of Iowa should refuse to host it, as the University of Minnesota faculty have voted to do. Or the Iowa Legislature should explicitly ban the use of human subjects in licensing exams, similar to the bill recently introduced in the Massachusetts Legislature.

No other health professional in Iowa is subject to this type of state licensing requirement. Imagine if a future physician was trolling for heart patients in a laundromat so he could perform a procedure to prove he was "competent" to a state board? What if a mental health counselor had to advertise on the Internet for patients to participate in a counseling session before board members?

"It is time for dentistry to align itself with the licensing practices of all other health care professionals and eliminate the use of patients as part of the examination process," Kanellis said.

Dental board executive director Jill Stuecker said the board believes this exam is necessary to ensure "minimum competency," but is considering a proposal that would make it easier for students to use "patients of record" at the university's dental clinic. "This would ensure that procedures were completed as part of ongoing patient care, and would eliminate the burden placed on dental students to find patients outside the school," she said.

Students already strive to use existing UI dental patients for exams whenever they can, Kanellis said. However, these patients may not have the exact problem or need the exact procedure required by the test. Students will still need to find what are essentially "test subjects" and get them to the clinic on a specific date or risk failing. And the ethical problems with using live patients on a state-required licensing exam remain.

The practice compromises the dignity of patients, who are frequently low-income and lack dental insurance and a regular dentist. A few years ago, a U of I dental school graduate, Jarod Johnson, told a Register editorial writer that in some cases patients delay a needed procedure so a student can perform it during the exam.

"No other profession would leave a disease untreated so an exam could be passed," Johnson said. "No one would want to leave a cancerous lesion to grow over a few months just so a doctor could pass a surgical exam."

The practice also compromises the dignity of dental students who are put in a position to violate the ethical standards of their profession. What if you can't find anyone who needs a cavity filled? How much can you pay someone to agree to a procedure? Are applicants making promises for follow-up care that they can't keep?

Who would have known that securing a license to practice dentistry in Iowa would hinge on whether you could coerce and drag patients to your chair?

This is another example of how licensing boards in this state excel at imposing outdated, onerous, and even ludicrous, requirements on potential licensees — not because it protects public safety, but because it's what has "always been done." This requirement should be eliminated.

Nightmares finding patients

In a July 6 letter to the dental board, Michael Kanellis of the University of Iowa dental school provided a glimpse of the absurd, and even dangerous, situations his students face in trying to round up volunteers.

One student found a woman willing to participate as long as he called her, woke her up and picked her up on exam day. Things did not go as planned.

"That morning, no one answered the phone," said the student. "When I went to pick her up, her boyfriend with a history of violence answered the door. He would not allow me to see or speak with her. I feared for my personal safety during our conversation. ... Then he ran me off the property. I drove back to the college already assuming that I had failed the examination."

Another told of "nightmares" about patients not showing up on the day of the student's evaluation. "Unfortunately, my nightmares proved to be true," the student said. The very first patient, originally found online, never arrived. "She did not answer or return any of my phone calls the day of the boards and I have not heard from her since," said the student.



COLLEGE OF DENTISTRY
 Clinic Administration
 440 Dental Science W
 Iowa City, Iowa 52242-1018
 815-335-2418 Fax 319-335-6138

July 6, 2015

Jill Stuecker, MPA, MA
 Executive Director, Iowa Dental Board
 400 SW 8th Street, Suite D
 Des Moines, IA 50309

Dear Jill:

Thank you for meeting with Dean Johnsen, David Holmes, Ron Eivers and myself on Wednesday, May 27 to discuss our concerns over the use of patients on the CRDTS clinical board exam. As follow-up, I am writing to request on behalf of the College of Dentistry that the Iowa Dental Board eliminate the use of patients on the CRDTS board exam effective 2016. We respect the role of the Iowa Dental Board in establishing criteria for the granting of licensure to practice in Iowa, but we believe that the use of patients in the exam has become extremely problematic and no longer defensible, and that alternate strategies exist that would be just as effective in protecting the public. Several troubling aspects of the patient portion of the exam are outlined below.

1) Reliable patients are increasingly difficult to find for the board exam

While our senior dental students were taking CRDTS this spring, I had the opportunity to sit in on a presentation that Kimber Cobb (Executive Director of CRDTS) made to the Iowa Dental Board of Trustees in Des Moines. During Kimber's presentation, she stated that the integrated format of CRDTS assures that patients treated by students during the CRDTS exam are patients of record at the College of Dentistry and that the treatment provided is part of a comprehensive treatment plan. Unfortunately, this has not been our experience. We spend a great deal of time and effort identifying patients for the CRDTS exam, including advertising on Craigslist, posting tear-sheets at area stores, and hosting multiple free evening screenings. Using patients for the clinical board exams has increasingly put our students in a position where they have very little control and are too often abused by their patients. Following this year's exam we surveyed students asking about their experiences. Two student comments from this year related to the difficulty identifying reliable patients follow:

- *I had a very difficult time finding patients. I found my Class II patient at a screening event who saw our ad on Craigslist. I found my SRP patient approximately 1-2 weeks prior to boards. She was a comprehensive patient of a classmate who was willing to share her with me on the day of boards. I found my Class III patient one week prior to boards. It was a comprehensive patient of a classmate. Being in Group 3 was very difficult in regards to finding patients for boards. It's also lack of the draw to some extent. Are you lucky to get the right patient to fall into your chair? I was not that lucky*

person. I had nightmares leading up to boards about my patients not showing up. Unfortunately,

Default on student loans, lose license to work

If you want to earn money interpreting in sign language, massaging necks, planning diets, blow-drying hair or performing scores of other tasks, you must obtain a license from one of Iowa's job licensing boards. Last month, the Obama administration issued a report underscoring how such occupational licensing has run amok in this country.

The 76-page report, prepared by the Department of Treasury, the Council of Economic Advisers and the Department of Labor

(https://www.whitehouse.gov/sites/default/files/docs/licensing_report_final_nonembargo.pdf), should be mandatory reading for Gov. Terry Branstad and state lawmakers. Iowa was specifically cited, and not in a way that reflect well on us.

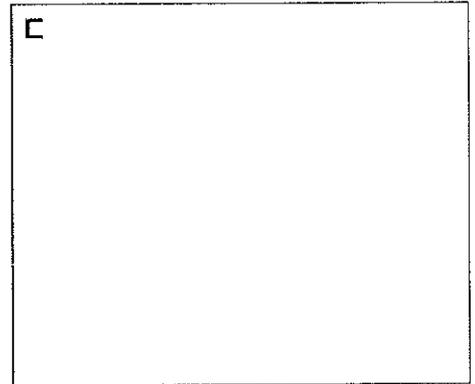
Iowa requires 16 months of education to be a licensed cosmetologist — twice as much as New York and Massachusetts, according to the report. Only 12 percent of workers in South Carolina are licensed compared with 33 percent in Iowa. One third of our state's workforce obtains permission from the state to earn a living. That is a higher percentage than any other state.

Iowa is also among the states with a "misguided" policy that allows a state board to revoke or suspend someone's license to work if he or she defaults on a student loan. The federal report noted a bill to repeal this counterintuitive provision was recently drafted "but did not make it out of the legislature" in Iowa.

That sure sounds like our state. Elected officials continue to refuse to reform job-killing, arcane and even retributive licensing laws.

Read more editorials this issue at DesMoinesRegister.com/joblicensing (<http://DesMoinesRegister.com/joblicensing>).

Read or Share this story: <http://dmreg.co/1NiLNFy>



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[\(/videos/opinion/2893066148001/433315301600\)](#)
01:03

[Lindsey Graham on recent Supreme Court ruling of gay](#)



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Executive Director, Iowa Dental Board
400 SW 8th Street, Suite D
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person. I had nightmares leading up to boards about my patients not showing up. Unfortunately, my nightmares proved to be true. I had called all of my patients several times the week of boards. They all confirmed with me that they would be there. Well, my first patient (Class II from craigslist) did not show up at all. She did not answer or return any of my phone calls the day of boards and I have not heard from her since. Luckily, a classmate had a backup Class II that she was willing to share with me the day of the exam, so I was able to at least do something; however, I was unprepared with this patient. I had to go get the radiographs moved to my candidate account and go through health history, etc. It was a very stressful experience because of paperwork and relying on patients to show up. I did not feel very stressed about the dentistry itself, just the things that are out of our control.

- My SRP patient agreed to and was eager to participate. She stated that she would have difficulty getting to the College and getting there on time. She agreed to allow me to call her to wake her up and to pick her up to give her a ride. That morning, no one answered the phone. When I went to pick her up, her boyfriend with a history of violence answered the door. He would not allow me to see or speak with her. I feared for my personal safety during our conversation due to both his verbal and nonverbal communication. He then ran me off the property. I drove back to the college already assuming that I had failed the examination because of my patient failure. I had to scramble to try to find a last minute SRP backup. The first available backup did not qualify, but thankfully a second backup that was beyond qualifying and had characteristics that “were NOT advised” became available. I had no other option other than to attempt a far from ideal case if I wanted any chance of passing. I ended up starting the exam late due to having to find a new patient. My Class III patient did not answer her phone the night before and was supposed to come in second. I called her and woke her up because she overslept. I frantically called and pleaded with my Class II patient to come in earlier than expected. My Class II was significantly larger clinically than indicated radiographically. This made this case extremely stressful when there was a pulp exposure. The total time of the multiple efficiently requested modifications and the exposure protocol set me back significantly on time. My Class III ran to 10 minutes before every final deadline. This is not a day that I ever wish to repeat!!

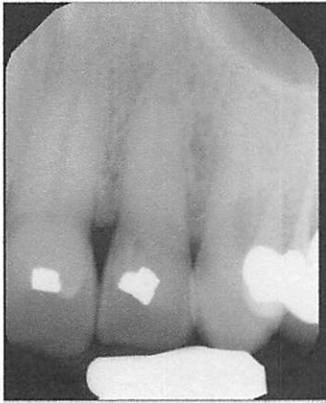
2) The patient portion of the CRDTS exam lack validity

During Kimber’s presentation, we learned that CRDTS examiners are calibrated for 8 hours prior to each clinical board exam. However, the calibration of examiners on caries detection is not done on patients, and does not include a tactile component. During one part of Kimber’s presentation she showed a slide of a prepared tooth and stated that “everyone can see there is caries remaining”. When I spoke to Kimber following her presentation and asked how CRDTS can claim their examiners are calibrated on caries detection, she stated that all examiners are licensed dentists in good standing with their state board, and CRDTS trusts they know caries when they see it. This is problematic given the current dynamic state of caries detection and decision making regarding caries removal in the academic world. The philosophy taught and followed in the Department of Operative Dentistry at the University of Iowa can be found on their website “Operative Best Practices for Clinical Care” at <https://www.dentistry.uiowa.edu/operative>.

3) There are serious ethical concerns with the use of patients for board exams

Kimber stated in her presentation that with the integrated format, the lesions treated on the restorative section of CRDTS are part of a comprehensive treatment plan. This has also not been our experience, with many students indicating in our survey (following boards) that the lesions they treated were not treatment planned for restorations, but were being monitored for remineralization. This creates an ethical dilemma. Moving forward, we anticipate that decisions regarding restoration of small asymptomatic lesions will become more complicated, as more small lesions become medically rather than surgically managed.

A periapical radiograph from a patient from this year's clinical board exam follows. A restoration was placed on the mesial of #10 during the CRDTS exam. The student response to our post-CRDTS survey also follows.



- *At times I felt that it was unethical to restore some of the lesions that we were looking so desperately for, as well as make SRP patients wait months and irritate or destroy more support structure over the waiting period. This does not follow what we are taught in our education or what the studies have shown.*

4) The use of patients in a clinical licensure exam does nothing to protect the public

With their central charge to the board of protecting the public, we understand the Iowa Dental Board believes that a patient-based exam (CRDTS) is essential in order to prevent incompetent dentists from practicing. However, at the University of Iowa College of Dentistry we cannot think of a single candidate that failed the exam, and did not eventually successfully pass it. I believe the Iowa Dental Board believes that passing on a second attempt is the result of successful remediation, but hardly ever is remediation even a possibility. By the time students find out they have failed a patient section of CRDTS, the deadline to take CRDTS in adjoining states has typically passed. We have to call to ask for permission to allow late registration. Meanwhile the students scramble to find patients, line up transportation and housing, and

take out loans to cover the additional expense. Some of these students are actually in "Group 4" of our senior curriculum which means they don't return to the College at all following the exam, but are on extramural rotations for the remainder of the year. There is typically no remediation available or offered. And yet, all eventually pass.

5) National sentiment against the use of patients is increasing

Following Kimber's presentation to the Iowa Dental Association Board of Trustees, the Board of Trustees voted unanimously to eliminate the use of patients for clinical board examinations. This is not the first group to oppose the inclusion of patients on exams. The American Dental Education Association Council of Deans representing deans from the U.S. and Canada has voted unanimously to oppose the use of patients on clinical board exams. Further, the University of Minnesota faculty has voted to no longer host a patient based exam at their College of Dentistry after 2016. , The State of New York offers licensure without a clinical board exam for anyone doing a PGY1 year. California now grants licensure based on successful completion of a portfolio exam. And earlier this month it was announced that Massachusetts' Senate Majority Leader has introduced a bill in their state legislature to eliminate using live patients for dental licensing exams. Dentistry is the only profession to require a patient care component for licensure, and we believe that it is time for Dentistry to align itself with the licensing practices of all other health care professionals and eliminate the use of patients as part of the examination process.

6) Options to a patient-based exam exist

Following her presentation to the Iowa Dental Board of Trustees I suggested to Kimber that CRDTS pilot test a patient-free exam at the University of Iowa College of Dentistry during the spring of 2016. We understand and respect the role of the Iowa Dental Board in granting licenses to practice in the state. The administration and faculty at the University of Iowa College of Dentistry respectfully submit that the time for using patients in the Clinical Board exam process needs to come to an end. We would be willing to work with the Iowa Dental Board and to come up with a reasonable alternative leading to licensure for Iowa Dentists. Several options that could be implemented by 2016 include the CRDTS exam without the use of patients, or the use of the OSCE exam being offered in Minnesota.

Respectfully Submitted,



Michael Kanellis, DDS, MS
Associate Dean for Patient Care

First UCSF student completes licensure by portfolio

The first student to complete the licensure by portfolio process at the UCSF School of Dentistry has graduated. Jose Molina, DDS, who is now practicing as an associate dentist in Fresno, chose to obtain his licensure through this process because he felt it was a more "complete assessment" of his competency as a dentist. He also appreciated the fact that he was able to work on his own patients, providing follow-up care as needed.



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The portfolio option gives students in California an alternative to being tested on a live patient over the course of one weekend, which is the method of assessing competency used in the Western Regional Examining Board (WREB) exam process, as well as other examinations throughout the country. The portfolio process offers multiple benefits to students and patients, including letting students extend treatment over multiple patient visits, which reduces the stress of a one-time testing event and more closely simulates real-world care; providing an opportunity for patients to receive follow-up treatment as needed; and providing a method by which students are ready for licensure upon graduation.

"You actually provide treatment on a patient over a period of months and I felt like it prepared me well for joining a practice as an associate," Molina said.

The Dental Board of California in November finalized the regulatory process of approval for the portfolio examination model in California's dental schools, which is optional for both the schools and students. UCSF and the University of the Pacific Arthur A. Dugoni School of Dentistry are the two schools CDA has been made aware of to have students obtain licensure by portfolio so far.

Peggy Leong, DMD, health sciences clinical professor, led the effort to implement licensure by portfolio at UCSF, working with a committee of students, faculty and other staff to come up with a plan for the school. There are now 30-35 calibrated faculty members at UCSF, according to Leong. Leong was Molina's "coach" during his licensure process, meeting with him monthly and going over what he needed to accomplish according to the *Portfolio Pathway Candidate Manual* sent to the school by the dental board.

"Dr. Molina was a strong advocate for this pathway, he felt he was much better equipped when he graduated than he would have been otherwise," Leong said.

Since portfolio examination is the first of its kind in the nation, there is no licensure reciprocity with other states. The dental board hopes that as the examination proves itself a model for other states, licensure portability will follow. This wasn't an issue for Molina, however, as he is originally from Fresno, attended Fresno State University and had known for a while that he wanted to return there to practice when he finished dental school.

Dorothy A. Perry, PhD, professor and associate dean at UCSF, oversaw the administration arrangements in the process. She is proud of Molina and the school for adopting this new process.

"We are very excited about giving our students an opportunity for a licensure pathway that allows them to provide treatment on patients and have it embedded in the curriculum," Perry said. "Instead of a one-shot deal, like other clinical licensure exams, we were able to embrace a philosophy of comprehensive care during licensure. It's a great opportunity for our students who want to practice in California."

The Dugoni School of Dentistry has also graduated students who received their dental license via the portfolio licensure process. [For more on this, read this article.](#)

CDA and ADA policy supports the elimination of the one-time "live patient" clinical licensure exam and California's dental students have been quite active in California's process. Students hosted licensure forums at *CDA Presents The Art and Science of Dentistry* in Anaheim and San Francisco in 2007, bringing together leaders from the Dental Board of California, CDA and selected dental school deans to discuss the future of licensure. In 2009, Assemblywoman Mary Hayashi (D-Hayward), introduced CDA-sponsored bill AB 1524, calling for the replacement of the California clinical examination with a "portfolio" model exam process that would take place over the course of students' clinical training in dental school. In 2010, Gov. Arnold Schwarzenegger signed the bill into law, and until this past November, it had been in the development phase.

For more information on licensure, visit the dental board's website, dbc.ca.gov.



June 24, 2015

Paul Kleinstub, MS, DDS
Oregon Board of Dentistry
1500 SW 1st Avenue., Ste. #770
Portland, Oregon

Dear Dr. Kleinstub,

Your application has been received and you have been selected to participate on the **Technical Review Board for the Dental Pilot Project Program**. Your expertise will be an invaluable contribution to the program and we thank you in advance for your time.

Each project application will be reviewed by a Technical Review Board comprised of stakeholders and subject matter experts. The role of the Technical Review Board is to determine if the project meets the minimum standards as prescribed in OAR 333-010-0400. Major responsibilities of the Technical Review Board include review of the application and participation and attendance in meetings.

The State Dental Director will consider the Technical Review Board's suggestions when making all final decisions. The Technical Review Board does not have final decision making authority; the State Dental Director has this responsibility.

We anticipate receiving two separate applications in the next few months in the areas of Tele-dentistry (Virtual Dental Home) and Dental Therapy (Dental Therapist). You will be contacted once a Dental Pilot Project application is received with detailed instructions for reviewing the application. Following the review of the application, a board meeting will be scheduled where your attendance is requested. Applicants may present at this meeting and board members may ask questions of the applicants.

The Technical Review Board is comprised of representatives of the following:

- Oregon Dental Association
- Oregon Dental Hygiene Association
- Oregon Primary Care Association
- Oregon Oral Health Coalition
- Oregon Board of Dentistry
- Oregon Health Authority Office of Equity and Inclusion
- At-Large
- At-Large

Staff: Dental Pilot Project Program Coordinator

State of Oregon Dental Director
Subject Matter Experts As Needed

The Technical Review Board is solely responsible for reviewing applications and making recommendations to the State Dental Director which is in contrast to the Evaluation Committee.

The Evaluation Committee is an interdisciplinary team composed of representatives of the dental boards, professional organizations, other state regulatory bodies and interested parties that have applied to participate in evaluating a Dental Pilot Project. Each Dental Pilot Project will have a unique Evaluation Committee. An individual may sit on multiple Evaluation Committees, however a new application is required for each pilot project on which the individual wishes to participate.

If you are interested in participating on the Evaluation Committee for a Dental Pilot Project, please contact me for an application.

Sincerely,

Sarah Kowalski, RDH
Dental Pilot Project Coordinator

Board Secretary Mary Harrison reaches 45 years of certification

This spring, DANB Board of Directors Secretary Mary Harrison, CDA, EFDA, EFODA, FADAA, celebrated a significant milestone: her 45th year as a DANB Certified Dental Assistant (CDA) certificant. Throughout the course of her impressive career, Harrison has impacted the field of dental assisting on the national, state and local levels.

"I am who I am today because I am and have been a Certified Dental Assistant," says Harrison. "My CDA certification has opened many doors for me."

As an active member in the American Dental Assistants Association (ADAA) for over 35 years, Harrison served as the ADAA 10th District Trustee, became an ADAA Fellow and in 2006 won the ADAA Achievement Award. She has held numerous officer positions with



Mary Harrison, CDA, EFDA, EFODA, FADAA

the Oregon Dental Assistants Association, including President and Vice President, and has been a representative to both the Oregon Dental Association and the Oregon Board of Dentistry (OBD), including testifying as a representative for all dental assistants in the state of Oregon before the OBD and the Oregon State Legislature.

"I am very proud to have been involved in some of the changes in the field," says Harrison, "but am even more excited about sharing knowledge and helping other dental assistants improve their skills and their status. I am inspired by other dedicated assistants who are able to teach and influence changes for the betterment of dentistry."

Harrison currently works as a clinical chairside dental assistant and has maintained DANB CDA certification

since 1969. "Taking the CDA exam was an automatic for me," she says, "because I wanted to be the very best I could. I remember being so nervous taking the test and then waiting six weeks to hear my results. Once I passed, it became very important to me to maintain my certification — it shows that I've gone the extra step."

Since August 2010, Harrison has served on DANB's Board of Directors and is currently Board Secretary. "Serving on DANB's Board is the most important activity I have been involved in my whole dental assisting career," she says. "I feel I am part of important changes and activities that will influence dentistry for the good of patients and dental assisting."

"Dental assisting has been my life," says Harrison. "I love my job — I love seating a patient and helping them ease into that chair they may fear and helping them relax. I believe the dental assistant is the go-to team member in a dental practice, and a DANB certification is vital to a good assistant — DANB CDA certification is your passport to bigger and better things."

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

H7021	RACHEL MARIE GAZELEY, R.D.H.	7/10/2015
H7022	SHEILA KATE BOWES, R.D.H.	7/13/2015
H7023	BAHAREH DEZFULLI, R.D.H.	7/13/2015
H7024	LINDSAY J HUEY, R.D.H.	7/15/2015
H7025	GRACE A SCHROEDER, R.D.H.	7/17/2015
H7026	BARBARA ANN PASTENES, R.D.H.	7/17/2015
H7027	LYNN KARAU DAWSON, R.D.H.	7/17/2015
H7028	JENNY D RUDD, R.D.H.	7/17/2015
H7029	ELEANOR MEGAN BARBO HARTNEY, R.D.H.	7/17/2015
H7030	PATRICIA I SPENCER, R.D.H.	7/17/2015
H7031	BRENNA LEIGH RICHARDS, R.D.H.	7/17/2015
H7032	VANN A RATH, R.D.H.	7/21/2015
H7033	KYLA NICOLE FISHER, R.D.H.	7/21/2015
H7034	REBEKAH A CORRIVEAU, R.D.H.	7/22/2015
H7035	LUCY K MORENO, R.D.H.	7/22/2015
H7036	DAWN ELAINE JOHNSON, R.D.H.	7/22/2015
H7037	NALYNN JEAN ANDERSON, R.D.H.	7/22/2015
H7038	AUDREA E WILLIAMS, R.D.H.	7/29/2015
H7039	ANGELA C KOZAK, R.D.H.	7/29/2015
H7040	JESSICA RANAE URENA, R.D.H.	7/29/2015
H7041	NELYA ALEKSANDROVNA VASHCHENKO, R.D.H.	7/29/2015
H7042	NATALYA A TYSHKEVICH, R.D.H.	7/31/2015
H7043	ELIZABETH B POWLISON, R.D.H.	7/31/2015
H7044	ANTONINA G ROBERTSON, R.D.H.	7/31/2015
H7045	NATALIE RENEE DAVIDSON, R.D.H.	7/31/2015
H7046	SARAH ELIZABETH RUZICKA, R.D.H.	7/31/2015
H7047	DANIELLE PEMPEK, R.D.H.	7/31/2015
H7048	MIA J MARTORELLI, R.D.H.	7/31/2015
H7049	SARAH MICHELLE WRIGHT, R.D.H.	7/31/2015
H7050	ALLISON M MILES, R.D.H.	7/31/2015
H7051	MEGAN DIANE HINCHCLIFF, R.D.H.	7/31/2015
H7052	STACEY L CARNEY, R.D.H.	8/3/2015
H7053	KASSANDRA LYNNE WALTERS, R.D.H.	8/4/2015
H7054	KATE LYNN OHRENSTEIN SHYBIB, R.D.H.	8/5/2015
H7055	SHAWNA ALLISON TAYLOR, R.D.H.	8/5/2015
H7056	CAREY L SPENCER, R.D.H.	8/5/2015
H7057	OKSANA URUSKIY, R.D.H.	8/6/2015
H7058	KAYLA RAFAELA CASILLAS, R.D.H.	8/6/2015
H7059	CHELSEA NICOLE EDDY, R.D.H.	8/6/2015
H7060	DEANNA M INNOCENTI, R.D.H.	8/13/2015
H7061	ANNA MIKHAYLOVNA MORAR, R.D.H.	8/13/2015
H7062	HEATHER LEILA BLAKENEY, R.D.H.	8/13/2015
H7063	YULIYA V MAYSTER, R.D.H.	8/13/2015

DENTISTS

D10260	IDA KHOBAHY, D.D.S.	6/18/2015
D10261	MARTA TOLMACH, D.M.D.	6/18/2015
D10262	NGAN HOANG, D.M.D.	6/18/2015
D10263	JAMES LAWRENCE BUSCH, D.D.S.	6/18/2015
D10264	RAMSEY G EDWARDS, D.M.D.	6/18/2015
D10265	JOSHUA M KUCHARSKI, D.M.D.	6/18/2015
D10266	REBECCA I TANSEY, D.M.D.	6/18/2015
D10267	SARAH ANN RODGERS, D.M.D.	6/18/2015
D10268	DANA L FOX, D.M.D.	6/18/2015
D10269	CODY SIMON NEGRETE, D.D.S.	6/24/2015
D10270	PARISA J ANSARI, D.M.D.	6/24/2015
D10271	BENNETT PACKARD LARSEN, D.D.S.	6/24/2015
D10272	EMMA CHIOMA ONWUKA, D.D.S.	6/30/2015
D10273	T. MICHAEL HALL, D.D.S.	6/30/2015
D10274	HIEU PHAM, D.M.D.	6/30/2015
D10275	CHRISTIAN M OKAFOR, D.D.S.	6/30/2015
D10276	IGOR A SITNIK, D.M.D.	6/30/2015
D10277	KATELYN RENEE NICHOLS, D.M.D.	6/30/2015
D10278	FRANCIS J HAIK, D.M.D.	6/30/2015
D10279	YUKTI GARG, D.D.S.	6/30/2015
D10280	AARON CHRISTOPHER LAU, D.M.D.	6/30/2015
D10281	BRIAN J BOLLWITT, D.M.D.	6/30/2015
D10282	STEFANIE M BECKLEY, D.M.D.	6/30/2015
D10283	LANDON GEORGE KING, D.D.S.	6/30/2015
D10284	MATTHEW T MAUGER, D.M.D.	7/7/2015
D10285	RYAN ALLAN MILLET, D.D.S.	7/7/2015
D10286	ANA C VIVES BARRETO, D.D.S.	7/7/2015
D10287	PATRICIA N PAPARCURI, D.M.D.	7/7/2015
D10288	ADITI D VYAS, D.D.S.	7/9/2015
D10289	BARDIA SINAEI, D.M.D.	7/9/2015
D10290	SOOYEON SHIM, D.M.D.	7/9/2015
D10291	K. KEVIN PULVER, D.D.S.	7/9/2015
D10292	JACOB JOSEPH FOUTZ, D.M.D.	7/9/2015
D10293	ANNA DNEPROV, D.D.S.	7/9/2015
D10294	FNU SABINA, D.M.D.	7/10/2015
D10295	TROY R BACON, D.D.S.	7/13/2015
D10296	BOBBY SOLEIMAN, D.D.S.	7/13/2015
D10297	LAURYN ESTES MARKS, D.M.D.	7/17/2015
D10298	CRYSTAL SUEJUNG THOMPSON, D.D.S.	7/17/2015
D10299	CODY LEE CHARRON, D.M.D.	7/17/2015
D10300	DIANE HENRIOT, D.M.D.	7/17/2015
D10301	JESSICA MINTIE KLOENNE, D.M.D.	7/17/2015
D10302	MARCUS DAVID UCHIDA, D.M.D.	7/17/2015
D10303	BRIAN ANDREW OGLE, D.M.D.	7/17/2015
D10304	BINSON THOMAS, D.D.S.	7/17/2015
D10305	NIKA MAHBAL, D.M.D.	7/17/2015
D10306	ALISON MARIE SHISLER, D.M.D.	7/17/2015
D10307	EVAN DAVID CAMPBELL, D.M.D.	7/20/2015
D10308	JORDAN M PETERSCHMIDT, D.M.D.	7/20/2015
D10309	ABIGAIL JACKIE BORMAN, D.D.S.	7/20/2015
D10310	KATHERINE LEAH STAHR, D.D.S.	7/21/2015
D10311	JUAN KIM, D.D.S.	7/21/2015
D10312	YANGSHIN WOO, D.M.D.	7/21/2015

D10313	JAMIE L.S. PRAGASAM, D.D.S.	7/21/2015
D10314	JUSTIN DAVID ANDERSON, D.D.S.	7/21/2015
D10315	MEHRON A KAZEMI, D.D.S.	7/21/2015
D10316	ZHEN HUI WUNG, D.D.S.	7/21/2015
D10317	REDDI SUMATHI NAGARIMADUGU, D.D.S.	7/22/2015
D10318	THOMAS JARED HOUGHTON, D.M.D.	7/22/2015
D10319	KAVEENDRA THUSHARA RANASINGHE, D.M.D.	7/22/2015
D10320	KRIKOR KEVORK GAZARIAN, D.M.D.	7/22/2015
D10321	MICHAEL ANTHONY RYAN MARTINS, D.D.S.	7/22/2015
D10322	MEERA JASMINE GREWAL, D.D.S.	7/24/2015
D10323	KERRY ELISABETH CSIGA, D.M.D.	7/24/2015
D10324	MELVIN E PEARSON, D.M.D.	7/29/2015
D10325	ANDREW R STEIDLEY, D.M.D.	7/31/2015
D10326	EUN YOUNG YU, D.M.D.	7/31/2015
D10327	CASEY J CARAHER, D.M.D.	7/31/2015
D10328	COLIN ALFRED DOLE, D.M.D.	7/31/2015
D10329	CINDY QUYEN HUYNH, D.D.S.	7/31/2015
D10330	GREG M LEE, D.M.D.	8/3/2015
D10331	DEVIN MICHAEL WAHLSTROM, D.M.D.	8/4/2015
D10332	FARIELLE IBRAHIM HOURAN, D.M.D.	8/5/2015
D10333	MEREDITH CHRISTINE MC CLAY, D.M.D.	8/5/2015
D10334	BRYAN R NEISH, D.M.D.	8/5/2015
D10335	DIANA D STEWART, D.M.D.	8/6/2015
D10336	TANNER A BARRATT, D.M.D.	8/7/2015
D10337	KATHLEEN R ROWLEY, D.D.S.	8/7/2015
D10338	SIMON TOADER, D.M.D.	8/13/2015
D10339	JAMES IAMSUREY, D.D.S.	8/13/2015
D10340	HOOMAN SHAKIBA, D.M.D.	8/13/2015
D10341	RONALD GRAHAM MCENTIRE, D.D.S.	8/13/2015
D10342	STEFAN MIHAI NEDELICU, D.M.D.	8/13/2015

DENTAL FACULTY

DF0030	DESPOINA BOMPOLAKI	6/18/2015
DF0031	TIMOTHY A SVEC, D.D.S.	6/30/2015
DF0032	YING WU	7/22/2015

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