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**OREGON BOARD
OF
DENTISTRY**

**BOARD MEETING
DECEMBER 18, 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
October 30, 2015**

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

STAFF PRESENT: Stephen Prisby, 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)
Jessica Conway, Office Manager (portion of meeting)

ALSO PRESENT: Lori Lindley, Sr. Assistant Attorney General
Susan Bischoff, Sr. Assistant Attorney General (portion of meeting)

VISITORS PRESENT: Heidi Jo Grubbs, R.D.H., Christina Swartz Bodamer, ODA; Mary Harrison, ODAA; R. Owen Combe, D.M.D. Anthony Medina, DAS; Bruce Burton, D.M.D., ODA; Thomas. L. Haymore, D.M.D., James Brown, Harold Hickok, Pamela Lynch, R.D.H., Nick Budnick, Oregonian Media Group

Call to Order: The meeting was called to order by the President at 7:40 a.m. at the Board office; 1500 SW 1st Ave., Suite 770, Portland, Oregon.

NEW BUSINESS

MINUTES

Dr. Underhill moved and Dr. Smith seconded that the minutes of the August 28, 2015 Board meeting be approved as amended. The motion passed with Dr. Smith, Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

ASSOCIATION REPORTS

Oregon Dental Association

Christina Swartz Bodamer reported on the ODA's peer review program. She reported that 90% of cases are being completed in 90 days or less.

Oregon Dental Hygienists' Association

Stephen Prisby stated that he spoke to Lynn Ironside and she was unable to attend the meeting but had nothing to report at this time. The ODHA's annual conference will be November 13-15, 2015 at The Sheraton Hotel at Portland Airport. Mr. Prisby planned to present a "Board Updates" presentation on Nov. 13th.

Oregon Dental Assistants Association

Mary Harrison commented about lead aprons and thyroid collars. The ODAA annual session will be held December 5, 2015.

COMMITTEE AND LIAISON REPORTS

WREB Liaison Report

Dr. Jonna Hongo had nothing to report at this time.

AADB Liaison Report

Dr. Amy Fine was absent and there was nothing to report at this time. The AADB annual meeting is scheduled for November 3-4, 2015 in Washington, D.C.

ADEX Liaison Report

Dr. Jonna Hongo had nothing to report at this time. The next meeting is scheduled for November, 2015.

CDCA Liaison Report

Dr. Amy Fine was absent and there was nothing to report at this time. The CDCA annual meeting will be held January 14-16, 2016 in Orlando, Florida.

Committee Meeting Dates

- Board Committee Meeting Reports
 - Licensing, Standards & Competency Committee Meeting – Amy Fine, DMD, Chair

Mr. Prisby reported on Dr. Fine's behalf. The Committee recommended that the Board send to the Rules Oversight Committee the request for the addition of a certificate for pediatric and/or prevention focused expanded function dental assistant. Dr. Schwindt moved and Dr. Beck seconded this recommendation. The motion passed with Dr. Smith, Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

The Committee recommended that the Board send OAR 818-042-0070(1) to the Rules Oversight Committee to add language to the rule regarding when a patient would need to be seen prior to discharge. Dr. Schwindt moved and Dr. Smith seconded this recommendation. The motion passed with Dr. Smith, Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

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EXECUTIVE DIRECTOR'S REPORT

Board Member & Staff Updates

Mr. Prisby introduced the new OBD Office Manager, Jessica Conway. The new Dental Investigator position interviews are in the final stages, second interviews will be held in November, with a tentative start date in December, 2015.

OBD Budget Status Report

Mr. Prisby reviewed the latest budget report for the 2015 - 2017 Biennium. The report, which is from July 1, 2015 through August 31, 2015, shows revenue of \$363,802.51 and expenditures of \$172,064.78. He reported that we have just completed the 1st RDH Renewal for the 2015-17 Biennium. Mr. Prisby said he would be happy to answer questions that the board members have regarding the report.

Dental Hygiene Renewal

The first renewal of the 2015-17 Biennium finished Sept 30th.

- 2107 Renewals mailed – July 16, 2015
- 1889 Renewed
- 188 Expired (118 out-of-state, 70 in Oregon)
- 30 Retired

Overview of OBD Workload

Mr. Prisby stated that he attached some statistics on licensing and investigative activities at the OBD. The information shows the OBD Staff are processing significantly more applications, renewals and investigative cases than the previous two years with staff turnover and no additional resources. The DPA has also been updated showing the amended rules effective October 1st. The DPA has been posted to the OBD website.

Customer Service Survey

Mr. Prisby stated that he attached the legislatively mandated survey results from July 1, 2015 - September 30, 2015, implementing our new online format and comments received. The results of the survey show that the OBD continues to receive positive ratings from the majority of those that submit a survey.

Board and Staff Speaking Engagements

Mr. Prisby gave a "Board Updates" presentation on Sept. 11, 2015 at the ODA House of Delegates meeting in Bend.

2015 Annual Performance Report

Mr. Prisby stated that he attached the 2015 Key Performance and Annual Performance report for the OBD.

Legislation

Mr. Prisby stated that he attached some information regarding cultural competence, certification for local school dental sealant programs, training health care workers to provide oral disease prevention services and disciplinary information available to the public.

OBD LEDS/data security

The Oregon State Police's Criminal Justice Information Services Division (CJIS) recently conducted training for all state agencies that utilize the LEDS (Law Enforcement Data Systems).
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Teresa Haynes attended the training and Mr. Prisby reported that there may be some possible changes the OBD will need to make to be in compliance with new and updated rules.

Strategic Planning Session

The next Strategic Planning Session will be April 22 -23, 2016. Mr. Prisby reported that the estimated cost of this session will be around \$12,000.00, including cost estimates on board member expenses, staff time, facility rental, use of a professional facilitator, catering and hotel accommodations.

Newsletter

The next newsletter is being assembled. Mr. Prisby hopes to have it finalized and distributed before the December Board meeting.

UNFINISHED BUSINESS

Rules

- Review and discuss qualifications and pathways to licensure.

Dr. Beck moved and Mr. Morris seconded that the Board refer to the Licensing, Standards and Competency Committee a review of the applicable statutes and rules regarding the pathways to licensure, including allowing teaching hours to be applicable to dentists for further review. The motion passed with Dr. Smith, Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

CORRESPONDENCE

- **The Board received a letter from** Gail Aamodt- Regarding use of EpiPen. The board asked staff and Lori Lindley to follow up with The Pharmacy Board and ODHA to determine best option for access to EpiPens.

OTHER BUSINESS

The board discussed 3 courses for Subgingival Cord Placement.

- Request Board Approval - Place Cord Subgingivally Course – Bonnie Marshall, EFDA, EFODA, BS
- Request Board Approval - Place Cord Subgingivally Course – Linda Selby, DMD
- Request Board Approval – Place Cord Subgingivally Course – Pablo Nicacio, DDS

Dr. Beck moved and Dr. Smith seconded that the board refer to the Licensing, Standards and Competency Committee, the issue of what criteria is needed in certified courses for Cord Placement for dental assistants. The motion passed with Dr. Smith, Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

Dr. Smith moved and Dr. Beck seconded that the board refer to the Licensing, Standards and Competency Committee, the issue regarding any course going to the board for approval meet an overall standard of criteria and follow specific guidelines applicable to all courses needing

Board approval. The motion passed with Dr. Smith, Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

The board reviewed the Dentistry Mentorship Program provided in packet.

- Review of Dentistry Mentorship Program Description

Dr. Underhill moved and Dr. Beck seconded that the board accept this mentorship program as a board standard for licensees needing a refreshment or necessary remediation. The motion passed with Dr. Smith, Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

Articles and News of Interest (no action necessary)

- Recognition of past OBD President and board member, Dr. Ken Johnson.

EXECUTIVE SESSION: The Board entered into Executive Session pursuant to ORS 192.660 (2)(f), (h) and (k); ORS 676.165; ORS 676.175 (1), and ORS 679.320 to review records exempt from public disclosure, to review confidential investigatory materials and investigatory information, and to consult with counsel.

PERSONAL APPEARANCES AND COMPLIANCE ISSUES

Licensee appeared pursuant to their Consent Order in case number **2008-0013**.

LICENSING ISSUES

OPEN SESSION: The Board returned to Open Session.

CONSENT AGENDA

2016-0065, 2016-0054, 2016-0061, 2016-0045 2016-0044 and 2016-0029

Dr. Smith moved and Dr. Hongo 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, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye. Dr. Smith and Dr. Schwindt recused themselves on case 2016-0029.

COMPLETED CASES

2014-0115, 2014-0214, 2015-0033, 2015-0035, 2016-0008, 2015-0130, 2015-0038, 2015-0043, 2014-0235, 2014-0208, 2015-0039 and 2015-0028

Dr. Smith moved and Dr. Hongo seconded that the above referenced cases be closed with a finding of No Further Action per the Board recommendations. The motion passed with Dr. Smith, Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt, and Dr. Underhill voting aye. Dr. Schwindt recused himself on 2015-0033.

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2015-0027

Dr. Beck moved and Dr. Smith seconded that for respondent #1 and #2 that the Board close with a Letter of Concern reminding Licensee to assure that their chart documentation is complete. The motion passed with Dr. Smith, Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

Bell, R. Bryan, D.D.S. 2014-0153

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

2014-0225

Dr. Schwindt moved and Dr. Hongo seconded that the Board close the matter with a Letter of Concern addressing the issue of ensuring that every effort is made to utilize adequate radiographs when formulating a treatment plan and that when there is apparent pathology visible on a radiograph, the pathology is documented in the patient records. The motion passed with Dr. Smith, Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

2015-0195

Ms. Riedman moved and Dr. Hongo seconded that the Board close the matter with a Letter of Concern addressing the issues of ensuring that the name, strength, and quantity of all anesthetics administered are documented in the patient record; that when surgically placing an implant, the brand of implant used is documented in the patient record; that when restoring an implant, the torque measurement confirming implant integration is documented in the patient record; that periodontal probing measurements taken during exam are documented in the patient record; and that adequate interproximal contacts are present when cementing a crown. The motion passed with Dr. Smith, Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

2015-0041

Dr. Hongo moved and Dr. Smith seconded that the Board close the matter with a Letter of Concern reminding Licensee to test his autoclave on a weekly basis, as per Board protocol. The motion passed with Dr. Smith, Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

Derebe, Samson S., D.M.D. 2013-0094

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

2014-0186

Ms. Martinez moved and Dr. Beck seconded that the Board close the matter with a **Strongly** Worded Letter of Concern reminding Licensee to ensure that records are provided to the patient within 14 days of request even when treatment is not transferred to a subsequent provider, and

testing of heat sterilizers is done on a weekly basis. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye. Dr. Hongo recused herself.

Engel, Andrew W., D.M.D. 2015-0053

Dr. Beck moved and Dr. Underhill seconded that the Board issue a Notice of Proposed Disciplinary Action and offer the licensee a Consent Order incorporating a reprimand, a \$3,000.00 civil penalty to be paid within 60 days of the effective date of the Order, 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. The motion passed with Dr. Smith, Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

Haghighat, Kamran 2014-0140

Mr. Morris moved and Dr. Schwindt 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 pay a \$1,000.00 civil penalty. The motion passed with Dr. Smith, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye. Dr. Beck recused himself.

Hahn, Kai-Uwe H., D.M.D. 2015-0037

Dr. Schwindt moved and Dr. Smith seconded that the Board close the matter with a Notice of Proposed Disciplinary Action and an offer of a Consent Order in which the Licensee would agree to be reprimanded. The motion passed with Dr. Smith, Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

2015-0024

Ms. Riedman moved and Dr. Hongo seconded that the Board close the matter with No Further Action. The motion passed with Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye. Dr. Beck and Dr. Smith recused themselves.

Hancock-Marshall, Karen J., R.D.H. 2015-0117

Dr. Hongo moved and Dr. Underhill 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, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

2015-0018

Dr. Underhill moved and Dr. Hongo seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that all prescriptions are completely documented, and that he is responsible for knowing that the instruments he uses are sterilized in an autoclave that is being spore tested on a weekly basis. The motion passed with Dr. Smith, Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

Heppler, Lance J., D.M.D. 2016-0039

Dr. Hongo moved and Ms. Martinez seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand for missing seven weeks of autoclave testing in eight and one half months of 2015, and for the omissions in

October 30, 2015

Board Meeting

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documentation take a 3 hour course on documentation within 6 months of the effective date of the Consent Order. The motion passed with Dr. Smith, Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

2014-0171

Dr. Schwindt moved and Dr. Hongo seconded that the Board write a Letter of Concern reminding the Licensee to take a CBCT study when suspected root resorption is detected on panoramic films prior or during the course of orthodontic therapy. The motion passed with Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye. Dr. Smith recused herself.

2015-0001

Ms. Martinez moved and Dr. Underhill seconded that the Board close the matter with No Further Action for both Respondents. The motion passed with Dr. Beck, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye. Dr. Smith and Dr. Hongo recused themselves.

2015-0046

Ms. Martinez moved and Dr. Hongo seconded that the Board close the matter with a finding of No Violation. The motion passed with Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye. Dr. Smith recused herself.

Kim, Sean S., D.M.D. 2014-0087

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

2015-0034

Dr. Underhill moved and Ms. Martinez seconded that the Board issue a Letter of Concern assuring that sterilization testing is done on a weekly basis. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye. Dr. Hongo recused herself.

Madugula, Kala Sagar, D.M.D. 2014-0201

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

Matsuda, Melvin, D.D.S. 2014-0227

Dr. Schwindt moved and Mr. Morris seconded that the Board issue a Notice of Proposed Disciplinary Action and offer the licensee a Consent Order in which the licensee would agree to be reprimanded, to pay a \$6000.00 civil penalty, to provide 40 hours of pro bono dental care and to submit sterilizer monitoring reports to the Board for a period of one year from the effective date of the Order. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye. Dr. Hongo recused herself.

Mueller, Thomas C., D.M.D. 2015-0014

Ms. Riedman moved and Dr. Hongo seconded that the Board issue a Notice of Proposed Disciplinary Action and offer the Licensee a Consent Order in which the Licensee would agree

to be reprimanded and pay a \$1,000.00 civil penalty. The motion passed with Dr. Smith, Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

2015-0047

Dr. Beck moved and Dr. Hongo seconded that the Board write a Letter of Concern ensuring that the Licensee is responsible for knowing that the instruments she uses are sterilized in an autoclave that is being spore tested on a weekly basis. The motion passed with Dr. Smith, Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

2015-0048

Dr. Hongo moved and Dr. Underhill seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that there is a diagnosis for all dental procedures and that they are documented completely and accurately. The motion passed with Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye. Dr. Smith recused herself.

2014-0204

Dr. Underhill moved and Dr. Hongo seconded that the Board close the matter with a Letter of Concern addressing the issue of ensuring that when there is pathology evident on radiographs, the pathology is documented in the patient records. The motion passed with Dr. Smith, Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

2016-0006

Ms. Martinez moved and Dr. Beck seconded that the Board close the matter with a Letter of Concern addressing the issue of ensuring that when nitrous oxide is administered every effort is made to accurately document the patient's vital signs, amount of nitrous oxide administered and the patient's condition upon discharge. The motion passed with Dr. Smith, Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

2015-0017

Dr. Beck moved and Dr. Underhill seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that all chart notes are complete and accurate. The motion passed with Dr. Smith, Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

2015-0042

Mr. Morris moved and Dr. Hongo seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that he documents a diagnosis in the treatment notes for all treatment that he performs. The motion passed with Dr. Smith, Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

Smith, Grant M., D.D.S. 2014-0165

Dr. Schwindt moved and Dr. Hongo seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand and to take a Board approved 3 hour course on record keeping unless taken in the last year and perform 20 hours of community service in the next six months. The motion passed with Dr. Smith, Dr.

Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye. Dr. Beck recused himself.

Smith, Dane E., D.D.S. 2015-0008

Ms. Riedman moved and Dr. Hongo seconded that the Board issue a Notice of Proposed Disciplinary Action and offer the Licensee a Consent Order incorporating a reprimand, a civil penalty of \$1,000.00 and reimbursement to the patient of \$688.00. The motion passed with Dr. Smith, Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

Tarrant, Terry W., D.M.D. 2015-0025

Dr. Hongo moved and Dr. Underhill seconded that the Board issue a Notice of Proposed Disciplinary Action, and offer Licensee a Consent Order incorporating a reprimand and a Civil penalty of \$1,000.00, reimbursement to patients of \$505.00, and the taking eight hours of Board approved course in Periodontal therapy within six months. The motion passed with Dr. Smith, Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

2015-0036

Dr. Schwindt moved and Dr. Beck seconded that the Board close the matter with a Letter of Concern reminding the Licensee to assure that correct tooth number is documented and that a pulpectomy should be performed when primary teeth demonstrate symptoms of irreversible pulpitis rather than a pulpotomy, and to list all medicaments utilized in the patient record. The motion passed with Dr. Smith, Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

2015-0010

Dr. Underhill moved and Dr. Hongo seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that he not use the term “cavity” or “decay” in discussing abfractions. The motion passed with Dr. Smith, Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

Tran, Tu D., D.D.S. 2015-0009

Ms. Martinez moved and Dr. Underhill seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order in which the Licensee would agree to be reprimanded, pay restitution to the complainant of \$2,292.00, pay a civil penalty of \$6,000.00, and perform 40 hours of board approved community service, as per Board protocol. The motion passed with Dr. Smith, Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

PREVIOUS CASES REQUIRING BOARD ACTION

Angle, Darrell L., D.D.S. 2011-0184, 0212-0031, 2012-0147, 2012-0172, 2013-0035 and 2014-0081

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

CASE 2011-0184.

2014-0198

Mr. Morris moved and Dr. Beck seconded that the Board close the matter with a determination of No Violation. The motion passed with Dr. Smith, Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

BAILEY, WILLIAM L., D.D.S. 2016-0031

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

Berg, Geoffrey A., D.M.D. 2012-0009

Ms. Riedman moved and Dr. Hongo seconded that the Board offer Licensee a re-written Consent Order incorporating a reprimand, a \$5,000.00 civil penalty, and completion of "Implant Dentistry: Surgical Placement and Restorative Study Club" between January and June 2016. The motion passed with Dr. Smith, Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye. Dr. Schwindt recused himself.

2015-0007

Dr. Hongo moved and Dr. Smith seconded that in regard to Respondent #2 the Board issue an Order of Dismissal, dismissing the Notice of Proposed Disciplinary Action and close the matter with a Letter of Concern reminding Licensee to ensure that the strength of local anesthetic be recorded in the patient record. The motion passed with Dr. Smith, Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

Haymore, Thomas L., D.M.D. 2008-0013

Dr. Underhill moved and Dr. Hongo seconded that the Board grant Licensee relief from the monitoring terms of his Second Amended Consent Order providing he agree to the terms of a Third Amended Consent Order incorporating a restriction to minimal sedation permit only, restriction to the administration of Scheduled Class IV drugs only, no authority to prescribe Scheduled controlled drugs, and a prohibition against the ordering, storing, inventorying, auditing, accessing, drawing or unilateral access to Scheduled controlled drugs. Licensee may, only with a witness, administer, dispense, and waste Scheduled Class IV drugs. The motion passed with Dr. Smith, Dr. Hongo, Ms. Martinez, Ms. Riedman and Dr. Underhill voting aye. Dr. Beck and Dr. Schwindt recused themselves.

2015-0189

Ms. Martinez moved and Dr. Hongo seconded that the Board issue a strongly worded letter of concern to ensure documentation of medication provided, treatment provided, patient's vitals when Nitrous Oxide is administered, PARQ, diagnosis and justification for dental treatment, amount and dosage of anesthetic and epinephrine used, and to ensure a pre-treatment radiograph is obtained. The motion passed with Dr. Smith, Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye. Dr. Schwindt recused himself.

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

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

2014-0090

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

Ludwick, Michelle A., D.D.S. 2014-0190

Dr. Schwindt moved and Dr. Hongo seconded that the Board issue a Default Order incorporating a reprimand, a \$5,000.00 civil penalty and completion of four hours of continuing education in pharmacology within 90 days of the effective date of this Order. The motion passed with Dr. Smith, Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

Lynch, Theodore R., D.D.S. 2014-0143

Ms. Riedman moved and Dr. Hongo seconded that the Board offer Licensee an Amended Consent Order incorporating a \$10,000.00 civil penalty to be paid within 12 months of the effective date of the Order providing he submit a partial payment of \$1,000 by 11/30/15. In the absence of that \$1,000.00 payment, no extension is granted and the Board will address the matter of failure to follow a Board order at its next meeting on 12/18/15. The motion passed with Dr. Smith, Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

2014-0151

Dr. Underhill moved and Dr. Smith seconded that the Board deny Licensee's request to permit him to provide simple third molar extractions. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye. Dr. Hongo recused herself.

Thurman, Leslie S., R.D.H. 2015-0118

Ms. Martinez moved and Dr. Smith seconded that the Board issue a Final Default Order incorporating a reprimand and a \$500.00 civil penalty. The motion passed with Dr. Smith, Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

LICENSURE AND EXAMINATION

Specialty Exam Results

Specialty Candidate Ashish Patel, DDS

Dr. Beck moved and Dr. Hongo seconded that the board issue the candidate a license to practice Oral and Maxillofacial surgery in the State of Oregon. The motion passed with Dr. Smith, Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

Ratification of Licenses Issued

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

DENTAL HYGIENISTS

H7064	DELANEY ERIKA JOHNSON, R.D.H.	8/20/2015
H7065	CHELSEA MARIE SMOTHERMAN, R.D.H.	8/20/2015
H7066	ANA LAURA DE LA TORRE-ORDAZ, R.D.H.	8/20/2015
H7067	VIVIANE M YAACOUB, R.D.H.	8/20/2015
H7068	ASHLEE NICOLE RAINVILLE, R.D.H.	8/20/2015
H7069	GENESIS A PEREZ, R.D.H.	8/20/2015
H7070	ROSALIE ANNE GOODE, R.D.H.	8/20/2015
H7071	MEGAN TYNE COFFELT, R.D.H.	8/20/2015
H7072	WHITNEY LYN BOWERS, R.D.H.	8/20/2015
H7073	JUSTIN CAINES STANTON, R.D.H.	8/20/2015
H7074	SHERYL P SMITH, R.D.H.	8/20/2015
H7075	SHAYLA Q COFFMAN, R.D.H.	8/20/2015
H7076	ASHLEY MARIE RODRIGUEZ, R.D.H.	8/20/2015
H7077	JESSICA HOPE MARIE PARKER, R.D.H.	8/20/2015
H7078	ASHLEYANN ROSE DERAAD, R.D.H.	8/20/2015
H7079	PATRICIA ANN FERRELL, R.D.H.	8/20/2015
H7080	MARIKA I BENSON, R.D.H.	8/20/2015
H7081	TAYLER P ROLAND, R.D.H.	8/21/2015
H7082	JANE U NGUYEN, R.D.H.	8/21/2015
H7083	MARCIE CARABALLO NGUYEN, R.D.H.	8/21/2015
H7084	OZIEL OREA-GARCIA, R.D.H.	8/21/2015
H7085	NICOLE USI, R.D.H.	8/25/2015
H7086	CAITLIN MARA CARLSON SUBIK, R.D.H.	8/28/2015
H7087	KALI E SCOTT, R.D.H.	8/28/2015
H7088	SHOSHANNA R ORDELHEIDE, R.D.H.	8/28/2015
H7089	FRANK W OHMES, R.D.H.	8/28/2015
H7090	ANDREA KAY AUDRITSH, R.D.H.	8/28/2015
H7091	MELINDA TENASHA DURAN, R.D.H.	8/28/2015
H7092	ALLISON M HAMBERGER, R.D.H.	8/28/2015
H7093	LYNSI ANN BARFUSS, R.D.H.	9/9/2015
H7094	AMANDA JOANNE SLADE, R.D.H.	9/16/2015
H7095	MIKAL L LEQUERICA, R.D.H.	9/16/2015
H7096	ANTHONY J BOURG, R.D.H.	9/16/2015
H7097	KATRINA C BAILEY, R.D.H.	9/16/2015
H7098	ARISHNA ASHLEEN SUDHIREDDY, R.D.H.	9/16/2015
H7099	DANA V GASAN, R.D.H.	9/16/2015
H7100	DIANE PHAN, R.D.H.	9/16/2015
H7101	ALEXIS D JACKSON, R.D.H.	9/25/2015
H7102	RACHEL ELIZABETH JOHNSON, R.D.H.	9/25/2015

Draft 1

H7103	VANESSA A MACIEL, R.D.H.	9/25/2015
H7104	REBECCA LOUISE HAGEN, R.D.H.	9/25/2015
H7105	MELISSA MICHELLE FARMER, R.D.H.	10/6/2015
H7106	EMMA TAYLOR SAMMONS, R.D.H.	10/6/2015
H7107	NATASHA N LONDON, R.D.H.	10/6/2015
H7108	JILL ANDREA LOGAN, R.D.H.	10/6/2015
H7109	WHITNEY ALLISON HOFF, R.D.H.	10/8/2015
H7110	JENNIFER COLLEEN HELLING, R.D.H.	10/8/2015
H7111	KELSEY D REED, R.D.H.	10/14/2015
H7112	KATHRYN LYNN HYSELL, R.D.H.	10/14/2015

DENTISTS

D10343	EVAN L BLACKWELL, D.D.S.	8/20/2015
D10344	RYAN W LUCHTEFELD, D.M.D.	8/20/2015
D10345	SETH MICHAEL MONSON, D.M.D.	8/20/2015
D10346	HAILEY Q NGUYEN, D.M.D.	8/20/2015
D10347	MELISSA J WAGES, D.D.S.	8/21/2015
D10348	CHELSEA E TWOHIG, D.D.S.	8/21/2015
D10349	JEFFREY CLEO BRYSON, D.D.S.	8/28/2015
D10350	DAN M SHAER, D.D.S.	9/16/2015
D10351	RACHEL G JABLONSKI, D.M.D.	9/16/2015
D10352	ELISE KAYLENE GRELLMANN, D.M.D.	9/16/2015
D10353	G. RYAN DAVIS, D.M.D.	9/16/2015
D10354	JACOB SCOTT HAMBLIN, D.D.S.	9/16/2015
D10355	ROSS HAVENS HART, D.D.S.	9/25/2015
D10356	S. TYLER SHOEMAKER, D.M.D.	9/25/2015
D10357	JUNG A BAK, D.D.S.	9/25/2015
D10358	DONALD G ECHOLS, D.D.S.	9/25/2015
D10359	BENJAMIN I FRIBERG, D.D.S.	10/6/2015
D10360	MINH QUANG HOANG, D.M.D.	10/6/2015
D10361	NASSER SAID-AL-NAIEF, D.D.S.	10/6/2015
D10362	LEEANN S WELCH, D.M.D.	10/8/2015
D10363	JUNE Y HOUSER, D.D.S.	10/8/2015
D10364	KYLE G GEELAN, D.M.D.	10/8/2015
D10365	HYUNGSUP LEE, D.M.D.	10/14/2015

DENTAL FACULTY

DF0033	GAYLE A LAUGHLIN, D.D.S.	8/20/2015
DF0034	JORGE L GARAICOA PAZMINO,	8/28/2015

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

Reinstatement of Licensee – Laurel D. Young, R.D.H

Mr. Morris moved and Dr. Beck seconded that the Board reinstate the License of Laurel D. Young, R.D.H. The motion passed with Dr. Smith, Dr. Beck, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt, and Dr. Underhill voting aye.

Announcement

No announcements

ADJOURNMENT

The meeting was adjourned at 2:00 p.m. President Harvey stated that the next Board meeting would take place December 18, 2015.

Alton Harvey Sr.
President

Draft 1

**OREGON BOARD OF DENTISTRY
SPECIALTELECONFERENCE BOARD MEETING MINUTES
November 12, 2015**

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

STAFF PRESENT: Stephen Prisby, Executive Director
Paul Kleinstub, D.D.S., M.S., Dental Director/Chief Investigator
Harvey Wayson, Investigator
Jessica Conway, Office Manager

ALSO PRESENT:
via Teleconference Lori Lindley, Sr. Assistant Attorney General

VISITORS PRESENT: Nick Budnick, Oregonian Media Group.

Call to Order: The meeting was called to order by the President at 6:08 p.m. via teleconference.

EXECUTIVE SESSION: The Board entered into Executive Session pursuant to ORS 192.606 (1)(f), (h) and (l); 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.

OPEN SESSION: The Board returned to Open Session.

Haymore, Thomas L., 2015-0221

Dr. Hongo moved and Mr. Morris seconded that the Board issue an Amended Notice of Proposed License Suspension in cases 2015-0222, 2015-0223 and 2015-0224 to include an allegation from the issues in case 2015-0221. The motion passed, with Dr. Fine, Dr. Hongo, Ms. Martinez, Mr. Morris, Ms. Riedman, and Dr. Underhill voting aye. Dr. Smith voted No.

ADJOURNMENT

The meeting was adjourned at 6:55 p.m. Mr. Harvey stated that the next Board meeting would take place December 18, 2015 as scheduled.

Alton Harvey Sr.
President

ASSOCIATION REPORTS

Nothing to report under this tab

COMMITTEE REPORTS

Nothing to report under this tab

**EXECUTIVE
DIRECTOR'S
REPORT**

EXECUTIVE DIRECTOR'S REPORT

December 18, 2015

Board Member & Staff Updates

We are in the process of hiring our Office Specialist 2. The dental investigator interviews are scheduled to be wrapped up the week of the Board meeting. I will have an update at the meeting. Dr. Gary Underhill has volunteered to participate in CODA's accreditation site evaluation of the OIT's Dental Hygiene program in October 2016. **Attachment #1**

Legislation & State Budget Updates

DAS-CFO George Naughton held an agency head budget meeting Dec. 7th. Agency budget instructions for '17-'19 will begin in March 2016. He reported that growing personnel costs (projected 10-12% increases per biennium for the next couple biennia) and a revenue shortfall as the economy's recovery slows down. He also reported that the next biennium, the culmination of rising personnel costs, PERS increases, and upsurges in caseload for large human-service agencies have the potential to be the major factors affecting the state's budget. The OBD will monitor this closely as well as pending rules and legislation on SB 660 (dental sealant programs), HB 2611 (cultural competency), HB 2024 (traditional health care workers providing oral disease prevention services) and SB 230 (OHA workforce database).

OBD Budget Status Report

Attached is the latest budget report for the 2015 - 2017 Biennium. This report, which is from July 1, 2015 through October 31, 2015, shows revenue of \$660,714.35 and expenditures of \$383,794.53. If Board members have questions on this budget report format, please feel free to ask me. **Attachment #2**

Customer Service Survey

Attached are the legislatively mandated survey results from July 1, 2015 - November 30, 2015, and comments received. The results of the survey show that the OBD continues to receive positive ratings from the majority of those that submit a survey. **Attachment #3**

Board and Staff Speaking Engagements

Dr. Kleinstub and I gave a "Board Updates" and "Enforcements" presentation to the Washington County Dental Society with DBIC on November 10, 2015 in Beaverton.

I gave a "Board Updates" presentation to the ODHA at their Convention on November 12, 2015 at the Portland Airport Sheraton.

I gave a "Board Updates" presentation to the Marion and Polk County Dental Society with DBIC on December 4, 2015 in Salem.

AADA & AADB Annual Meetings

The Annual Meetings were held in Washington D.C, November 1 – 4, 2015.

CDCA Annual Meeting

The board members and I have been invited to attend the CDCA's annual meeting in Orlando, FL, January 14 -16, 2016. I request that the Board approve my attendance at this meeting. The CDCA reimburses the OBD for the travel/trip expenses. **Action Requested**

HPSP Program

The boards (Medical, Pharmacy, Nursing & Dentistry) utilizing the HPSP Program have been in discussions regarding the administration and costs of the program with the OHA. A proposal regarding legislation to move the administration of the HPSP program from the OHA to the boards' control is being discussed and reviewed.

Strategic Planning Session

The next Strategic Planning Session will be April 22 -23, 2016. I convened the Administrative Workgroup for a teleconference meeting on November 30th to review some initial plans for the session. I will provide an overview of the discussion at the board meeting.

2016 Calendar

The 2016 calendar is attached. **Attachment #4**

Newsletter

The next newsletter is being finalized and the plan is to have it available and distributed before the end of the year.



Commission on Dental Accreditation

RECEIVED

NOV 16 2015

Oregon Board
of Dentistry

November 9, 2015

Mr. Stephen Prisby
Executive Director
Oregon Board of Dentistry
1500 SW 1st Ave., Ste. 770
Portland, OR 97201

Dear Mr. Prisby:

RE: *State Board Participation on Accreditation Site Visits*

This letter is to notify you that the institution(s) listed below have indicated a willingness to have a representative of the state board participate in the Commission on Dental Accreditation's 2016 on-site evaluations of the following advanced dental education program(s):

Allied Education Site Visits:

Oregon Institute of Technology
Klamath Falls, OR
October 10-14, 2016

Appointment Process and Reimbursement: In accordance with the attached policy statement for state board participation on site visit teams, the state board of dentistry is requested to submit the names of *two* representatives who are *current members* of the board for each site visit listed. The Commission will then ask the institution to select *one* of the individual to participate on the visit. You will be notified when the institution has selected a representative. Prior to the visit, the representative will receive an informational packet from the Commission and the self-study document from the institution. The state board is responsible for reimbursing its representative for expenses incurred during a site visit.

Confirmation of State Board Participation Form (to be returned): Each program that has elected to invite the board of dentistry is identified on the attached Confirmation of State Board Participation Form(s). The board of dentistry is requested to complete this form, as described above.

Please note: The Confirmation of State Board Participation Form(s) must be returned by the due date indicated on each form. If communication is not received from the state board by this date, it will be assumed that the state board is unable to participate on the site visit.

Conflicts of Interest: When selecting its representatives, the state board should consider possible conflicts of interest. These conflicts may arise when the representative has a family member employed by or affiliated with the institution; or has served as a current or former faculty member, consultant, or in some other official capacity at the institution. Please refer to the enclosed policy statements for additional information on conflicts of interest.

Time Commitment: **It is important that the selected representative be fully informed regarding the time commitment required.** In addition to time spent reviewing program documentation in advance of the visit, the representative should ideally be available the evening before the visit to meet with the team. Only one state board representative may cover each visit to ensure that continuity is maintained; it is desirable that the representative be present for the entire visit.

Confidentiality and Distribution of Site Visit Reports: Please note that, as described in the enclosed documents, state board representatives serving on a team must consider the site visit report confidential. Release of the report to the public, including the state board, is the prerogative of the institution sponsoring the program.

If I can provide further information regarding the Commission and its activities related to dental education site visits, please contact me at 1-800-621-8099 extension 2672 or baumannc@ada.org . Thank you in advance for your efforts to facilitate the board's participation in the accreditation process.

Sincerely,



Catherine Baumann
Manager, Advanced Specialty Education
Commission on Dental Accreditation

CB/sp

cc: Dr. Catherine Horan, Manager, Pre-Doctoral Education, Commission on Dental Accreditation (CODA)
Ms. Jennifer Snow, Manager, Advanced Specialty Education
Ms. Peggy Soeldner, Manager, Postdoctoral General Dentistry Education, CODA
Ms. Patrice Renfrow, Manager, Allied Education Programs, CODA
Ms. Alyson Ackerman, Manager, Allied Program Reviews, CODA
File

Enclosures: CODA Confirmation of State Board Participation Form(s)
Policy on State Board Participation and Role During a Site Visit
Policy on Conflict of Interest
Policy on Public Disclosure and Confidentiality

**Commission on Dental Accreditation
Confirmation of State Board Participation
on Advanced Dental Education Site Visits**

Name of Institution: Oregon Institute of Technology
Program(s) to be Evaluated: Allied Education Site Visit
Dates of Site Evaluation: October 10-14, 2016

To aid the Commission on Dental Accreditation in preparing for the site evaluation noted above, please check the appropriate statements and complete the information requested by **November 30, 2015*** or call if **additional time is needed**.

The State Board is unable to participate in the site evaluation.
 The State Board wishes to participate in the site evaluation and submits the following names of current Board members for the institution's consideration.

Name:	_____	Name:	_____
Address:	_____	Address:	_____
City:	_____	City:	_____
State/Zip:	_____	State/Zip:	_____
Phone:	_____	Phone:	_____
Fax:	_____	Fax:	_____
E-Mail:	_____	E-Mail:	_____

Signature

Name (Print/Type): _____

Title: _____

Phone: _____ Fax: _____ Date: _____ E-Mail: _____

Return by fax to: 1-312-587-5104

Attn: Ms. Catherine Baumann, Manager, Advanced Specialty Education
Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, Illinois 60611

***If a response is not received by the date indicated above, it will be presumed that the State Board is unable to participate.**

POLICY ON STATE BOARD PARTICIPATION DURING SITE VISITS

It is the policy of the Commission on Dental Accreditation that the state board of dentistry is notified when an accreditation visit will be conducted in its jurisdiction. The Commission believes that state boards of dentistry have a legitimate interest in the accreditation process and, therefore, strongly urges institutions to invite a current member of the state board of dentistry to participate in Commission site visits. The Commission also encourages state boards of dentistry to accept invitations to participate in the site visit process.

If a state has a separate dental hygiene examining board, that board will be contacted when a dental hygiene program located in that state is site visited. In addition, the dental examining board for that state will be notified.

The following procedures are used in implementing this policy:

1. Correspondence will be directed to an institution notifying it of a pending accreditation visit and will include a copy of Commission policy on state board participation. The institution is urged to invite the state board to send a current member. The Commission copies the state board on this correspondence.
2. The institution notifies the Commission of its decision to invite/not invite a current member of the state board. If a current member of the state board is to be present, s/he will receive the same background information as other team members.
3. If it is the decision of the institution to invite a member of the state board, Commission staff will contact the state board and request the names of at least two of its current members to be representatives to the Commission.
4. The Commission provides the names of the two state board members, to the institution. The institution will be able to choose one of the state board members. If any board member is unacceptable to the institution, the Commission must be informed in writing.
5. The state board member, if authorized to participate in the site visit by the institution, receives the self-study document from the institution and background information from the Commission prior to the site visit.
6. The state board member must participate in all days of the site visit, including all site visit conferences and executive sessions.
7. In the event the chairperson of the site visit committee determines that a vote is necessary to make a recommendation to the Commission, only team members representing the Commission will be allowed to vote.
8. The state board reimburses its member for expenses incurred during the site visit.

The following statement was developed to assist state board members by clearly indicating their role while on-site with an accreditation team and what they may and may not report following a site visit. The statement is used on dental education, advanced dental education and allied dental education site visits.

The state board member participates in an accreditation site visit in order to develop a better understanding of the accreditation site visit process and its role in ensuring the competence of graduates for the protection of the public. The dental, advanced dental and allied dental education programs are evaluated utilizing the Commission's approved accreditation standards for each respective discipline.

The state board member is expected to be in attendance for the entire site visit, including all scheduled conferences and during executive sessions of the visiting committee. While on site the state board member:

CONFLICT OF INTEREST POLICY

Evaluation policies and procedures used in the accreditation process provide a system of checks and balances regarding the fairness and impartiality in all aspects of the accreditation process. Central to the fairness of the procedural aspects of the Commission's operations and the impartiality of its decision making process is an organizational and personal duty to avoid real or perceived conflicts of interest. The potential for a conflict of interest arises when one's duty to make decisions in the public's interest is compromised by competing interests of a personal or private nature, including but not limited to pecuniary interests.

Conflict of interest is considered to be: 1) any relationship with an institution or program, or 2) a partiality or bias, either of which might interfere with objectivity in the accreditation review process. Procedures for selection of representatives of the Commission who participate in the evaluation process reinforce impartiality. These representatives include: Commissioners, Review Committee members, consultants/site visitors, and Commission staff.

In addition, procedures for institutional due process, as well as strict guidelines for all written documents and accreditation decisions, further reinforce adherence to fair accreditation practices. Every effort is made to avoid conflict of interest, either from the point of view of an institution/program being reviewed or from the point of view of any person representing the Commission.

Reaffirmed: 8/12, 8/10

1. Visiting Committee Members: Conflicts of interest may be identified by either an institution/program, Commissioner, consultant/site visitor or Commission staff. An institution/program has the right to reject the assignment of any Commissioner, consultant/site visitor or Commission staff because of a possible or perceived conflict of interest. The Commission expects all programs, Commissioners and/or consultants/site visitors to notify the Commission office immediately if, for any reason, there may be a conflict of interest or the appearance of such a conflict. Because of the nature of their positions, a state board representative will be a resident of the state in which a program is located and may be a graduate of the institution/program being visited. These components of the policy do not apply for state board representatives, although the program retains the right to reject an individual's assignment for other reasons.

Conflicts of interest include, but are not limited to, a consultant/site visitor who:

- is a graduate of a program at the institution;
- has served as a consultant/site visitor, consultant, employee or appointee of the institution;
- has a family member who is employed or affiliated with the institution;
- has a close professional or personal relationship with the institution/program or key personnel in the institution/program which would, from the standpoint of a reasonable person, create the appearance of a conflict;
- manifests a partiality that prevents objective consideration of a program for accreditation;
- is affiliated with an institution/program in the same state; and/or
- is a resident of the state.

If an institutional administrator, faculty member or consultant/site visitor has doubt as to whether or not a conflict of interest could exist, Commission staff should be consulted prior to the site visit. The Chairperson, Vice-Chairperson and a public member of the Commission, in consultation with Commission staff and legal counsel, may make a final determination about such conflicts.

Revised: 2/13; 8/10; Reaffirmed: 8/12

POLICY ON PUBLIC DISCLOSURE

Following each meeting, final accreditation actions taken with respect to all programs, are disclosed to all appropriate agencies, including the general public. The public includes other programs or institutions, faculty, students and future students, governing boards, state licensing boards, USDE, related organizations, federal and state legislators and agencies, members of the dental community, members of the accreditation community and the general public. In general, it includes everyone not directly involved in the accreditation review process at a given institution.

If the Commission, subsequent to and following the Commission's due process procedures, withdraws or denies accreditation from a program, the action will be so noted in the Commission's lists of accredited programs. Any inquiry related to application for accreditation would be viewed as a request for public information and such information would be provided to the public. The scheduled dates of the last and next comprehensive site visits are also published as public information.

The Commission has procedures in place to provide a brief statement summarizing the reasons for which it takes an adverse accreditation action. If initial accreditation were denied to a developing program or accreditation were withdrawn from a currently accredited program, the reasons for that denial would be provided to the Secretary of the U.S. Department of Education, the appropriate accrediting agencies, any appropriate state-licensing or authorizing agencies, and to the public. In addition, the official comments that the affected institution or program may wish to make with regard to that decision, or evidence that the affected institution has been offered the opportunity to provide official comment will also be made available to the Secretary of the U.S. Department of Education, the appropriate accrediting agencies, any appropriate state licensing or authorizing agencies, and to the public.

All documents relating to the structure, policies, procedures, and accreditation standards of the Commission are available to the public upon written request. Other official documents require varying degrees of confidentiality.

Reaffirmed: 8/12, 8/10; Revised: 1/05, 2/01, 7/00; Adopted: 7/94, 5/93

CONFIDENTIALITY POLICY

Confidentiality of the following materials is maintained to ensure the integrity of the institution/programs and of the accreditation process. In all instances Protected Health Information must not be improperly disclosed. The Commission's confidentiality policies apply to Commissioners, Review Committee members, members of the Appeal Board, and consultants/site visitors.

SELF-STUDY DOCUMENT: At the discretion of the institution, the administration may either release information from this document to the public or keep it confidential. The Commission will not release any information in the self-study document without the prior written approval of the institution.

SITE VISIT REPORT: The preliminary draft of a site visit report is an unofficial document and remains confidential between the Commission and the institution's executive officers and may not, under any circumstances, be released. Members of a visiting committee who review preliminary drafts of the report must consider the report as privileged information and must not discuss it or make its contents known to anyone, under any circumstances. Reasons for assigning any non-adverse status other than full approval remain confidential between the institution and the Commission unless the institution wishes to release them.

Public release of the final draft of the site visit report that is approved by the Commission is at the sole discretion of the institution. If there is a point of contention about a specific section of the final site visit report and the institution elects to release the pertinent section to the public, the Commission reserves the right to make the entire site visit report public.

INSTITUTION'S RESPONSE TO A SITE VISIT REPORT: Release of this information is at the sole discretion of the institution. An institution's response must not improperly disclose any Protected Health Information; however, if any such information is included in the response, such information will not be made public.

TRANSMITTAL LETTER OF ACCREDITATION NOTIFICATION: Information such as accreditation status granted and scheduled dates for submission of additional information is public information.

PROGRESS REPORT: The scheduled date for submission of progress reports is public information. Release of the content of a progress report is at the sole discretion of the institution. If there is a point of contention about a particular portion of the progress report and the institution elects to release the pertinent portion to the public, the Commission reserves the right to make public the entire progress report. Progress reports must not improperly disclose Protected Health Information. If any Protected Health Information is included in the progress report, such information will be redacted before the progress report is made public.

SURVEYS: Routinely gathered data are used in the accreditation process and also provide a national data base of information about the accredited dental and dental-related educational programs. The Commission may release to the public any portion of survey data that is collected annually unless the terms of confidentiality for a specific section are clearly indicated on the survey instrument. Subsections of each survey instrument containing data elements which are confidential are clearly marked. Any data which may be reported from confidential subsections are published in a manner which does not allow identification of an individual institution/program.

EXIT INTERVIEWS: The final conference or exit interview between the site visit committee and the chief executive officer, dental dean, chief of dental service or the program director(s) is also confidential. Additional people may be included at the discretion of the institutional administration. The interview is a

confidential summation of the preliminary findings, conclusions, recommendations and suggestions which will appear in the site visit report to the institution. This is a preliminary oral report and the preliminary written report is often only in draft stage at this point; therefore, this session is not recorded on tape or by a stenographer. Note taking is permitted and encouraged.

ON-SITE ORAL COMMUNICATIONS: In order to carry out their duties as on-site evaluators, visiting committee members must communicate freely with administrators, faculty, staff and students and any other appropriate individuals affiliated with an education program. As part of their on-site accreditation duties, committee members are expected to share with other team members pertinent and relevant information obtained during interviews. All oral communications occurring on-site, however, are confidential among team members. When the site visit ends, team members may communicate orally, or in writing, only with Commission staff or other team members about any on-site interview or conversation. All questions related to any aspect of the site visit including oral communications must be referred to the Commission office.

MEETING MATERIALS/DISCUSSIONS: Background reports and informational materials related to accreditation matters are regularly prepared for review by the Commission and its Review Committees. These materials and all discussions related to accreditation matters routinely remain confidential. The Commission determines when, and the manner in which, newly adopted policy and informational reports will receive public distribution.

PROTECTED HEALTH INFORMATION: Patients' protected health information, which includes any information that could identify an individual as a patient of the facility being site visited, may not be used by the consultants/site visitors, Review Committee members, or Commissioners for any purpose other than for evaluation of the program being reviewed on behalf of the Commission. Protected Health Information may not be disclosed to anyone other than Commissioners, Commission staff, Review Committee members or consultants/site visitors reviewing the program from which the Protected Health Information was received. Individual Protected Health Information should be redacted from Commission records whenever that information is not essential to the evaluation process. If a consultant/site visitor, Review Committee member, or Commissioner believes any Protected Health Information has been inappropriately used or disclosed, he/she should contact the Commission office.

MEETINGS: Policy portions of the Review Committee and Commission-meetings are open to observers, while accreditation actions are confidential and conducted in closed session. All deliberations of the Appeal Board are confidential and conducted in closed session.

NOTICE OF REASONS FOR ADVERSE ACTION: Notice of the reasons for which an adverse accreditation action (i.e. deny or withdraw) is taken is routinely provided to the Secretary of the U.S. Department of Education, any appropriate state agencies, and, upon request, to the public.

Reaffirmed: 8/12, 8/10; Revised: 1/05, 2/01, 7/00; Adopted: 7/94, 5/93

Appn Year 2017
BOARD OF DENTISTRY
Fund 3400 BOARD OF DENTISTRY
For the Month of OCTOBER 2015

REVENUES

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
0605	INTEREST AND INVESTMENTS	920.75	384.79	1,305.54	8,000.00	6,694.46
0975	OTHER REVENUE	6,189.81	1,017.50	7,207.31	55,001.00	47,793.69
0205	OTHER BUSINESS LICENSES	585,002.00	26,312.00	611,314.00	3,141,259.00	2,529,945.00
0410	CHARGES FOR SERVICES	6,009.50	126.00	6,135.50	17,200.00	11,064.50
0505	FINES AND FORFEITS	28,002.00	5,000.00	33,002.00	75,000.00	41,998.00
0210	OTHER NONBUSINESS LICENSES AND FEES	1,400.00	350.00	1,750.00	16,000.00	14,250.00
		627,524.06	33,190.29	660,714.35	3,312,460.00	2,651,745.65

TRANSFER OUT

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
2443	TRANSFER OUT TO OREGON HEALTH AUTHORITY	0.00	0.00	0.00	216,000.00	216,000.00
		0.00	0.00	0.00	216,000.00	216,000.00

PERSONAL SERVICES

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
3110	CLASS/UNCLASS SALARY & PER DIEM	99,256.82	36,999.79	136,256.61	1,099,464.00	963,207.39
3170	OVERTIME PAYMENTS	648.38	328.61	976.99	3,771.00	2,794.01
3180	SHIFT DIFFERENTIAL	12.75	5.63	18.38	0.00	-18.38
3220	PUBLIC EMPLOYES' RETIREMENT SYSTEM	14,980.29	5,015.38	19,995.67	168,815.00	148,819.33
3250	WORKERS' COMPENSATION ASSESSMENT	51.04	19.84	70.88	552.00	481.12
3230	SOCIAL SECURITY TAX	7,552.13	2,855.62	10,407.75	87,416.00	77,008.25
3210	ERB ASSESSMENT	26.88	9.60	36.48	352.00	315.52
3260	MASS TRANSIT	570.30	203.10	773.40	6,881.00	6,107.60
3270	FLEXIBLE BENEFITS	23,652.93	8,776.93	32,429.86	244,224.00	211,794.14
3221	PENSION BOND CONTRIBUTION	5,647.81	1,890.23	7,538.04	58,360.00	50,821.96
3190	ALL OTHER DIFFERENTIAL	0.00	0.00	0.00	35,483.00	35,483.00
3160	TEMPORARY APPOINTMENTS	0.00	0.00	0.00	3,920.00	3,920.00
		152,399.33	56,104.73	208,504.06	1,709,238.00	1,500,733.94

SERVICES and SUPPLIES

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
4100	INSTATE TRAVEL	3,557.30	893.30	4,450.60	49,208.00	44,757.40
4300	PROFESSIONAL SERVICES	31,908.28	8,034.09	39,942.37	125,917.20	85,974.83
4150	EMPLOYEE TRAINING	2,615.40	752.40	3,367.80	68,577.04	65,209.24
4125	OUT-OF-STATE TRAVEL	0.00	0.00	0.00	0.00	0.00

Attachment #2

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
4575	AGENCY PROGRAM RELATED SVCS & SUPP	28,801.90	1,695.25	30,497.15	165,516.01	135,018.86
4425	FACILITIES RENT & TAXES	19,210.42	6,466.25	25,676.67	154,455.00	128,778.33
4650	OTHER SERVICES AND SUPPLIES	12,164.41	1,116.18	13,280.59	71,185.81	57,905.22
4175	OFFICE EXPENSES	11,409.23	1,678.50	13,087.73	84,561.00	71,473.27
4200	TELECOMM/TECH SVC AND SUPPLIES	1,167.48	865.95	2,033.43	23,155.99	21,122.56
4275	PUBLICITY & PUBLICATIONS	1,274.34	168.68	1,443.02	13,800.00	12,356.98
4250	DATA PROCESSING	1,135.77	94.56	1,230.33	6,412.00	5,181.67
4715	IT EXPENDABLE PROPERTY	601.00	0.00	601.00	5,421.00	4,820.00
4400	DUES AND SUBSCRIPTIONS	3,688.00	0.00	3,688.00	1,043.96	-2,644.04
4225	STATE GOVERNMENT SERVICE CHARGES	4,615.38	13,649.40	18,264.78	39,124.99	20,860.21
4325	ATTORNEY GENERAL LEGAL FEES	17,727.00	0.00	17,727.00	224,149.00	206,422.00
4375	EMPLOYEE RECRUITMENT AND DEVELOPMENT	0.00	0.00	0.00	655.00	655.00
4475	FACILITIES MAINTENANCE	0.00	0.00	0.00	542.00	542.00
4700	EXPENDABLE PROPERTY \$250-\$5000	0.00	0.00	0.00	5,421.00	5,421.00
4315	IT PROFESSIONAL SERVICES	0.00	0.00	0.00	52,460.00	52,460.00
		139,875.91	35,414.56	175,290.47	1,091,605.00	916,314.53

SPECIAL PAYMENTS

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
6443	DIST TO OREGON HEALTH AUTHORITY	0.00	0.00	0.00	185,128.00	185,128.00
		0.00	0.00	0.00	185,128.00	185,128.00

		3400		
		Monthly Activity	Biennium Activity	Financial Plan
REVENUES	REVENUE	33,190.29	660,714.35	3,312,460.00
	Total	33,190.29	660,714.35	3,312,460.00
EXPENDITURES	PERSONAL SERVICES	56,104.73	208,504.06	1,709,238.00
	SERVICES AND SUPPLIES	35,414.56	175,290.47	1,091,605.00
	SPECIAL PAYMENTS	0	0	185,128.00
	Total	91,519.29	383,794.53	2,985,971.00
TRANSFER OUT	TRANSFER OUT	0	0	216,000.00
	Total	0	0	216,000.00



Survey Reports

OBD

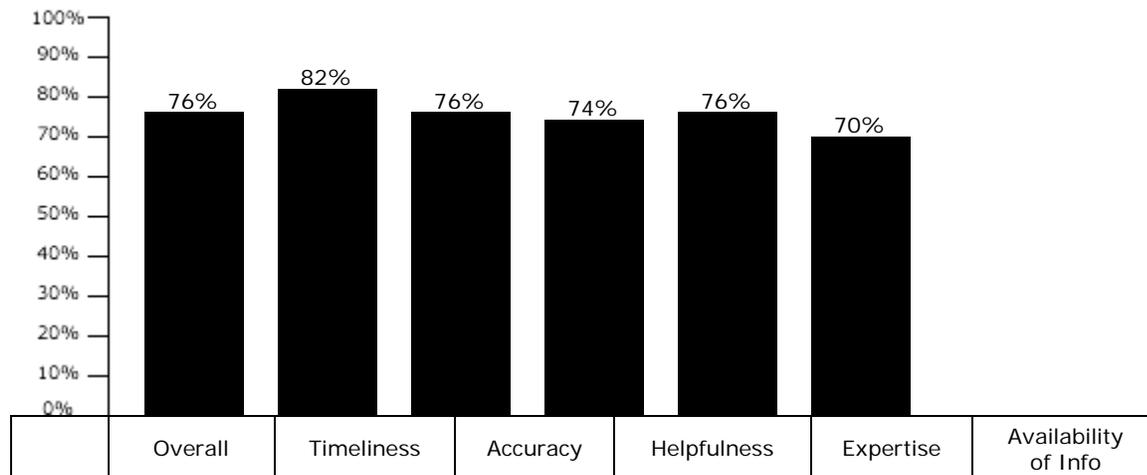
Showing Data for: OBD

Time Period: 7/2015 to 6/2016

Change View

Number of Responses: 41

Percent Rating Service Good or Excellent



Rating Totals By Question

Question	Don't Know	Poor	Fair	Good	Excellent
Q1	2	5	2	12	20
Q2	3	6	3	9	20
Q3	7	4	5	5	20
Q4	7	4	4	7	19
Q5	4	5	6	7	19
Q6	3	5	4	11	18

Question #1: TIMELINESS: How would you rate the timeliness of services provided by the Oregon Board of Dentistry?

Question #2: ACCURACY: How do you rate the ability of the Oregon Board of Dentistry to provide services correctly the first time?

Question #3: HELPFULNESS: How do you rate the helpfulness of the Oregon Board of Dentistry employees?

Question #4: EXPERTISE: How do you rate the knowledge and expertise of the Oregon Board of Dentistry employees?

Question #5: AVAILABILITY OF INFORMATION: How do you rate the availability of information at the Oregon Board of Dentistry?

Question #6: OVERALL SERVICE: How do you rate the overall quality of service provided by the Oregon Board of Dentistry?

Comments Received

Posted	Comment
11/11/2015 9:03:10 PM	I appreciate all your help making this move easier Thank you Wendy
10/21/2015 7:09:40 AM	She just had to look I me up to see where my license renewal was due.
10/21/2015 7:09:34 AM	She just had to look I me up to see where my license renewal was due.
10/9/2015 11:53:53 AM	It took 3 phone calls to get the retirement form I needed. Ms Haynes quickly sent me an email form, the previous office help apparently couldn't get the request taken care of at all
9/10/2015 7:03:31 PM	Teresa was very prompt about sending my receipt for my license. Thank you, Barb
9/9/2015 7:47:23 PM	The board is not staffed sufficiently for investigators. Some cases take a year to resolve just due to sheer case load. The data provided is not a clear data visual representation. It would be great i
9/9/2015 4:00:35 PM	I would appreciate knowing what the mandatory five dollar workforce survey fee covers. A survey, in my experience, should be a voluntary experience to receive the best results.
9/9/2015 3:59:04 PM	why is a notary involved? that step will inhibit many providers from signing up. I don't have to have a notary for basically anything else these days.
9/9/2015 2:35:55 PM	I would like to see a response given when a provider gets their CE courses audited. A Pass for all courses accepted or a Fail if they aren't-some type of follow up for all the info we send in.
9/9/2015 12:12:54 PM	I have tried to use the Prescription Drug Monitoring website a few times and find it Very Difficult to Access patient information. Can you make more User Friendly?
9/1/2015 8:16:34 AM	I have called several times for licensing information. Each call, I received a warm, friendly correct answer instantly. Refreshing that this caliber of service does exist somewhere in the world.
8/7/2015 8:21:03 AM	You efficiently let us know of the meeting for rule changes, but what ARE the rule changes you are considering? Please email us of the summary of the issues with links of information on each issue.
8/5/2015 9:07:36 PM	Keep up the good work!
8/5/2015 5:22:46 PM	I am retired and won't be renewing my license.
8/4/2015 5:28:59 PM	End Tidal CO2 monitoring is unnecessary for enteral moderate sedation due to the fact that patients do not enter into significant respiratory depression.
8/4/2015 11:57:17 AM	it is ridiculous you are charging hygienist a mandatory 5.00 to take a survey. When I told the dentist I work for that, he laughed. That is extortion!!
8/4/2015 9:46:22 AM	Keep up the great work!
8/4/2015 7:22:27 AM	It would be nice if the Board of Dentistry would actually hire an Executive Director that had a clue about dentistry!
8/4/2015 7:14:06 AM	Happy with obd services.
7/24/2015 2:57:17 PM	Teresa gave excellent service and helped me immediately. She went over an above the expectation of service. She is knowledgeable, efficient and helpful. She helped me navigate the Web site.

2016 Calendar

January

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HOLIDAYS

Jan 1	New Year's Day
Jan 18	Martin Luther King Day
Feb 15	Presidents' Day
Mar 27	Easter Sunday
May 30	Memorial Day
Jul 4	Independence Day
Sep 05	Labor Day
Oct 3-4	Rosh Hashana
Oct 12	Yom Kippur
Oct 10	Columbus Day
Nov 11	Veterans Day
Nov 24	Thanksgiving Day
Nov 25	OBD Staff Holiday
Dec 24 - Jan 1	Chanukah
Dec 25	Christmas Day
Dec 26	Staff Holiday

IMPORTANT OBD DATES

○	Evaluator's Meeting
□	Board Meeting
January 14-16	CDCA Annual Conference
April 7-9	ODC Conference
April 10-11	AADB Conference
April 23	Strategic Planning Session
August 7	ADEX House Meeting
October 17-19	AADA & AADB Conference

OTHER SIGNIFICANT EVENTS

TBD	ODA House of Delegates
TBD	Mission of Mercy

UNFINISHED
BUSINESS
&
RULES

At the October 30th Board meeting, the staff was directed to research the rules regarding epinephrine (the EpiPen) for dental hygienists in emergency situations and have available in an emergency kit.

Below is the Oregon Pharmacy's rule and the Oregon Health Authority's rules regarding epinephrine relevant to the discussion.

Oregon Pharmacy Board Rule:

855-041-2320

Epinephrine

(1) A pharmacist may fill an order for epinephrine to be used by trainees to treat an anaphylactic reaction. Trainees must be 18 years of age or older and must have responsibility for or contact with at least one (1) other person as a result of the trainee's occupation or volunteer status, such as, but not limited to, a camp counselor, scout leader, forest ranger, school employee, tour guide or chaperone.

(2) Individuals must successfully complete a training program approved by the Oregon Health Authority, Public Health Division. Upon successful completion, the trainee will receive the following certificates:

(a) Statement of Completion; and

(b) Authorization to Obtain Epinephrine.

(3)(a) Distribution of epinephrine from a pharmacy to be used for the treatment of allergic emergencies may occur in the following manner:

(b) A trainee may obtain epinephrine upon presentation of the Statement of Completion and Authorization to Obtain Epinephrine certificate to a pharmacy which:

(A) A pharmacist may generate a prescription for, and dispense an emergency supply of epinephrine for not more than one (1) child and one (1) adult in an automatic injection device, as specified by the supervising professional whose name, signature, and license number appear on the Authorization to Obtain Epinephrine certificate.

(B) The pharmacist who generates the hardcopy prescription for epinephrine in this manner shall reduce the prescription to writing, and file the prescription in a manner appropriate for a non-controlled substance.

(C) Once the pharmacist generates the epinephrine prescription, the pharmacist shall write in the appropriate space provided on the Authorization to Obtain Epinephrine certificate, the date and the number of doses dispensed, and return the certificate to the trainee.

(4) The Statement of Completion and the Authorization to Obtain Epinephrine certificate may be used to obtain epinephrine up to four (4) times within three (3) years from the date of the initial training.

(a) Both the Statement of Completion and the Authorization to Obtain Epinephrine certificate expire three (3) years from the date of the trainee's last Oregon Health Authority approved allergy response training.

(b) Upon completion of the training, the trainee will receive a new Statement of Completion and Authorization to Obtain Epinephrine certificate, with a valid duration of three (3) years.

Stat. Auth: ORS 689.205

Stats. Implemented: ORS 689.155

Hist.: BP 6-2013(Temp), f. 9-23-13, cert. ef. 9-24-13 thru 3-23-14; BP 2-2014, f. & cert. ef. 1-24-14

Oregon Health Authority – Public Health Division Rules:

DIVISION 55

PROGRAMS TO TREAT ALLERGIC RESPONSE OR HYPOGLYCEMIA

333-055-0000

Purpose

(1) The purpose of OAR 333-055-0000 through 333-055-0035 is to define the procedures for authorizing certain individuals, when a licensed health care professional is not immediately available, to administer epinephrine to a person who has a severe allergic response to an allergen, and glucagon to a person who is experiencing severe hypoglycemia when other treatment has failed or cannot be initiated, and to define the circumstances under which these rules shall apply.

(2) Severe allergic reactions requiring epinephrine will occur in a wide variety of circumstances. Severe hypoglycemia requiring glucagon, in settings where children prone to severe hypoglycemia are known to lay providers and arrangements for the availability of glucagon have been made, will occur primarily in, but not limited to, school settings, sports activities, and camps.

Stat. Auth.: ORS 433.800 & 433.830

Stats. Implemented: ORS 433.800 - 433.830

Hist.: HD 10-1982, f. & ef. 5-25-82; HD 23-1990(Temp), f. & cert. ef. 8-15-90; OHD 7-1998, f. & cert. ef. 7-28-98; OSHA 4-2012, f. 9-19-12, cert. ef. 1-1-13; PH 14-2012, f. & cert. ef. 9-19-12

333-055-0006

Definitions

(1) "Allergen" means a substance, usually a protein, which evokes a particular adverse response in a sensitive individual.

(2) "Allergic response" means a medical condition caused by exposure to an allergen, with physical symptoms that may be life threatening, ranging from localized itching to severe anaphylactic shock and death.

(3) "Emergency Medical Services Provider (EMS Provider)" means a person who has received formal training in pre-hospital and emergency care and is state-licensed to attend to any ill, injured or disabled person. Police officers, fire fighters, funeral home employees and other personnel serving in a dual

capacity, one of which meets the definition of "emergency medical services provider" are "emergency medical services providers" within the meaning of ORS chapter 682.

(4) "Hypoglycemia" means a condition in which a person experiences low blood sugar, producing symptoms that may range from drowsiness to loss of muscle control so that chewing or swallowing is impaired, to irrational behavior in which food intake is resisted, or to convulsions, fainting or coma.

(5) "Other treatment" means oral administration of food containing glucose or other forms of carbohydrate, such as jelly or candy.

(6) "Other treatment has failed" means the hypoglycemic student's symptoms have worsened or the student has become incoherent, unconscious or unresponsive.

(7) "Paramedic" means a person who is licensed by the Oregon Health Authority as a Paramedic.

(8) "Supervising professional" means a physician licensed under ORS chapter 677, or a nurse practitioner licensed under ORS chapter 678 to practice in this state and who has prescription writing authority.

Stat. Auth.: ORS 433.810

Stats. Implemented: ORS 433.800 & ORS 433.810

Hist: PH 14-2012, f. & cert. ef. 9-19-12

333-055-0015

Educational Training

(1) Individuals to be trained to administer glucagon shall be trained under the supervision of a physician licensed under ORS chapter 677, or a nurse practitioner licensed under ORS chapter 678 to practice in this state. The training may be conducted by a registered nurse licensed under ORS chapter 678 as delegated by a supervising professional.

(2) Individuals to be trained to administer epinephrine shall be trained under the supervision of a physician licensed under ORS chapter 677, or a nurse practitioner licensed under ORS chapter 678 to practice in this state. The training may be conducted by a registered nurse licensed under ORS chapter 678 as delegated by a supervising professional, or a paramedic as delegated by an EMS medical director defined in OAR chapter 333, division 265.

(3) The training shall be conducted following an Oregon Health Authority, Public Health Division training protocol (or approved equivalent). The Public Health Division approved training protocol for emergency glucagon providers is available on the Internet at <http://healthoregon.org/diabetes>. The training protocol for the treatment of severe allergic reaction is available on the Internet at <http://healthoregon.org/ems>.

(Complete Link to training protocol:

<https://public.health.oregon.gov/ProviderPartnerResources/EMSTraumaSystems/Pages/epi-protocol-training.aspx>.)

Stat. Auth.: ORS 433.810

Stats. Implemented: ORS 433.800 - 433.830

Hist.: HD 10-1982, f. & ef. 5-25-82; HD 23-1990(Temp), f. & cert. ef. 8-15-90; OHD 7-1998, f. & cert. ef. 7-28-98; PH 10-2004, f. & cert. ef. 3-23-04; PH 14-2012, f. & cert. ef. 9-19-12

333-055-0021

Eligibility for Training

In order to be eligible for training, a person must:

- (1) Be 18 years of age or older; and
- (2) Have, or reasonably expect to have, responsibility for or contact with at least one other person as a result of the eligible person's occupational or volunteer status, such as, but not limited to, a camp counselor, scout leader, forest ranger, school employee, tour guide or chaperone.

Stat. Auth.: ORS 433.810

Stats. Implemented: ORS 433.820

Hist: PH 14-2012, f. & cert. ef. 9-19-12

333-055-0030

Certificates of Completion of Training

(1) Persons who successfully complete educational training under OAR 333-055-0000 through 333-055-0035 shall be given a Public Health Division statement of completion signed by the individual conducting the training. The statement of completion for the treatment of allergic response training may also be used as an authorization to obtain epinephrine if fully completed and personally signed by a nurse practitioner or a physician responsible for the training program. Statements of completion for the treatment of allergic response training may be obtained from the Oregon Health Authority, Public Health Division, 800 NE Oregon Street, Suite 290, Portland, Oregon 97232, Phone: (971) 673-1230. A statement of completion for emergency glucagon providers is included in the training protocol available at <http://healthoregon.org/diabetes>.

(2) The statement of completion and authorization to obtain epinephrine form allows a pharmacist to generate a prescription and dispense an emergency supply of epinephrine for not more than one child and one adult in an automatic injection device if signed by a nurse practitioner or physician. Whenever such a statement of completion form for an emergency supply of epinephrine is presented, the pharmacist shall write upon the back of the statement of completion form in non-erasable ink the date that the prescription was filled, returning the statement of completion to the holder. The prescription may be filled up to 4 times. The pharmacist who dispenses an emergency supply of epinephrine under this rule shall also reduce the prescription to writing for his files, as in the case of an oral prescription for a non-controlled substance, and file the same in the pharmacy.

(3) A person who has successfully completed educational training in the administration of glucagon may receive, from the parent or guardian of a student, doses of glucagon prescribed by a health care professional with appropriate prescriptive privileges licensed under ORS chapters 677 or 678, and the necessary paraphernalia for administration.

(4) Completion of a training program and receipt of a statement of completion does not guarantee the competency of the individual trained.

(5) A statement of completion and authorization to obtain epinephrine shall expire three years after the date of training identified on the statement of completion. Individuals trained to administer epinephrine or glucagon must be trained every three years in accordance with OAR 333-055-0015 in order to obtain a new statement of completion.

(6) Individuals trained to administer epinephrine or glucagon may be asked to provide copies of a current statement of completion to their employers or to organizations or entities to which they volunteer.

[ED. NOTE: Figures referenced are available from the agency.]

Stat. Auth.: ORS 433.810

Stats. Implemented: ORS 433.800 & 433.830

Hist.: HD 10-1982, f. & ef. 5-25-82; HD 23-1990(Temp), f. & cert. ef. 8-15-90; OHD 7-1998, f. & cert. ef. 7-28-98; PH 10-2004, f. & cert. ef. 3-23-04; PH 14-2012, f. & cert. ef. 9-19-12

333-055-0035

Circumstances in Which Trained Persons May Administer Epinephrine or Glucagon

(1) A person who holds a current statement of completion pursuant to OAR 333-055-0030 may administer, in an emergency situation when a licensed health care professional is not immediately available, epinephrine to any person suffering a severe allergic response to an insect sting or other allergen. The decision to give epinephrine should be based upon recognition of the signs of a systemic allergic reaction and need not be postponed for purposes of identifying the specific antigen which caused the reaction.

(2) A person who holds a current statement of completion pursuant to OAR 333-055-0030 may administer, in an emergency situation involving an individual who is experiencing hypoglycemia and when a licensed health care professional is not immediately available, physician-prescribed glucagon to a person for whom glucagon is prescribed, when other treatment has failed or cannot be initiated. The decision to give glucagon should be based upon recognition of the signs of severe hypoglycemia and the inability to correct it with oral intake of food or drink.

Stat. Auth.: ORS 433.810

Stats. Implemented: ORS 433.800 - 433.830

Hist.: HD 10-1982, f. & ef. 5-25-82; OHD 7-1998, f. & cert. ef. 7-28-98; PH 10-2004, f. & cert. ef. 3-23-04; PH 14-2012, f. & cert. ef. 9-19-12

TREATMENT OF SEVERE ALLERGIC REACTION

A Protocol for Training

Revised April, 2013

Oregon Health Authority – Public Health Division

Authorized for use by the Oregon Health Authority, Public Health Division

If you need more information on Epinephrine and/or its use, please contact:

**Leslie Huntington
503-931-0659
Leslie.D.Huntington@state.or.us.**

For additional copies or if you need this document in an alternate format, contact:

Dan Nielsen
971-673-1230
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daniel.m.nielsen@state.or.us

CREDITS

Astrid Newell, MD and the late Beth Epstein, MD, of the Oregon Department of Human Services, Public Health Division, for the development of the original training protocol and the Oregon Administrative Rules (OARs) regarding the use of epinephrine by the general public.

Jan Sanderson, RN, BSN, of the Multnomah Educational Service District (MESD), for the development of the original Power Point.

Jeanne Fratto, RN, BS, of the MESD for the revisions and updates to subsequent versions of the epinephrine training materials and editing assistance with the 2013 revisions.

Ritu Sahni, MD, and Mellony Bernal of the Oregon Health Authority Public Health Division, for the 2012 revisions to the OARs.

Leslie Huntington, BS, Paramedic, of the Oregon Health Authority-Emergency Medical Services and Trauma Systems Office for the 2013 revisions of the training protocol and creation of the new Power Point presentation.

Kathleen Mahaffy-Dietrich, RN, BSN, MPA, of the MESD for her editing assistance with the 2013 revisions.

I. INTRODUCTION

Anaphylaxis is a severe, potentially fatal allergic reaction. It is characteristically unexpected and rapid in onset. Immediate injection of epinephrine is the single factor most likely to save a life under these circumstances. Several hundreds of deaths each year are attributed to insect stings and food allergies.

In 1981 legislation was passed by the state of Oregon to provide a means of authorizing certain individuals to administer lifesaving treatment to people suffering severe insect sting reactions when a physician is not immediately available. In 1989 the Legislature expanded the scope of the original statute by providing for the availability of the same assistance to people having a severe allergic response to other allergens. The statute underwent minor revisions again in 1997 and 2012.

These bills were introduced at the request of the Oregon Medical Association. This legislation is intended to address situations where medical help often is not immediately available: school settings, camps, forests, recreational areas, etc. The following protocol for training is intended as an administrative document outlining the specific applications of the law, describing the scope of the statute, people to be trained, and proposing the content of that training.

II. BACKGROUND

A. An explanation of the law and rules

According to the law (**ORS 433.805-830**), a person who meets the prescribed qualifications may obtain a prescription for pre-measured doses of epinephrine. The epinephrine may be administered in an emergency situation to a person suffering from a severe allergic response when a licensed health care provider is not immediately available.

The Oregon Administrative Rules supporting this law (**OAR 333-055-000 to 333-055-0035**) stipulate those who complete the training prescribed by the Oregon Health Authority, Public Health Division, receive a statement of completion signed by the licensed health care professional conducting the training. This statement of completion includes an authorization for a prescription to obtain an emergency supply of epinephrine auto injectors for one adult and one child.

In order for the prescription to be filled, the authorization must be signed by the nurse practitioner or physician responsible for the oversight of the training. This prescription may be filled up to four times in a three-year period. The training and

subsequent authorization will expire three years after the date of the class as identified on the form. The individual must complete retraining in order to receive a new statement of completion and authorization.

B. Who can be trained?

In order to qualify for this training, a person must be 18 years of age or older and must “have, or reasonably expect to have, responsibility for or contact with at least one other person as a result of the eligible person’s occupational or volunteer status.”

Individuals who are likely to fall under the definition of the law include public or private school employees, camp counselors or camp employees, youth organization staff or volunteers, forest rangers and foremen of forest workers, public or private employers/employees with demonstrated exposure to risk.

In addition to taking the required training course described above, **trainees are strongly encouraged to obtain and maintain current training in approved first aid and CPR courses** that are offered through organizations such as Medic First Aid, the American Heart Association or the American Red Cross.

C. The training program

The training program must be conducted by either:

1. A physician licensed to practice in Oregon; or,
2. A nurse practitioner licensed to practice in Oregon; or,
3. A registered nurse, as delegated by a licensed physician or nurse practitioner; or
4. A paramedic, as delegated by an EMS medical director defined in OAR 333-265.

No other personnel are qualified to conduct these trainings under this law.

The training must include the following subjects:

1. Recognition of the symptoms of systemic allergic response (anaphylactic reaction) to insect stings and other allergens;
2. Familiarity with factors likely to cause systemic allergic response;
3. Proper administration of an injection of epinephrine; and,
4. Necessary follow-up treatment.

The Oregon Health Authority, Public Health Division, is responsible for approving this training program as well as adopting the rules necessary for administering the law.

III. ALLERGY DEFINITIONS

- Allergen:** A protein not normally found in the body that may cause an exaggerated allergic response by the body upon exposure. Examples of allergens include insect venom, food, medication, pollen and others.
- Normal Reaction:** Exposure to an allergen either causes no response by the body or produces expected, minimal signs as a result. An example of a normal reaction is the minor swelling and redness as a response to a bee sting.
- Localized Reaction:** An exaggerated response by the body to an allergen; it is limited to one side of the body and extends beyond a major joint line. Any of the following signs may be present swelling, redness, itching and hives.
- Anaphylaxis:** An exaggerated response to an allergen that involves multiple areas of the body or the entire body. It is a life-threatening event.

IV. THE NATURE OF ANAPHYLAXIS

As stated in the definition above, anaphylaxis is a life-threatening condition and is almost always unexpected. It can start within minutes of exposure to an allergen. The reaction may be delayed by several hours. Death often occurs as a result of swelling and constriction of the airway and the significant drop in blood pressure.

Once someone is having an anaphylactic reaction, the most important factor in whether they live or die is how quickly they receive an injection of epinephrine.

Because epinephrine must be given promptly at the first signs of anaphylaxis, the decision to treat must be based on recognition of the symptoms.

V. RECOGNIZING ANAPHYLAXIS

Anaphylaxis is evidenced by the following symptoms, **ANY OR ALL OF WHICH MAY BE PRESENT:**

- Shortness of breath or tightness of chest; difficulty in or absence of breathing
- Sneezing, wheezing or coughing
- Difficulty swallowing
- Swelling of eyes, lips, face, tongue, throat or elsewhere
- Low blood pressure, dizziness and/or fainting
- Rapid or weak pulse
- Blueness around lips, inside lips, eyelids
- Sweating and anxiety
- Itching, with or without hives; raised red rash in any area of the body
- Skin flushing or extreme pallor
- Hoarseness
- Sense of impending disaster or approaching death
- Involuntary bowel or bladder action
- Nausea, abdominal pain, vomiting and diarrhea
- Burning sensation, especially face or chest
- Loss of consciousness

Although anaphylactic reactions typically result in multiple symptoms (e.g., hives, difficulty breathing and loss of normal blood pressure), reactions may vary substantially from person to person with possibly only one symptom being present.

Previous history of anaphylactic reactions and known exposure to potential allergens should increase the suspicion that the above signs or symptoms represent an anaphylactic reaction. Because reactions vary little from time to time in the same individual, obtain a description of previous reactions, if possible.

An anaphylactic reaction to an insect sting or other allergen usually occurs quickly; death has been reported to occur within minutes after a sting. Highly food-sensitive individuals may react within seconds to several minutes after exposure to allergens. An anaphylactic reaction occasionally can occur from up to one to two hours after exposure.

It is common for people who are having an anaphylactic reaction to be in an

increased state of anxiety. This is especially so if they have a history of a previous severe reaction.

VI. IDENTIFYING THE SENSITIVE INDIVIDUAL

If your staff, students or clients will be facing possible exposure to insect stings (in school settings, camps, tour groups, or outdoor settings such as forests, etc.), and/or may be remote from medical assistance, you should:

- Make EVERY EFFORT to identify beforehand who in the group has a history of allergic reactions (to insects, foods, etc.). This information should be obtained from the student, parent and/or physician as appropriate.
- Obtain signed forms allowing emergency treatment.
- Know how to access emergency medical help, including:
- Location of nearest hospital;
- Location of nearest Emergency Medical Services (EMS) response unit; and
- Determine ahead of time how you will call for help (e.g., cell phone, radio).

If a person has had an anaphylactic reaction in the past, it is possible that his or her next exposure to the allergen (for instance to bee stings or peanuts) may cause a more severe reaction.

VII. WHAT CAN TRIGGER ANAPHYLAXIS?

A. Overview of the causes of anaphylaxis

The most common identifiable causes of anaphylaxis are:

- Insect stings or bites (e.g., yellow jackets, wasps);
- Foods (e.g., nuts, shellfish, eggs, milk);
- Medications;
- Latex (e.g., balloons, duct or adhesive tape); and
- Physical exercise.

It is important to know that in a high percentage of cases, no specific cause of anaphylaxis is found.

Severe reactions can occur in someone with no history of previous allergic reaction. While anyone may experience anaphylaxis, individuals with a history of previous severe reaction, and those with asthma are most at risk for life-threatening anaphylaxis.

Severe life-threatening allergic response to various allergens occurs in only a small percentage of the general population. It is estimated between 1 and 2 percent of the population will experience anaphylaxis in their lifetime. (Mustafa, 2012, Epidemiology section, para.2).

When severe allergic reactions occur, immediate administration of injectable epinephrine is vital. Often the person suffering the reaction is unable to self-administer epinephrine or is unequipped for the situation. Recognizing the signs of anaphylaxis quickly and administering epinephrine are critical actions you will learn in this training.

B. Insect stings

1. Epidemiology/likely culprits

- Fatal or serious reactions to insect stings are confined almost entirely to bees, wasps, hornets and yellow jackets.
- Insects are more likely to sting during late summer and fall when it is dry and few flowers are still in bloom. Venom is more potent during this time of the year and stinging insects are easier to arouse.
- Bees are more likely to sting on warm bright days, particularly following a rain.
- The yellow jacket is the most frequent cause of an allergic reaction in the Pacific Northwest.
- Patients are seldom able to identify the offending insect. When possible, an attempt at identification should be made once the reaction is treated so the sensitive person can avoid future exposure and his or her doctor can be informed.

2. Avoiding insect stings

Avoid as much as possible:

- Flowers, flowering trees/shrubs;
- Certain colors and types of clothing (especially blue, yellow or dark brown), or rough fabrics (e.g., smooth, hard finish white or tan clothing

is safest);

- Fragrant cosmetics, perfumes, lotions;
- Walking outside without shoes;
- Exposed skin (hats, long sleeved shirts, slacks, socks and shoes are recommended);
- Picnics, cooking or eating outdoors;
- Areas of trash or garbage;
- Known areas of insect habitat; and
- Becoming excited, swatting or hitting at the insect (to remove the insect, a gentle brushing motion is recommended).

3. What is not an anaphylactic reaction to an insect sting?

a. Normal reactions to stings

- A sting in a nonallergic person produces localized, sharp pain that varies in duration following the insertion of the stinger.
- Within minutes, a small reddened area appears at the sting site and may enlarge to about the size of a quarter with hardening and redness. Varying levels of pain and itching may accompany the redness, heat and swelling.
- This response usually lasts about 24 hours, although a sting on the hand or foot may produce swelling that lasts for several days.
- This reaction does not generally require professional medical attention.
- Treatment includes washing the area and removing the stinger.
- The individual with no history of allergic reactions should be observed for one-half hour after the sting.
- If a child will return home later, then the parent or guardian should be notified of the sting.

If the sting occurs around the eye, nose, or throat the reaction may be more severe because even minimal swelling may cause obstruction. These types of stings need immediate medical attention. Stings around eyes are particularly serious and should be evaluated by a physician because long-term eye damage is a possibility.

b. Localized allergic reaction to stings

- A localized reaction may involve pain, itching and swelling that extends over an area larger than a quarter.
- The pain, itching and swelling may extend past a major joint line but limited to the affected extremity. This response may be delayed for several hours.
- Treatment includes washing the area and removing the stinger.
- Apply an ice pack to the sting site and elevate the limb, if applicable.
- Administer an antihistamine if the agency policy allows for this action.
- The person should be observed for at least 30 minutes after the sting.
- Contact the parent or guardian of the child.
- It is not unusual for these symptoms to persist for up to a week or more.

c. Toxic reactions to multiple stings

Toxic reactions are the result of multiple stings (usually 10 or more) — for instance when a person steps on a yellow jacket nest. Call 9-1-1 immediately. The evaluation and treatment should be the same as you would for anaphylaxis.

C. Foods

1. Epidemiology/likely culprits

Nearly any food can trigger an allergic reaction at any age. Food allergies are most common in children, and appear to be increasing in frequency. Approximately 8 percent of children in the U.S. have a food allergy (Gupta, 2011, Results section).

Foods commonly associated with severe allergic reactions

- Peanuts*
- Milk
- Eggs
- Wheat
- Soy
- Tree nuts (walnuts, pecans, hazelnuts, etc.)

- Fish
- Shellfish**

* Peanuts are the most common cause of anaphylaxis in children, and is the food most frequently causing fatal reactions (Sicherer 2007)

** Shellfish are the most frequent food causing anaphylaxis in adults.

2. Avoiding food allergens

- Avoid exposure to known allergens;
- Inform food preparation personnel of individuals with known food allergies;
- Lunch “swapping” or sharing (for instance, among children in a school setting) should be avoided;
- Read labels on food and skin care products for hidden ingredients (e.g., nut oils in lotions);
- Avoid cross-contamination of food via utensils, cutting surfaces, etc.; and
- Encourage hand washing to prevent secondary exposure to allergens.

D. Medications

- People can experience severe allergic reactions to medications even if they have previously taken the medication without incident.
- Of all drugs, penicillin is the most frequent cause of anaphylactic reactions.
- Allergy injections may precipitate an allergic reaction.

E. Other allergens

- Pollens and some foods (for example, wheat, eggs, and seafood) can cause anaphylaxis in certain sensitive individuals who exercise after being exposed to these substances.
- Latex allergy has become increasingly common, especially among people whose work requires latex gloves, or who undergo frequent medical procedures. Latex is present in many common items such as:
 - Balloons;

- Ace wraps or first-aid tape;
- Rubber bands and bungee cords;
- Erasers;
- and art supplies.

An increasing number of patients also are being recognized as having anaphylaxis to unknown substances.

VIII. TREATMENT FOR ANAPHYLAXIS

A. Responding to anaphylaxis: Basic sequence of steps

1. Determine if the person is suffering an anaphylactic reaction. **It is safer to give the epinephrine than to delay treatment. This is a life-and-death decision.**
2. Do not move the person, unless the location possesses a safety threat.
3. Have the person sit or lie down.
4. Select the proper version of the auto-injector.
5. Administer epinephrine through the device.
6. **Have someone call for emergency medical assistance (9-1-1). DO NOT LEAVE THE PERSON UNATTENDED.**
7. Note the time when the auto-injector was used.
8. Remove the stinger if one is present. Do this by scraping with a plastic card of fingernail. Do not pinch or squeeze the stinger because this can cause more venom to be released.
9. Check and maintain the person's airway and breathing. Administer CPR if required and trained. If the person has stopped breathing and does not respond to rescue breathing, he/she may have severe swelling of the throat, which closes the airway. Continue CPR efforts.

10. Monitor for changes such as an improvement in breathing, increase in the person's consciousness, or a decrease in swelling.
11. If EMS is more than 10 minutes away and if the person's condition does not change or worsens after 5 minutes of the auto-injector, then administer a second dose or auto-injector.
12. Upon the arrival of EMS, advise them of the person's signs before the auto-injector was given and any changes of the person's condition since then.

If the person experiencing an anaphylactic reaction is also asthmatic, you can assist the person in the use of his or her own inhaler if desired, **after epinephrine is given.**

It is recommended that any person who received epinephrine for an anaphylaxis reaction follow-up with medical care as soon as possible.

*All people meeting the criteria for severe allergic reaction training are strongly encouraged to take an approved First Aid / CPR training course.

B. Information about epinephrine

1. Description

Epinephrine (also known as adrenaline) is a powerful drug, used for the treatment of anaphylactic reactions. Oregon law does not authorize the use of epinephrine for any other condition including asthma.

It is obtained by prescription only. In the case of a life-threatening allergic reaction, it is the most immediate and effective treatment available.

Epinephrine acts on the body by constricting blood vessels and raising the blood pressure, relaxing the bronchial muscles and reducing tissue swelling. The actions of this drug will directly oppose the life-threatening effects of anaphylaxis.

Although epinephrine is very fast acting, its beneficial effects are short-lived (approximately 20 minutes), so it is vitally important to call 9-1-1 immediately.

2. Possible side effects of epinephrine

Temporary and minor side effects of epinephrine include:

- Rapid heart rate
- Nervousness
- Anxiety
- Nausea, vomiting
- Sweating
- Pallor
- Tremor
- Headache

These effects are temporary and will subside with rest and reassurance. Some of the possible side effects of epinephrine may resemble symptoms of anaphylactic shock; however, symptoms related to injection of epinephrine are temporary. Reassurance and a calm demeanor by the caregiver are important.

3. How epinephrine is supplied and stored

The epinephrine prescription will be filled as an auto-injector device. In 2012, revisions to the Oregon Administrative Rule allow for the dispensing and use of a twin pack of epinephrine as a single prescription for an individual who has gone through this training.

A few different brands are available for use: EpiPen®, Auvi-Q® and Twinject®. The Twinject® device is not OSHA-approved for the school setting, as the device allows for an exposed needle after injection. It is important to know which epinephrine auto-injector you will be using, since the method for administration differs between manufacturers. In a school setting, the school nurse will be able to give you this information.

Epinephrine should be stored in a dark place at room temperature (between 59 – 86 degrees F). Do not store it in a refrigerator. The epinephrine auto-injector must be protected from freezing or from exposure to extreme heat or cold (for example, do not store it in your car's glove box). Exposure to sunlight will hasten deterioration of epinephrine more rapidly than exposure to room temperatures.

Regularly inspect your supply of epinephrine. Inspect each auto-injector for the following:

- The solution should be clear and without particles. Solution that appears cloudy, discolored (brown) or with particles must be replaced.
- The auto-injector should be in date and not expired.

However, if the only epinephrine available during an emergency has expired, it is better to use the expired drug than none at all. If the expired epinephrine is still clear and without particles, it is better to give it than to not give it at all.

4. How epinephrine is administered

A pre-measured dose of epinephrine is delivered via an auto-injector into the outside of the outer thigh. This location is a safe site for injection. The auto-injector is designed to work through clothing for all ages.

The typical dose of epinephrine is 0.3 milligrams for adults. The epinephrine dosing for children is based on weight. Younger children may require a smaller dose with the use of a pediatric auto-injector device.

The following table gives guidelines for choosing the adult versus the pediatric version of the epinephrine auto-injector for children. However, it must be emphasized: **DON'T DELAY BY WEIGHING!!** Use your best guess, but do not spend time trying to ascertain the person's actual weight (e.g., weighing the person, looking up records, etc.).

Devices	USE	Approximate WEIGHT	Dose automatically delivered by device
EPIPEN® AUVI-Q .3® TWINJECT®	Older child or adult (> 9-10 years old)	> 66 lbs	0.3 milligrams
EPIPEN® JR AUVI-Q .15®	Younger child (3 to 9 or 10 years old) **	33– 65 lbs	0.15 milligrams

** Although the EpiPen® JR and Auvi-Q .15 are not recommended for use with small children (infants and toddlers), the risks of death from true anaphylaxis are greater than the risks for administering epinephrine to this age group.

5. When epinephrine is administered

Administer epinephrine at the first sign of anaphylaxis. It is safer to give the epinephrine than to delay treatment for anaphylaxis. The sooner that anaphylaxis is treated, the greater the person's chance for surviving the reaction.

The **most important** aspect of intervention for severe allergic response is **timing**. Because of the dangers involved, **you should always be ready to treat the affected person immediately**.

The effects of epinephrine last approximately 10-20 minutes. If the signs of anaphylaxis continue after 5 minutes from the first injection, then administer the second auto-injector. If the signs of anaphylaxis return and EMS has not arrived, administer the second auto-injector.

C. Use of the epinephrine auto-injector

Remember, only epinephrine works for anaphylaxis. **It is safer to give the epinephrine than to delay treatment. This is a life-and-death decision.**

The basic steps of the administration of epinephrine from an auto-injector device are outlined below. Variability exists between the devices and specific manufacturer's instructions should be followed. However, the basic procedure for the use of an auto-injector is below.

1. Remove the auto-injector from its protective case.
2. Remove the safety caps of the injector, which are typically found on the trigger (if applicable) and or/ the tip of the injection device
3. Hold the auto-injector firmly. Keep fingers away from the tip of the device.
4. Position the device at a 90-degree angle to the outer thigh. For those devices that will trigger upon contact with the skin, jab the device firmly into the thigh until a click is heard.

5. Hold the device against the thigh firmly for 5-10 seconds to allow the full dose to be administered. Consult the product directions for the exact timing.
6. Remove the device and place it back into its protective case when applicable.
7. Massage the skin at the injection site for 10 seconds.
8. If medical assistance has not been summoned, then call 9-1-1 or have someone do this for you. **DO NOT LEAVE THE PERSON UNATTENDED.** Advise the dispatcher that epinephrine was given.

NOTE: Any person who received epinephrine for anaphylaxis ultimately requires evaluation by a physician. Ambulance transport to the emergency department is recommended.

9. Note the time when the auto-injector was used.

IX. REVIEW

A. Definition of anaphylaxis:

- Anaphylaxis is a severe, potentially fatal systemic allergic reaction. It is characteristically unexpected and rapid in onset.
- Immediate injection of epinephrine is the single action most likely to save a life under these circumstances.

Remember, it is safer to give the epinephrine than to delay treatment while waiting for more severe symptoms!

B. Causes of anaphylaxis and reactions

- The most common causes of anaphylaxis are insect stings, foods and medications.
- Severe reactions can occur in someone with no history of previous allergic reaction.
- Onset of anaphylaxis may be from minutes to hours after contact with the allergy-causing substance.

C. The signs of anaphylaxis (ANY or ALL of which may be present):

- Shortness of breath or tightness of chest; difficulty in or absence of breathing
- Sneezing, wheezing or coughing
- Difficulty swallowing
- Swelling of eyes, lips, face, tongue, throat or elsewhere
- Low blood pressure, dizziness and/or fainting
- Sense of impending disaster or approaching death
- Blueness around lips, inside lips, eyelids
- Rapid or weak pulse
- Itching, with or without hives; raised red rash in any area of the body
- Burning sensation, especially face or chest
- Hoarseness
- Skin flushing or extreme pallor
- Involuntary bowel or bladder action
- Nausea, abdominal pain, vomiting and diarrhea
- Sweating and anxiety
- Loss of consciousness

D. Responding to anaphylaxis: Basic sequence of steps

1. Determine if the person is suffering an anaphylactic reaction.
2. Do not move the person, unless the location possesses a safety threat.
3. Have the person sit or lie down.
4. Select the proper version of the auto-injector.
5. Administer epinephrine through the device.
6. **Have someone call 9-1-1. DO NOT LEAVE THE PERSON UNATTENDED.**
7. Note the time when the auto-injector was used.
8. Remove the stinger if one is present.
9. Check and maintain the person's airway and breathing. Administer CPR if required and trained.
10. Monitor for changes in the person's breathing and consciousness and also swelling.
11. If EMS is more than 10 minutes away and if the person's condition does not change or worsens after 5 minutes of the auto-injector, then administer a second

dose or auto-injector.

12. Upon the arrival of EMS, advise them of the person's signs before the auto-injector was given and any changes of the person's condition since then.

X. Prevention of and preparation for allergic reactions and anaphylaxis

- A. Make every effort to identify beforehand who in the group has a history of allergic reactions. This information should be obtained from the student, parent and/or physician as appropriate.
- B. Provide information to the person regarding the prevention of and preparation for anaphylaxis:
 - Methods to avoid exposure to allergens
 - Encourage the person to carry an emergency supply of epinephrine
 - Wear a Medic Alert® identification bracelet/necklace or other identification
- C. Obtain and update signed forms allowing emergency treatment
- D. Familiarize yourself with the local emergency response capabilities in your area, including:
 - How you will call for help (cell phone, radio, etc.)
 - Location and general response time of first response or ambulance personnel
 - Location of the nearest hospital
- E. Assure the epinephrine supply you or the person carries is in date and contains clear solution
- F. Have an emergency response plan in place and practice it at least annually

X. BIBLIOGRAPHY

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XI. APPENDICES

A. ORS January, 2012

433.800 Definitions for ORS 433.800 to 433.830. As used in ORS 433.800 to 433.830, unless the context requires otherwise:

(1) “Allergen” means a substance, usually a protein, which evokes a particular adverse response in a sensitive individual.

(2) “Allergic response” means a medical condition caused by exposure to an allergen, with physical symptoms that may be life threatening, ranging from localized itching to severe anaphylactic shock and death.

(3) “Hypoglycemia” means a condition in which a person experiences low blood sugar, producing symptoms that may range from drowsiness to loss of muscle control so that chewing or swallowing is impaired, to irrational behavior in which food intake is resisted, or to convulsions, fainting or coma.

(4) “Other treatment” means oral administration of food containing glucose or other forms of carbohydrate, such as jelly or candy.

(5) “Other treatment has failed” means the hypoglycemic student’s symptoms have worsened or the student has become incoherent, unconscious or unresponsive. [1989 c.299 §2; 1997 c.345 §1]

433.805 Policy. It is the purpose of ORS 433.800 to 433.830 to provide a means of authorizing certain individuals when a licensed health care professional is not immediately available to administer lifesaving treatment to persons who have severe allergic responses to insect stings and other specific allergens and to persons who are experiencing severe hypoglycemia when other treatment has failed or cannot be initiated. [1981 c.367 §1; 1989 c.299 §3; 1997 c.345 §2]

433.810 Duties of Oregon Health Authority; rules. The Oregon Health Authority shall:

(1) Adopt rules necessary for the administration of ORS 433.800 to 433.830 including defining circumstances under which 433.800 to 433.815 and 433.825 shall apply. The authority shall include input from the educational system, health care provider organizations and other interested parties when adopting rules or amending those rules.

(2) Develop or approve protocols for educational training as described in ORS 433.815, including the use of mechanisms for periodic retraining of individuals, and provide the protocols for educational training upon request to schools, health care professionals, parents or guardians of students or other interested parties. [1981 c.367 §2; 1989 c.299 §4; 1997 c.345 §3; 2009 c.595 §683]

433.815 Educational training. (1) Educational training on the treatment of allergic responses, as required by ORS 433.800 to 433.830, shall be conducted under the supervision of a physician licensed under ORS chapter 677 or a nurse practitioner licensed under ORS chapter 678 to practice in this state. The training may be conducted by a health care professional licensed under ORS chapter 678 as delegated by a supervising professional or by an emergency medical technician meeting the requirements established by the Oregon Health Authority by rule. The curricula shall include, at a minimum, the following subjects:

(a) Recognition of the symptoms of systemic allergic responses to insect stings and other allergens;

(b) Familiarity with common factors that are likely to elicit systemic allergic responses;

(c) Proper administration of an intramuscular or subcutaneous injection of epinephrine for severe allergic responses to insect stings and other specific allergens; and

(d) Necessary follow-up treatment.

(2) Educational training on the treatment of hypoglycemia, as required by ORS 433.800 to 433.830, shall be conducted under the supervision of a physician licensed under ORS chapter 677 or a nurse practitioner licensed under ORS chapter 678 to practice in this state. The training may be conducted by a health care professional licensed under ORS chapter 678 as delegated by a supervising professional. The curricula shall include, at a minimum, the following subjects:

(a) Recognition of the symptoms of hypoglycemia;

(b) Familiarity with common factors that may induce hypoglycemia;

(c) Proper administration of a subcutaneous injection of glucagon for severe hypoglycemia when other treatment has failed or cannot be initiated; and

(d) Necessary follow-up treatment. [1981 c.367 §3; 1989 c.299 §5; 1997 c.345 §4; 2011 c.70 §8]

433.820 Eligibility for training. A person eligible to receive the training described in ORS 433.815 must meet the following requirements:

(1) Be 18 years of age or older; and

(2) Have, or reasonably expect to have, responsibility for or contact with at least one other person as a result of the eligible person's occupational or volunteer status, such as camp counselors, scout leaders, school personnel, forest rangers, tour guides or chaperones. [1981 c.367 §4; 1997 c.345 §5; 2011 c.70 §9]

433.825 Availability of doses of epinephrine and glucagon to trained persons. (1) A person who has successfully completed educational training

described in ORS 433.815 for severe allergic responses may receive from any health care professional with appropriate prescriptive privileges licensed under ORS chapter 677 or 678 in this state a prescription for premeasured doses of epinephrine and the necessary paraphernalia for administration. The person may possess and administer in an emergency situation when a licensed health care professional is not immediately available such prescribed epinephrine to any person suffering a severe allergic response.

(2) A person who has successfully completed educational training in the administration of glucagon as described in ORS 433.815 for hypoglycemia may receive from the parent or guardian of a student doses of glucagon prescribed by a health care professional with appropriate prescriptive privileges licensed under ORS chapter 677 or 678 in this state, as well as the necessary paraphernalia for administration. The person may possess and administer glucagon to the student for whom the glucagon is prescribed, if the student is suffering a severe hypoglycemic reaction in an emergency situation when a licensed health care professional is not immediately available and other treatment has failed or cannot be initiated. [1981 c.367 §5; 1989 c.299 §6; 1997 c.345 §6]

433.830 Immunity of trained person and institution rendering emergency assistance. (1) No cause of action shall arise against a person who has successfully completed an educational training program described in ORS 433.815 for any act or omission of the person when acting in good faith while rendering emergency treatment pursuant to the authority granted by ORS 433.800 to 433.830, except where such conduct can be described as wanton misconduct.

(2) No cause of action shall arise against an institution, facility, agency or organization when acting in good faith to allow for the rendering of emergency treatment pursuant to the authority granted by ORS 433.800 to 433.830, except where such conduct can be described as wanton misconduct. [1981 c.367 §6; 1997 c.345 §7]

433.800 Definitions for ORS 433.800 to 433.830. As used in ORS 433.800 to 433.830, unless the context requires otherwise:

- (1) “Allergen” means a substance, usually a protein, which evokes a particular adverse response in a sensitive individual.
- (2) “Allergic response” means a medical condition caused by exposure to an allergen, with physical symptoms that may be life threatening, ranging from localized itching to severe anaphylactic shock and death.
- (3) “Hypoglycemia” means a condition in which a person experiences low blood sugar, producing symptoms that may range from drowsiness to loss of

muscle control so that chewing or swallowing is impaired, to irrational behavior in which food intake is resisted, or to convulsions, fainting or coma.

(4) “Other treatment” means oral administration of food containing glucose or other forms of carbohydrate, such as jelly or candy.

(5) “Other treatment has failed” means the hypoglycemic student’s symptoms have worsened or the student has become incoherent, unconscious or unresponsive. [1989 c.299 s.2; 1997 c.345 s.1]

B. OAR January, 2012

333-055-0000

Purpose

(1) The purpose of OAR 333-055-0000 through 333-055-0035 is to define the procedures for authorizing certain individuals, when a licensed health care professional is not immediately available, to administer epinephrine to a person who has a severe allergic response to an allergen, and glucagon to a person who is experiencing severe hypoglycemia when other treatment has failed or cannot be initiated, and to define the circumstances under which these rules shall apply.

(2) Severe allergic reactions requiring epinephrine will occur in a wide variety of circumstances. Severe hypoglycemia requiring glucagon, in settings where children prone to severe hypoglycemia are known to lay providers and arrangements for the availability of glucagon have been made, will occur primarily in, but not limited to, school settings, sports activities, and camps.

Stat. Auth.: ORS 433.800 & 433.830

Stats. Implemented: ORS 433.800 - 433.830

Hist.: HD 10-1982, f. & ef. 5-25-82; HD 23-1990(Temp), f. & cert. ef. 8-15-90;

OHD 7-1998, f. & cert. ef. 7-28-98; OSHA 4-2012, f. 9-19-12, cert. ef. 1-1-13; PH 14-2012, f. & cert. ef. 9-19-12

333-055-0006

Definitions

(1) “Allergen” means a substance, usually a protein, which evokes a particular adverse response in a sensitive individual.

(2) “Allergic response” means a medical condition caused by exposure to an allergen, with physical symptoms that may be life threatening, ranging from localized itching to severe anaphylactic shock and death.

(3) “Emergency Medical Services Provider (EMS Provider)” means a person who has received formal training in pre-hospital and emergency care and is state-licensed to attend to any ill, injured or disabled person. Police officers, fire fighters, funeral home employees and other personnel serving in a dual capacity, one of which meets the definition of "emergency medical services provider" are "emergency medical services providers" within the meaning of ORS chapter 682.

(4) “Hypoglycemia” means a condition in which a person experiences low blood sugar, producing symptoms that may range from drowsiness to loss of muscle control so that chewing or swallowing is impaired, to irrational behavior in which food intake is resisted, or to convulsions, fainting or coma.

(5) “Other treatment” means oral administration of food containing glucose or other forms of carbohydrate, such as jelly or candy.

(6) “Other treatment has failed” means the hypoglycemic student’s symptoms have worsened or the student has become incoherent, unconscious or unresponsive.

(7) “Paramedic” means a person who is licensed by the Oregon Health Authority as a Paramedic.

(8) “Supervising professional” means a physician licensed under ORS chapter 677, or a nurse practitioner licensed under ORS chapter 678 to practice in this state and who has prescription writing authority.

Stat. Auth.: ORS 433.810

Stats. Implemented: ORS 433.800 & ORS 433.810

Hist: PH 14-2012, f. & cert. ef. 9-19-12

333-055-0015

Educational Training

(1) Individuals to be trained to administer glucagon shall be trained under the supervision of a physician licensed under ORS chapter 677, or a nurse practitioner licensed under ORS chapter 678 to practice in this state. The training may be

conducted by a registered nurse licensed under ORS chapter 678 as delegated by a supervising professional.

(2) Individuals to be trained to administer epinephrine shall be trained under the supervision of a physician licensed under ORS chapter 677, or a nurse practitioner licensed under ORS chapter 678 to practice in this state. The training may be conducted by a registered nurse licensed under ORS chapter 678 as delegated by a supervising professional, or a paramedic as delegated by an EMS medical director defined in OAR chapter 333, division 265.

(3) The training shall be conducted following an Oregon Health Authority, Public Health Division training protocol (or approved equivalent). The Public Health Division approved training protocol for emergency glucagon providers is available on the Internet at <http://healthoregon.org/diabetes>. The training protocol for the treatment of severe allergic reaction is available on the Internet at <http://healthoregon.org/ems>.

Stat. Auth.: ORS 433.810

Stats. Implemented: ORS 433.800 - 433.830

Hist.: HD 10-1982, f. & ef. 5-25-82; HD 23-1990(Temp), f. & cert. ef. 8-15-90; OHD 7-1998, f. & cert. ef. 7-28-98; PH 10-2004, f. & cert. ef. 3-23-04; PH 14-2012, f. & cert. ef. 9-19-12

333-055-0021

Eligibility for Training

In order to be eligible for training, a person must:

(1) Be 18 years of age or older; and

(2) Have, or reasonably expect to have, responsibility for or contact with at least one other person as a result of the eligible person's occupational or volunteer status, such as, but not limited to, a camp counselor, scout leader, forest ranger, school employee, tour guide or chaperone.

Stat. Auth.: ORS 433.810

Stats. Implemented: ORS 433.820

Hist: PH 14-2012, f. & cert. ef. 9-19-12

333-055-0030

Certificates of Completion of Training

(1) Persons who successfully complete educational training under OAR 333-055-0000 through 333-055-0035 shall be given a Public Health Division statement of completion signed by the individual conducting the training. The statement of completion for the treatment of allergic response training may also be used as an authorization to obtain epinephrine if fully completed and personally signed by a nurse practitioner or a physician responsible for the training program. Statements of completion for the treatment of allergic response training may be obtained from the Oregon Health Authority, Public Health Division, 800 NE Oregon Street, Suite 290, Portland, Oregon 97232, Phone: (971) 673-1230. A statement of completion for emergency glucagon providers is included in the training protocol available at <http://healthoregon.org/diabetes>.

(2) The statement of completion and authorization to obtain epinephrine form allows a pharmacist to generate a prescription and dispense an emergency supply of epinephrine for not more than one child and one adult in an automatic injection device if signed by a nurse practitioner or physician. Whenever such a statement of completion form for an emergency supply of epinephrine is presented, the pharmacist shall write upon the back of the statement of completion form in non-erasable ink the date that the prescription was filled, returning the statement of completion to the holder. The prescription may be filled up to 4 times. The pharmacist who dispenses an emergency supply of epinephrine under this rule shall also reduce the prescription to writing for his files, as in the case of an oral prescription for a non-controlled substance, and file the same in the pharmacy.

(3) A person who has successfully completed educational training in the administration of glucagon may receive, from the parent or guardian of a student, doses of glucagon prescribed by a health care professional with appropriate prescriptive privileges licensed under ORS chapters 677 or 678, and the necessary paraphernalia for administration.

(4) Completion of a training program and receipt of a statement of completion does not guarantee the competency of the individual trained.

(5) A statement of completion and authorization to obtain epinephrine shall expire three years after the date of training identified on the statement of completion. Individuals trained to administer epinephrine or glucagon must be trained every three years in accordance with OAR 333-055-0015 in order to obtain a new statement of completion.

(6) Individuals trained to administer epinephrine or glucagon may be asked to provide copies of a current statement of completion to their employers or to organizations or entities to which they volunteer.

[ED. NOTE: Figures referenced are available from the agency.]

Stat. Auth.: ORS 433.810

Stats. Implemented: ORS 433.800 & 433.830

Hist.: HD 10-1982, f. & ef. 5-25-82; HD 23-1990(Temp), f. & cert. ef. 8-15-90; OHD 7-1998, f. & cert. ef. 7-28-98; PH 10-2004, f. & cert. ef. 3-23-04; PH 14-2012, f. & cert. ef. 9-19-12

333-055-0035

Circumstances in Which Trained Persons May Administer Epinephrine or Glucagon

(1) A person who holds a current statement of completion pursuant to OAR 333-055-0030 may administer, in an emergency situation when a licensed health care professional is not immediately available, epinephrine to any person suffering a severe allergic response to an insect sting or other allergen. The decision to give epinephrine should be based upon recognition of the signs of a systemic allergic reaction and need not be postponed for purposes of identifying the specific antigen which caused the reaction.

(2) A person who holds a current statement of completion pursuant to OAR 333-055-0030 may administer, in an emergency situation involving an individual who is experiencing hypoglycemia and when a licensed health care professional is not immediately available, physician-prescribed glucagon to a person for whom glucagon is prescribed, when other treatment has failed or cannot be initiated. The decision to give glucagon should be based upon recognition of the signs of severe hypoglycemia and the inability to correct it with oral intake of food or drink.

Epinephrine Quiz

Name _____ Date _____

Affiliation _____

Evaluation Tool (Open book — you may use your class notes.)

1. The three most common types of substances that cause anaphylaxis are:

- (a)
- (b)
- (c)

2. If a person exhibits symptoms of anaphylaxis, one should wait until a complete history has been obtained before giving epinephrine.

_____ True _____ False

3. List two protective actions that should be taken by a person who knows he or she has previously had a severe allergic reaction to insects, foods, or other allergens:

- (a)
- (b)

4. If an insect sting causes swelling of an extremity beyond a major joint, but does not extend beyond the extremity, then it should be considered an anaphylactic reaction.

_____ True _____ False

5. If someone is having symptoms of a severe allergic reaction to food, it is generally safe to wait for 10 to 15 minutes before treating them.

_____ True _____ False

6. Multiple sting sites or a sting site in the mouth or on the face may cause a serious reaction in a person not allergic to insect stings.

_____ True _____ False

7. If a person has been exposed to a particular allergen in the past (e.g., a particular food, or a sting by a particular insect), but demonstrated no serious symptoms, it is safe to assume he/she will never develop a serious reaction to that same allergen.

_____ True _____ False

8. One of the side effects of epinephrine includes a fast heart rate.

_____ True _____ False

9. A 7 year-old is showing signs of anaphylaxis. Which of the following concentrations of epinephrine should be used?

- a) 0.3 milligram
- b) 0.15milligram

10. If a stinger is present at the site of a bee sting of a person experiencing anaphylaxis, it should be removed as soon as possible.

_____ True _____ False

Treatment of Allergic Response – Statement of Completion

This certifies that:

Address:

Has completed an approved training program covering recognition of symptoms of systemic reactions to allergens and proper administration of epinephrine, pursuant to ORS 433.605 to 433.830 and rules of the Oregon Health Authority, Public Health Division. Under ORS 433.825 this person is authorized to administer epinephrine in a severe allergic reaction emergency.

Signature of Authorized Trainer

Date Trained

Rev. 06/2012

CORRESPONDENCE

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October 30, 2015

Alton Harvey Jr, President
Board of Dentistry
1500 SW 1st Ave, Suite 770
Portland, Oregon 97201-5837

Re: Response to the Board of Dentistry Request:
Defense Counsel's Perspective of the Board's Administrative Investigatory Process

Mr. Harvey:

First of all, I want to thank the Board of Dentistry sincerely for their request that we present to the Board, our view of the Board's administrative investigatory process for dealing with complaints filed against licensed dental professionals. You may recall that during the Board's June 26, 2015 meeting we took issue with the Memorandum from Stephen Prisby to the Board regarding Recovering Costs of Referrals to Hearings. That Memo, said that "licensees and/or their attorneys delay seeking resolution to a case until after it has been referred to [contested case] hearing [before and administrative law judge]." The Memo accuses the licensee or his attorney of stonewalling and stalling the settlement process as a tactic to obtain a more favorable settlement. Nothing could be further from the truth.

As currently conducted, the Board's investigatory process denies the defendant licensee due process of law, namely:

- to know the nature of the complaint filed against him, the specific statutes or administrative rules that the licensee has allegedly violated,
- to know the evidence the investigator has obtained in support of the violation,
- to have the opportunity to confront the evidence, to cross-examine the witness and where necessary, the investigator, and
- To be heard by the decision-maker.

As discussed in the attached Memorandum, it is only after the Board has voted to impose discipline and the defendant licensee has requested a contested case hearing that the Court of Appeals has ruled the licensee has a right to see everything the Board considered in its decision to impose discipline. Therefore, in order for the defendant licensee to know what the charges are and the basis for the Board's decision, the licensee must ask for the contested case hearing. The Board's vote to pass the motion to seek "approximately \$400" from the licensee to cover the Board's cost of forwarding the licensee's case to the Office of Administrative Hearings to conduct the contested case hearing has a further chilling effect on the licensee's due process rights.

Please be advised that the Board's Investigators and counsel actively resist disclosure of the Investigator's

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full Final Report to the licensee even after a licensee has asked for a contested case hearing. They will not produce the Investigator's Recommendations and Rationale from the Investigator's Final Report to the Board, leaving the licensee to guess as to the nature of the charges, the development of the case, or the legal rules the Board applied. This practice violates the provisions of ORS Chapter 183, Oregon's Administrative Procedures Act (APA) that the Board has adopted as its procedural requirements for disciplinary actions, as well as the licensee's constitutional due process rights under the Fourteenth Amendment to the US Constitution.

By asserting his right to a contested case hearing the defendant licensee is simply asking for fairness, for the right to be heard by the Board, and for the Board to consider both sides of the story before rendering a decision. While we recognize and understand the important Board's Mission statement:

The Mission of the Oregon Board of Dentistry is to protect the public by assuring that the citizens of Oregon receive the highest possible quality oral health care.

We also recognize the need for the Board to comport its actions in accord with fundamental principles of transparency and fairness in dealing with Oregon's licensed dental professionals in disciplinary matters. After all, the Board's decisions have the potential to devastate a licensee financially, take away his livelihood, and destroy everything a licensee holds dear. Constitutional due process requires nothing more or less than that power so potentially destructive be exercised with great care and fairness.

At the end of the attached Memorandum, we have made suggestions to the Board on improving the procedural process related to disciplinary matters so as to respect the licensee's rights and comply the Oregon APA's due process requirements. Thereby, establishing a more equitable manner of dealing with dental licensees against whom complaints have been filed.

It is our sincere hope that the enclosed Memorandum will add to the Board's understanding of the disciplinary process from the defendant's point of view and the due process issues in dispute. We would welcome the opportunity to discuss the Memo more fully with the Board at its next meeting.

We respectfully request that this letter and the Memorandum be included in the New Business, Correspondence section of the Board's December 18, 2015, Notice of Regular Meetings. It is written as a generic document and is not related to any specific Case before the Board.

If you have any questions or concerns regarding these instructions, please contact me.

Sincerely,



James C. Brown
Attorney at Law

C: Stephen Prisby, Executive Director
Lori Lindley, DOJ

TO: Oregon Board of Dentistry

FROM: James C. Brown, Attorney

DATE: October 30, 2015

RE: The Administrative Processes of the Board of Dentistry: A Defense Counsel's Perspective

Introductory Note:

First, I want to thank the members of the Oregon Board of Dentistry for this opportunity to present this Memorandum offering a defense counsel's view of the investigatory/disciplinary procedures now in use by the Board of Dentistry to assess complaint(s) regarding a dental professional licensee. This memorandum will focus on how these procedures square with the requirements of due process of law under the United States Constitution. In preparing this Memo, I have tried to steer clear the case minutiae, although I will refer to some cases as these present particularly meaningful and forceful examples of current process. The factual statements in this Memo are based on actual case situations, although they are not intended to address the merits of any specific case. In discussing the way the Board currently handles cases, I must also call to you attention several deficiencies in the Board's procedures.

What is Due Process?

The "due process clause" is part of the Fourteenth Amendment of the U. S. Constitution: "[N]or shall any State deprive any person of life, liberty, or property, without due process of law."

Due process protects people when the government tries to take things. Protection of life and liberty are fairly straightforward because deprivation of life or liberty are easily understood. The state can execute a man, but it cannot execute a person without going through many procedural steps to safeguard the process. Similarly, government cannot imprison a man without a proper trial with all of its attendant features.

We must focus on the third element: no state can deprive – that is, rescind or restrict any person's property without due process of law. Property is a broader concept because we

recognize that many relationships create property interests. A professional license is a form of property protected by due process. Once a state, or a state-sponsored government board, issues a license, the board cannot take away that license except through procedures that comply with due process of law. *In re Ruffalo*, 390 U.S. 544 (1968). This is not to say that once a board issues a license, the license cannot be taken. Rather there are legal steps with which the government must comply to legally take or restrict a license. The Board must proceed in its investigatory actions in a manner that respects and, complies with the rules that courts have articulated to provide due process of law.

If the Board of Dentistry finds it necessary to rescind or restrict a dental professional's license, it must follow legal procedures relating to due process of law.

The Board's Procedure:

As a Defense Counsel, it would be presumptuous of me to tell you the procedure the Oregon Board of Dentistry follows. Instead, I will refer you to the Oregon Board of Dentistry's website which states.

Investigative Process

Complaints are assigned to an investigator and an initial summary of the issues involved is [sic. presented?] to the Board at its next scheduled meeting. However, due to the workload of the investigative staff and the complexity of many of the complaints received, it is not always possible to begin the investigative process immediately unless the issues involved constitute an immediate danger to the public or to the respondent. Most case investigations are completed and the Board makes a determination on the matter within about six months are [sic. after?] the initial complaint is received.

When a complaint is received, it is assigned a number and the person submitting the complaint will receive a letter from the Board advising them of the case number and that they will be contacted during the course of the active investigation. A staff investigator sends a letter to the licensee (respondent) who is the subject of the complaint requesting a copy of patient records where appropriate and a response to the allegations in the complaint. Once the information is received, the investigator reviews the records, interviews the respondent, interviews the person filing the complaint, interviews any prior and subsequent treating dentists, and interviews any other witnesses **as may be necessary to elicit sufficient information for a fair and accurate inquiry into the issues raised.** The Board also utilizes the services of expert consultants in especially complex or specialized situations where independent evaluations are necessary.

The investigative report describing the facts and findings of the investigator is presented to the Board for consideration and action. ORS 676.165 and 676.175 specify that the information gathered during the investigation and the investigative report are confidential and not subject to public disclosure except that the Board may provide sufficient summary to the complainant to explain the action the Board took in the matter. (Emphasis added.)

Again, this is the Investigative Process as described on the Board's own website. We could quibble over the exact accuracy of several points, whether the procedures described here are always followed or not. Instead, let us assume that the investigators and the staff of the Board of Dentistry follow these procedures to the letter. Will that satisfy constitutional due process? No.

I state that conclusion with great confidence, because the U.S. Supreme Court, in Goldberg v. Kelly, 397 U.S. 254 (1970), considered the challenge of welfare recipients whose benefits were being cut off, offering them an after-the-fact hearing as their only recourse. In a careful, thorough review of the problem, the Court set down what due process requires in a situation such as this. The principles in Goldberg v. Kelly are very similar to that of a licensee before the Board, one can readily substitute the "Board" for the "City" or "licensing entity" and "licensee" for "recipient" when reading the case.

These are the basic principles that the Supreme Court articulated in Goldberg v. Kelly:

1. Someone holding a license issued under a statute has a property interest in his license, and if the licensing entity tries to terminate that license, it must use procedures that meet the constitutional requirements of procedural due process. The constitutional challenge cannot be answered by an argument that "[license] benefits are a 'privilege' and not a 'right'" Goldberg v. Kelly, 397 U. S. at 261-263.

2. Because his license provides him with his living, the interest of the license holder in the uninterrupted use of his license, coupled with the Board of Dentistry's interest that no license be terminated erroneously, outweighs any increase in bureaucratic burdens the Board would incur by having hearings before suspending licenses. The stakes are simply too high for the [licensee], and the possibility of honest error or irritable misjudgment too great, to allow

termination of a [license] without giving the [licensee] a chance, if he so desires, to be fully informed of the case against him so that he can contest it spaces and produce evidence in rebuttal. *Goldberg v. Kelly*, 397 U. S. 264-266.

3. A pre-suspension evidentiary hearing is required to ensure the licensee procedural due process. *Goldberg v. Kelly*, 397 U. S. 264 and 266-271.

4. The hearing does not need to be a trial, but in any proceeding, the licensee must be given timely and adequate notice explaining the reasons the Board is seeking punitive sanctions, and an effective opportunity to defend himself by confronting adverse witnesses, and by presenting his own arguments and evidence, orally to the decision-maker. **“The fundamental requisite of due process of law is the opportunity to be heard.”** This requires that:

- a. *A licensee have timely and adequate notice detailing the reasons for a proposed suspension or revocation of a license ,*
- b. *A licensee have an effective opportunity to defend himself by confronting adverse witnesses, and*
- c. *A licensee be able to argue his case directly to the Board.*

These rights are especially important where a licensee challenges a ruling as a misapplication of rules or policies. *Goldberg v. Kelly*, 397 U. S. 266-270.

5. The Board is not required to provide counsel to a licensee, but if the licensee retains counsel, counsel must be allowed to participate fully as the licensee's representative throughout the proceeding. *Goldberg v. Kelly*, 397 U. S. 270.

6. The decision-maker does not need to file a full opinion or make formal findings of fact or conclusions of law, but he must state the reasons for his determination and indicate the evidence he relied on. *Goldberg v. Kelly*, 397 U. S. 271.

7. The decision-maker must be impartial. While prior involvement in limited aspects of a case will not necessarily bar a Board member from acting as decision-maker, he must be disqualified if he has participated in making the determination under review. Goldberg v. Kelly, 397 U. S. 271.

Thus says the United States Supreme Court.

In comparing the Board's current procedures with these seven points from Goldberg v. Kelly, do the procedures used by the Board of Dentistry measure up to what due process requires?

1. Goldberg said that the holder of license issued under a state statute has a property interest in his license. If the licensing entity tries to terminate that license, the entity must use procedures that meet the requirements of due process.

Does the Board of Dentistry agree that its procedures must meet the requirements of due process? The Board certainly does not claim that the requirements of due process have no application to these procedures, but, as is discussed below, the Board has imposed many obstacles which have the effect of burdening or restricting due process.

2. The Supreme Court has ruled that because his license provides him with his living, the licensee's interest in the uninterrupted use of his license, coupled with the Board's interest that no license be terminated erroneously, clearly outweighs any concern that might justify suspending a dentist's license before hearing the matter fully.

Due process requires that the Board give a licensee a hearing before rescinding or restricting his license. The dentist has an obvious interest in being allowed to earn his living until it is proven that he has done something wrong. By the website's admission, the Board of Dentistry's typical investigation goes on for several months. In this investigation, the Board has two goals: first, the Board wants to impose discipline when that is appropriate. And, second, the Board has a powerful interest in not suspending licenses wrongly. Is any interest advanced by allowing the Board of Dentistry to suspend a dentist's license before providing a hearing? No.

3. Goldberg ruled that a pre-suspension evidentiary hearing is central to due process.

Here we reach the heart of the matter. Does the Oregon Board of Dentistry allow a licensee a hearing before it suspends his license? The clear and simple answer is, "No."

Consider how the Board's website describes the process:

A staff investigator sends a letter to the licensee . . . requesting a copy of patient records where appropriate and a response to the allegations in the complaint . . . the investigator reviews the records, interviews the respondent, interviews the person filing the complaint, interviews any prior and subsequent treating dentists, and interviews any other witnesses as may be necessary to elicit sufficient information for a fair and accurate inquiry into the issues raised. The Board also utilizes the services of expert consultants in especially complex or specialized situations where independent evaluations are necessary.

The investigative report describing the facts and findings of the investigator is presented to the Board for consideration and action.

What does the "investigative report" present, and what "action" is the Board asked to take? The Investigator's Report, often labeled the Investigator's Final Report, presents the evidence as interpreted by the investigator, the investigator's evaluation of the case, and the investigator's rationale for his recommended action. For purposes of this discussion, presume the recommended action is the suspension of the dentist's license.

Is this a hearing? No.

The licensee has no right to be present before the Board. The only materials presented to the Board come from the investigator; the licensee is not able to present anything that explains or refutes the investigator's evidence or his findings. The licensee is given no details of the evidence against him. The investigator's Final Report to the Board is alleged not to be evidence, and is kept secret, in whole or in controlling parts, from the licensee. The licensee is not allowed to confront witnesses against him. Barred from the hearing, the licensee cannot make his own case, or challenge the investigator's case to the Board. No, this is not a hearing.

If the Board votes to suspend or restrict a license, a packet of materials is then sent to the licensee. The licensee will receive a Notice of Proposed License Suspension. This consists of a list of "allegations," an abbreviated Notice of Rights and sometimes a draft Consent Order proposing to settle the case. The first paragraph of an allegation recites the licensee's offensive act, which is commonly to the effect, "On [date,] while treating patient GJ, you failed to

document" A second paragraph generally announces that this is "unacceptable patient care" and lists the statutes and regulations that are implicated by this action.

This Notice of Proposed License Suspension presents the licensee with two alternatives: he can ask for a Contested Case Hearing before an administrative law judge (ALJ); but the Board may ignore the ALJ's findings of facts and conclusion of law that emerge from the contested case hearing. Or, he can submit to a settlement agreement proffered by the Board.

Note a critical point here: the licensee can get a hearing, but the Board has already decided his case by issuing the Notice of Proposed License Suspension. By issuing the Notice of Proposed License Suspension, the Board has already decided the case. At the contested case hearing, he licensee is left disputing a decision that has already been made. Under *Goldberg v. Kelly*, the hearing is the setting in which the decision is to be made. Under the Board's existing procedures, the decision had already been made, when the Board adopting the investigator's Final Report, with no meaningful input from the licensee. By so doing, the Board precludes the licensee from participating in the Board's decision-making process. The licensee is precluded from participating in the process whereby the Board's decision is made. The licensee's objective in requesting a contested case hearing is to pursue his due process rights to prepare an adequate defense, confront and cross-examine the investigator's case before an unbiased ALJ and win on the merits of his case. He then must rely on the ALJ's findings of fact and conclusions of law to the Board to convince the Board to overturn its prior decision.

4. Under *Goldberg*, whatever form the hearing takes, the licensee must be given timely and adequate notice explaining the reasons the Board is seeking punitive sanctions, and an opportunity to defend himself effectively by confronting adverse witnesses, and by presenting his own arguments and evidence, orally before the decision-maker.

On this point, the Oregon Board of Dentistry fails. It does not provide the required hearing before making its decision to propose to suspend a dentist's license. One might argue that the licensee is given notice of the allegations against him at the outset. After all, the Board's website says, "A staff investigator sends a letter to the licensee requesting a copy of patient records where appropriate and a response to the allegations in the complaint." In practice, the notice has atrophied. In many cases, the investigator's first letter to the licensee announces that

the Board is conducting an investigation, requests the records for one or more named patients, generally stating a complaint has been made, but as a rule discloses nothing as to the nature of the complaint and that the licensee must respond within 10 days.

If the licensee has any questions, he is given a number to call. If the licensee requests to know the nature of the complaint the usual response is to the effect "the Board is not prepared to disclose any further information regarding the nature of the complaint at this time."

Notwithstanding the fact that ORS 679.140 (8) and 679.250 (8) only give the Board legal jurisdiction to investigate **upon a motion by the board or upon a complaint being filed with the Board**. Many times the Board's investigator asks for patient records without ever alleging that a complaint has been filed or a motion has been made by the Board. The investigator simply asserts unlimited authority to require licensees to provide patient records. In some cases as many as 18 patient records at a time have been demanded without alleging any Board action or the filing of a complaint. It is simply a naked "fishing expedition" to search patient records for record-keeping errors and to charge the licensee subsequently with record-keeping violations mischaracterized as "unacceptable patient care" under the Dental Practices Act.

Does the licensee have an opportunity to confront the witnesses against him? No. In fact the Board does not see most of the witnesses. The "evidence" presented to the Board is the investigator's report, discussing what the investigator chooses to disclose to the Board. The Investigator's Report can freely edit the licensee's submittals, and omit the licensee's attachments or exhibits where they are "inconvenient" to the Investigator's desired outcome. As a result, the Board receives a distorted picture of the evidence or facts in the case that is tailored to the Investigator's perspective.

Goldberg holds that a defense restricted to written submissions is inadequate. Particularly where credibility and veracity are at issue, proceedings based on written submissions alone, are a wholly unsatisfactory basis for decision. The second-hand presentation to the decision-maker by the investigator is fatally deficient because the investigator usually gathers the facts upon which the charge is based. The investigator's job is to build the case against the licensee. Forcing the licensee to depend on the investigator to present the licensee's case fairly and vigorously is unreasonable. A licensee must be allowed to state his position directly to the Board, not through anyone else. Finally, **where decisions turn on questions of fact, due**

process requires an opportunity to confront and cross-examine adverse witnesses.

Goldberg, 397 U.S. at 269.

The Board bases its understanding of the case on the investigator's biased report. The licensee is denied any opportunity to review or challenge that report. Absent a contested case hearing, the Investigator's Report is treated by the Board as a confidential document. Even in the contested case setting, the Board's counsel asserts confidentiality over the Final Report's Recommendations and Rationale for the proposed discipline. This position must then be contested before the ALJ.

And what of the licensee's opportunity to present his own side of the case to the Board? NONE! Barred from the hearing, a licensee has no opportunity to be heard.

5. *Goldberg* says the decision-maker must state the reasons for his determination and indicate the evidence he relied upon.

Does the Board's procedure do that? No.

In fact, the Investigator's practice is to hide the facts and the reasons for his determinations from the licensee. Under current practice, the licensee's full due process rights are not recognized until he requests a contested case hearing, and then, only after a potentially contentious discovery process.

One must ask, Why is the Board unwilling to require the investigator to provide the licensee in the Investigator's Preliminary Report a clear statement of the investigator's findings, the administrative rule or statute allegedly violated, and the potential penalty associated with that violation? Then, allow the licensee and his counsel to meet with Investigator and a disinterested person to try to resolve the case. In this meeting, each side must present its position with supporting evidence showing the existence, nature, and extent of the actual violations to the unbiased person. That practice is common with other state and federal agencies such as the DEQ, Department of Agriculture, EPA, Army Corps of Engineers, Forest Service, OSHA, and many others. It generally leads to an agreed-upon resolution acceptable to both parties and avoids time-consuming and costly formal contested case hearings. It also provides a needed check on the investigator's authority. Because informal adjudication requires the investigator to articulate and prove his case and to respond to counterargument/evidence presented by the

licensee, the investigator must establish by a preponderance of the evidence the merits of his case. If the case cannot be resolved through informal meetings, that process has the added advantage of focusing the issues in the case that comes before the Board.

According to the Board of Dentistry's website:

ORS 676.165 and 676.175 specify that the information gathered during the investigation and the investigative report are confidential and not subject to public disclosure except that the Board may provide sufficient summary to the complainant to explain the action the Board took in the matter.

In many instances, the Board does not provide even a summary of the proceedings. Even if it did, the controlling question is, Does the Board do enough? Sadly, the answer is No.

Additionally, recent practice has shown that the Board's investigators have become increasingly arbitrary in their behavior. The Board's investigators hide behind a series of barriers, more designed to conceal their decisions than to explain them.

7. *Goldberg* requires that the decision-maker be impartial. Limited prior involvement with a case may not bar a Board member from acting as a decision-maker. But, if he participated in making the decision under review, then he is disqualified.

The Board does not comply with this rule. Because the Board has already adopted the recommendations in the Investigator's Report by issuing the Notice of Proposed License Suspension, the members of the Board have all participated in a decision against the licensee. In the contested case hearing the licensee is finally allowed to make his case, assuming the licensee wins at the contested case hearing; he must still hope that the ALJ's findings of fact and conclusions of law in his draft written opinion to the Board are sufficient to change the Board's mind. The Board may overturn the ALJ's written opinion. By the Board adopting the Investigator's Recommendation prior to the outcome of a contested case hearing, the licensee is placed in the position of having to argue his case to a Board that has already ruled against him. *Goldberg* holds that this procedure is so inherently unfair that, on its face, it violates due process.

In a contested case hearing, the ALJ is the only person who is not already committed to a position against the licensee. Nevertheless, the Board does not have to accept the ALJ's opinion, even though the ALJ is the only person to have actually heard "both sides of the story." Even if the ALJ presents a strong case for reversing the Board's decision, the Board has the discretion to

ignore it. I respectfully remind the Board of the Supreme Court's finding in *Goldberg*: **The fundamental requisite of due process of law is the opportunity to be heard.** Procedures that do not allow a licensee to appear personally before the actual decision-maker are inherently flawed. If a licensee is not permitted to present evidence to the official decision maker to present evidence orally, or to confront or cross-examine adverse witnesses, **"these omissions are fatal to the constitutional adequacy of the procedures."** *Goldberg*, 297 U.S. at 267-268[emphasis added]. The Board's current procedures fail to meet the standard the Constitution requires.

In this Memo, I have compared the procedure that the Board of Dentistry claims it follows against the requirements that the Supreme Court has established. Before moving on, there is one additional point I must make. In the Board's description of how cases are handled, there are several inaccuracies. One of these requires correction.

According to the Board's account of how cases are processed, "The investigative report describing the facts and findings of the investigator is presented to the Board for consideration and action." Now consider just what that says. In particular, I want to focus on the sequence by which the report is created.

In his investigation, the investigator gathers evidence of various kinds from various sources. In the process of preparing his final report, he weighs the evidence and considers the value of each item. He has complete discretion in assessing evidence. He gives credence to some evidence while dismissing other items, but he is not required to disclose or explain his determinations. The results go into the portions of the Final Report which the licensee is not allowed to see. Because the licensee cannot examine the report, the Investigator can stack the evidence as he pleases. Does he do this? Circumstantial evidence suggests that he does.

In several recent cases, licensees have submitted evidence to the investigator showing unequivocally that the licensee had not committed alleged acts. The licensees explicitly asked that this information be incorporated in any report to be submitted to the Board and that documentary evidence be made a part of the administrative record in the case. In cases with which I am familiar, evidence submitted in this manner appears to have been ignored entirely and omitted entirely from the administrative record presented to the Board. Under current practice, the investigator has sole control over what evidence the Board sees, according to his

own rules and standards that are never published, leading to results that are never shared, reached by paths of reasoning that are never disclosed.

So who is the decision-maker in these cases that come before the Board? Nominally, you, the Board makes the decision. There is a certain truth to this. A Notice of Proposed License Suspension, Consent Order, and many other documents issued in the name of the Board of Dentistry require some Board action, but how many of these Board "actions" amount to little more than "rubber stamping" of an investigator's recommendation.

I again remind the Board of the Supreme Court's holding in *Goldberg*, that a second-hand presentation to the decision-maker by the investigator has fatal deficiencies. The investigator gathers the facts upon which the charge rests, the presentation of the licensee's side of the case cannot safely be left to him. The licensee must be allowed to state his case orally to the Board. Additionally, where important decisions turn on questions of fact, due process requires an opportunity to confront and cross-examine adverse witnesses, including the investigator.

Certain principles are immutable parts of our jurisprudence. One of these is that **where governmental action seriously injures an individual, and the validity of the action depends on factual findings, the evidence used to prove the Government's case must be disclosed to the individual so he has an opportunity to show what is untrue.** The right to challenge this evidence is even more important where the evidence consists of the testimony of individuals whose memory might be faulty or who might be motivated by malice, vindictiveness, intolerance, prejudice or jealousy. **We have formalized these protections in the requirements of confrontation and cross-examination.** They have ancient roots, they find expression in criminal law in the Sixth Amendment. The courts has been zealous to protect these rights from erosion. The courts have spoken out not only in criminal cases, but **in all types of cases where administrative actions have come under scrutiny.** *Goldberg v. Kelly*, 367 U.S. at 269-270 (emphasis added).

So who is the decision-maker? Unfortunately, the decision-maker in these situations is the investigator, and among the Board's investigators, the moving force is the chief investigator, Paul Kleinstub. The Investigator's Final Report often invites the Board to abdicate the Board's

duties and responsibilities to its professional peers, accepting the investigator's recommendation without analysis, discussion, confrontation or cross-examination.

Summarizing, I have presented a comparison of the Board of Dentistry's procedure and practice against the Constitution's requirements of due process, the Board of Dentistry's procedure does not provide adequate notice of the claim against the licensee. Board of Dentistry's existing practices deny the licensee the right to appear before the actual decision-maker, to know and confront the evidence, the right to present his side of the case and cross-examine witnesses and the investigator. The Board's procedures rely on the second-hand presentation of the investigator, which is inherently deficient. Board procedure does not allow for a hearing before penalties are proposed. Board procedure does not allow the licensee to discover materials critical for an adequate defense. The contested case hearing which is finally offered is not a forum in which the issues are to be decided. At best it is a setting in which the licensee seeks to challenge a decision already made. In the best outcome of a contested case hearing with a finding for the licensee, the licensee is then placed in the position of asking Board members to repudiate their earlier decision in order to grant relief to the licensee. The real decision-maker is the Chief Investigator, who offers no explanation to the licensee of how he reaches his decisions.

How This Happened?

When I first realized how thoroughly deficient the administrative procedures of the Oregon Board of Dentistry were in providing licensed dental professionals due process of law, I was stunned! I have been actively involved in administrative law in Oregon for over 40 years, eight years as a county health department inspector and a State Health Division administrator enforcing Oregon's administrative rules and codes, administering regulatory programs, writing administrative rules and revising statutes; two years as a member of a State Regulatory Board; four years as the Environmental Compliance Coordinator for Tektronix Inc. (then a \$1.8 billion per year electronics company), with responsibility for environmental compliance on Tek's Vancouver and seven metropolitan Portland campuses. I had responsibility for hazardous waste

management and RCRA compliance, Superfund and Clean Water Act compliance. Lastly for almost 30 years I have been a practicing attorney, defending clients before state and federal agencies and boards.

Historically, Oregon has led the way in innovations to make government responsive and transparent in its actions. Therefore one must ask, How can a Board of Oregon state government so extensively ignore ORS Chapter 183, in its rulemaking and enforcement procedures, and not realize its policies and practices are fundamentally flawed?

I would suggest these deficiencies are attributable to several factors. First, the present regulatory system is biased against the licensee and pressures the Board's Investigators to find ways, by hook or by crook, to win these cases. This is because money received from disciplinary actions is factored explicitly into the Board's budget, accounting for approximately 10% of the Board's 2013-2015 revenue. This means the Board's investigators are like police officers trying to meet a ticket quota when conducting an investigation. The Board's investigators must develop cases that allow the Board to levy thousands of dollars per month in fines to balance the Board's budget. Such a financial mandate inherently introduces adverse bias in the investigator's approach to a case.

Second, the Board has, by administrative rule, classified a plethora of administrative record-keeping minutia as "unacceptable patient care" and given the investigators the power to cast an investigative net as broadly as they wish. The Investigators can carry on an investigation until they find some flaw in almost any dentist's records. Paul Kleinstub has reportedly said, "No dentist can comply with all of the provisions of the Dental Practices Act. I can find violations on anyone." Additionally, the offenses are often very easy to prove. Virtually any missing note in a complex reporting system can be a violation.

The Board has adopted many of its regulations in violation of the APA's administrative rulemaking procedures. The Board's "Rulemaking" often ignores the cautionary, limiting language of ORS 679.140 (1)(e) and (4) that "unacceptable patient care" should be "due to a

deliberate or negligent act or failure to act by the dentist... ” and “in determining what constitutes unacceptable patient care, the board may take into account all relevant factors and practices, including practices generally and currently followed and accepted by persons licensed to practice dentistry in the state.” In practice, however, the investigators treat any rule violation as a strict liability offense, so that regardless of circumstances, if the rule is violated, the dentist is guilty. The investigators violate the statute’s reasonable constraints by requiring that Oregon’s dental professionals be perfect in their record keeping practices.

In many instances, a licensee confronted with a punitive Notice will face multiple allegations. This brings out the unfairness of a contested case hearing. To prevail, the licensee must defeat every allegation against him. Anything less still leaves him at the mercy of the Board. Often this need for complete exoneration is effectively impossible to achieve, so that a licensee finds it less dangerous to accept an overreaching consent decree rather than fight for what will be at most a partial victory.

At this point, the Investigators use a vague feature in the system to coerce consent from the licensee. There are no published guidelines for punishments. The Board may have adopted internal guidelines or standard protocols that have not been properly noticed or announced and are unpublished, illegal administrative rules.¹

To discourage the licensee from taking a matter to a contested case hearing, the investigator can threaten to increase the penalty if the licensee seeks a hearing. Finally, even if the licensee is completely exonerated in the contested case hearing, he must pay the Board’s costs incurred in prosecuting the case. For most licensees who receive disciplinary Notices, the costs of refusing to submit to the Board’s proposed Consent Order make it discouragingly easy to acquiesce to whatever violation of his due process rights he faces.

¹ Under the APA, a “rule” is “any agency directive, standard, regulation or statement of general applicability that implements, interprets or prescribes law or policy, or describes the procedure or practice requirements of any agency.” ORS 183.310 (9).

With many pressures inducing the licensee's need to settle the claim and return to an orderly life rather than fight the system, many licensees will forego contested case hearings. Very few have gone to the Court of Appeals in defense of their rights.

Proposed Solutions

In order to meet the minimum due process standards required by the Constitution, I suggest that the Board consider the following procedural adjustments:

1. The Board needs to require each member of its disciplinary and rulemaking staff to acquire an individual copy of the July 2014, *Oregon Attorney General's Administrative Law Manual and Uniform and Model Rules of Procedure under the Administrative Procedure Act*. The APA, ORS chapter 183, is the State's codification of administrative due process. This Manual needs to be required reading for the Board's Executive Director, the Board's investigators, and each Board member.

The Manual is written to guide state agencies, employees, and regulatory boards charged with conducting administrative rulemaking and contested case proceedings in their duties. It is essential reading for anyone who wants to actually understand and comply with the regulatory requirements to conduct those activities successfully. Further, compliance with the APA provisions is mandatory for the Board to be able to defend its actions.

2. When a complaint is received or the Board votes on its own initiative to request information from an Oregon licensed dental professional, in the initial letter to the Licensee, the Board must set forth the basis for the request and the basic nature of the complaint or the Board's reasons for requesting the records.
3. In the course of responding to several Board requests, serious concern has arisen as to whether or not the Board's request for patient records, especially **ORIGINAL** patient records, violates the federal HIPAA Privacy Rule and compliance with the Board's request may cause the responding dentist to violate HIPAA. I suggest that the Board

consider asking for an Attorney General's opinion on that issue. Paul Kleinstub's assertion that the Board is a "health oversight agency" under HIPPA is highly suspect.

4. When the investigator prepares a Preliminary Report, the report must include actual copies of all submittals from the licensee, as well as setting forth the specific violations found, listing of the rule or statute governing the violation, and disclose the potential penalty associated with each violation.
5. Permit the licensee to submit evidence that explains or negates alleged violations; and amend the Preliminary Report accordingly.
6. Have the licensee or his counsel meet with the investigator and Board counsel, and an unbiased person to review and evaluate the case. This will require the investigator to prove his case and gives the licensee an opportunity to present their position/evidence to the person who can evaluate the merits of the case. In doing this with other agencies, I have found that the strengths and weaknesses of the respective cases are readily exposed and the parties are generally able to reach a satisfactory resolution based on a common understanding of all the relevant facts. In such instances, our clients have agreed to pay civil penalties where warranted; and, if the parties were unable to come to a common understanding, they can proceed with the contested case hearing or a hearing before the decision-maker. In any event, the facts of the case are more sharply focused and resolution proceeds in a more timely and straightforward manner.
7. If the Board wants to be the ultimate decision-maker, it should either afford the licensee the opportunity to have a hearing before the Board or refer the case to a contested case hearing without considering the Investigator's Report. This will preserve the Board's ability to make an unbiased decision based upon the findings of fact and conclusions of law of the Administrative Law Judge, rather than prejudging the case as is the Board's current procedure.

8. Some may argue that invoking these procedural safeguards will increase the Board's operating expenses. Because these safeguards are designed to protect all licensed dental professionals in the state, it would be appropriate for the Board to request an increase in the biannual licensing fees to cover those costs. The goodwill the Board would engender as a result of licensees' perception that they are being treated fairly and with transparent openness by the Board would more than offset the carping generally associated with a license fee increase.

Thank you for this opportunity to present these due process concerns and remedial suggestions for your consideration.

Southern Regional Testing Agency, Inc.

*4698 Honeygrove Road, Suite 2
Virginia Beach, Virginia 23455-5934
Tel. (757) 318-9082 / Fax (757) 318-9085
www.srta.org*

December 2015

To: State Board of Dentistry

Having responded to a legislature mandated examination review request, I thought that your dental board may also be interested in this data. Please feel free to share this letter with your board members. If you have additional questions, or would welcome one of our examiners as a guest to further clarify items (and/or answer questions), please let me know and I will make arrangements.”

I must let you know, that I respect the State Dental Boards for their efforts in keeping abreast of initial licensure examinations. As you are aware, the ADA during its’ July 14, 2015 meeting of the “Taskforce on Licensure”, again urged all states to accept all regional clinical licensure examinations. This motion was made to further portability for the students, while continuing to work toward a patient-free examination for licensure.

Prior to addressing the eight questions presented, I would like to advise you that I will be sending via email, electronic versions of our 2016 Candidate Manuals for both Dentistry and Dental Hygiene. As I write this letter now, we are close to leaving the “Draft” stage, but you will be receiving “Draft” copies!

Question 1: “How to determine the eligibility of a candidate?”

Candidate eligibility is first based on enrollment at or graduation from a CODA accredited institution. If one has not yet graduated, the dean of the individual’s school must provide a letter certifying that the student(s) listed are eligible to take the exam, and are in good standing with an anticipated graduation date within 18 months of the examination date.

For international students that have not graduated from a CODA accredited school or have not successfully completed an AEGD program, the candidate may take the examination based on “State Only” status. The candidate must furnish a letter from a State Board of Dentistry that

Marcus Muncy, D.D.S. – President

Dianne Embry, R.D.H. - Secretary

Robert B. Hall, Jr., D.D.S. - Treasurer

Kathleen M. White – Executive Director

clearly states that this candidate, if successful on the examination, may be licensed within their state. A copy of the candidate's diploma along with an English translation is also required. All of the candidate records for state only status, remain marked as "Restricted" to the accepting state. (The candidate cannot seek/obtain initial licensure anywhere but in the sponsoring state).

Question 2: "Describe topics tested and scoring methodology for each topic". [Note scoring methodology and passing score questions from Question 2- rolled into Question 4].

Dental: Manikin based

Manikin setup used: Acidental Modu-Pro

Endodontics- two procedures.

->**Anterior:** Access opening, instrumentation and obturation of tooth #8.

->**Posterior:** Access opening on tooth # 14, must achieve direct access to all three canals.

Prosthodontics: - three procedures.

->**PFM (Porcelain-Fused-to-Metal)** crown preparation. Tooth #5. An anterior abutment for a 3-unit bridge, plus an evaluation of the line of draw for the bridge abutment preparations.

->**Cast Metal/All Zirconia** crown preparation on tooth # 3. This is the posterior abutment for the 3-unit bridge.

->**All-Ceramic** crown preparation on tooth #9. Anterior central incisor.

Dental Patient-Based

Anterior:

->Class III Composite prep and restoration

Posterior:

->Class II (select one of the following three)- Amalgam Prep & restoration; Composite Prep and restoration or slot prep and restoration. (Note: Wyoming requires a slot prep & restoration for initial licensure and we so note this for candidates).

Periodontal

->Must select, identify, scale and polish selected teeth keeping within the parameters listed in the candidate manual. Selected teeth must have adequate subgingival calculus, 3 teeth required for pocket depth measurement- these teeth need not be those teeth selected for calculus removal but must be within the treatment selection. This section remains optional based on our task analysis of 2005 and 2011. Candidates may take this section if they so choose without additional cost.

Marcus Muncy, D.D.S. – President

Question 4: “Determining a passing score for individual components and the complete exam”

Scoring Methodology

The scoring methodology for all components of the exam is as follows: a triple blind system is used (no one knows status of previous evaluators), all examination materials are numbered using the candidate(s) unique number. The candidate's name and school data does not appear on any testing materials. All examiners are vetted current and past State Dental Board members that are experienced practitioners with diverse backgrounds. We also utilize faculty examiners, although they cannot examine in their respective state, the knowledge they gain through their experience is imparted to the students. Examiners are trained and standardized prior to each examination and are evaluated to ensure they are grading to established criteria. The examiners are separated from the candidates and will remain in a separate area of the clinic.

Candidates must observe all signs and follow instructions so as not to breach anonymity. Anonymity is preserved between the scoring examiners and the candidates. Examiners may consult with the SRTA Clinic Floor Coordinator (CFC) or Scoring Area Coordinator (SAC) whenever necessary. Examiners are assigned to grading operatories via a computer generated randomization of those examiners that are available to examine. All times are recorded, from the first “encounter” on the clinic floor (approval of Medical History, BP etc.). Also recorded is every patient check in or out, the examiners in and out times etc. Thus we know from start to finish the stage of each candidate.

The scoring system is criterion referenced and based on an analytical model. The examination is conjunctive in that the contents are divided into 5 separate sections and each section is scored independently. The examination is compensatory within each section for determining the final score within the section. A numeric grade equal to or greater than 75 is a Pass. Less than a numeric grade of 75 is a Fail. This value represents a scale score that is consistent with commonly used interpretive scales for scoring performance. The underlying performance standard that corresponds to minimum competency is based on a combination of standard setting methods, specifically the Dominant Profile Judgment method and the Extended Angoff Method. Both of these methods are discussed in Hambleton and Pitoniak’s chapter about standard setting in *Educational Measurement*, 4th ed. (Brennan, 2006). Similar descriptions of these and other methods that are appropriate for credentialing examinations like SRTA’s clinical skills tests can be found in Buckendahl and Davis-Becker’s chapter about standard setting for credentialing examinations in *Setting Performance Standards* (Cizek, 2012).

All scoring and score calculations are completed using specifically designed computer software. Input is via Kindles. Those examiners that follow the first examiner have no means by which to view the “grading” of any previous examiner(s). Statistics are compiled throughout the day and reviewed with the examiners as necessary to ensure all criteria are being consistently assessed. We are the only clinical examination agency that does immediate/on-site remediation of examiners. This enables the examiner to be aware and to self-correct any defined areas.

Marcus Muncy, D.D.S. – President

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A passing determination for a candidate is automatically determined via evaluation by the calibrated grading examiners, based on the defined criteria. Our computer software provides the end result, whether it be numeric or Pass/Fail. On an exam overall approach, the candidate must be successful in all procedures as noted on Page 2 to have “Passed the exam”. The candidate retake of single sections may be required to achieve the overall “exam passed” status. (Passing grade numeric is 75).

As a side note, SRTA was the first regional agency in the country to successfully implement computer driven scoring... via PDA's - beginning with the exam cycle of 2008. We of course have continued to enhance our software and we even upgraded to full color Kindles!

Question 3: Process for examiner calibration

Examiner calibration is a multi-step process. An annual (once per exam cycle/year) on-line test is required. This on-line test covers all policies, procedures and protocols. A passing grade of 80% is required for examiners to be eligible to participate in operational scoring.

At each exam site, examiner calibration to the scoring criteria occurs. The calibration takes approximately 4 hours with a 10 question quiz upon completion of each section/segment as outlined on Page 2. All criteria are reviewed during this process. The quizzes consist of photographs of both acceptable and unacceptable preps/restorations. We have 3 different quiz sets which are used throughout the year, such that examiners do not always see the same photos and respond to questions by rote. All examiners must obtain a score of 80% or higher to be considered calibrated and allowed to examine. A failing examiner has one additional attempt to reach 80%. If not successful on the second attempt, the examiner is sent home.

Questions 5 - 8: When was the last review of the examination? What were the Results? Updates to the examination? Comparison to other examinations?

A review of the examination is ongoing with specific milestones that occur at key phases in development and validation. Some of these key milestones include a nationwide job (task) analysis that was most recently conducted in 2011 with a plan to begin conducting the next one in late 2016. This aligns with SRTA's policy to systematically evaluate the content of its examinations relative to the field every 5-6 years. Additional reviews of the examinations occur at least annually with our Examination Committees who review the tasks and scoring criteria associated with each examination to ensure that they continue to align with expectations for minimally competent practice in dentistry or dental hygiene respectively. Ongoing, empirical evaluation of examiners occurs throughout the examination cycle and then annually as part of a technical review of the program. These evaluations focus on the validity and reliability of judgments as applied to candidates' performance. SRTA also maintains an ongoing relationship with a psychometrician (measurement consultant) who provides input on each of these activities.

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The results of these activities support use of the scores for making decisions about candidates' minimum competency in dentistry and dental hygiene, respectively. Content and empirical evidence are evaluated to support this assertion.

Perhaps the best example I can provide as a comparison to other clinical examinations is the nationwide job analysis (task analysis) noted above. This project was conducted in 2011 as a joint effort between SRТА and NERB (now CDCA) under the ADEX partnership. This 2011 nationwide task analysis further points to SRТА as a leader in the development of clinical examinations as the SRТА task analysis of 2006 indicated a lack of the requirement for the periodontal procedure. The periodontal task was deemed as one that was typically referred to periodontists, and not performed by general dentists. Thus, the periodontal procedure became optional in the SRТА examination in 2006 and in the ADEX exam of 2012, when the same conclusion was reached again, via the 2011 task analysis.

SRТА does not include the use of computer assisted examinations in either the Dental or Dental Hygiene exams due to the lack of current data indicating relevancy and assurance that the exam(s) do not duplicate the National Boards in a significant manner.

We continue to have a long-standing relationship with our psychometrician, Chad Buckendahl, PhD. Trust me- we do not make any changes without his blessing! In addition, we would be happy to provide Chad as a supplemental resource for Board Members if they have specific questions about some of the technical features of our examination.

I believe I have answered all of the questions outlined in your letter. Should you find that I missed something or if you need additional clarification, please do not hesitate to contact me.

Again, the Dental and Dental Hygiene candidate manuals are DRAFT versions- close to complete. The Dental forms are newly revised for 2016 and are ready for use.

Again, please feel free to contact me if you have additional questions or if I thoroughly confused you!

Best regards-

Kathleen M. White
Executive Director

Marcus Muncy, D.D.S. – President

Dianne Embry, R.D.H. - Secretary

Robert B. Hall, Jr., D.D.S. - Treasurer

Kathleen M. White – Executive Director

Highlights of the American Board of Dental Examiners, Inc. (ADEX)
11th House of Representatives
November 15, 2015
Rosemont, IL

The following are highlights of the 11th ADEX House of Representatives:

There were 52 out of 59 Jurisdictions, District Hygiene and District Consumer Representatives present.

2015 – 2016 Officers were elected: Dr. Stanwood Kanna, HI, President; Dr. William Pappas, NV, Vice-President; Dr. Jeffery Hartsog, MS, Secretary; Dr. Conrad “Chip” McVea, LA, Treasurer, and Dr. Bruce Barrette, WI remains as Immediate Past President.

District 2 re-elected Dr. Patricia Parker, OR to the ADEX Board of Directors.

District 3 elected Dr. Bryan Chapman, MO to the ADEX Board of Directors.

District 4 re-elected Dr. Keith Clemence, WI to the ADEX Board of Directors.

District 6 elected Dr. John Douglass, TN to the ADEX Board of Directors.

District 7 re-elected Dr. John Reitz, PA to the ADEX Board of Directors.

District 11 elected Dr. Millard “Buddy” Wester, NC to the ADEX Board of Directors.

District 13 elected Dr. Irving McKenzie, Jamaica to the ADEX Board of Directors.

Ms. Mary Johnston, RDH, MI was re-elected as one of the Dental Hygiene Members to the ADEX Board of Directors.

Ms. Nan Kosydar Dreves, RDH, MBA, WI was elected as one of the Dental Hygiene Members to the ADEX Board of Directors.

Ms. Clance LaTurner, IN was re-elected as one of the Consumer Members to the ADEX Board of Directors.

Mr. Alton Harvey, Sr., OR was elected as one of the Consumer Members to the ADEX Board of Directors.

ADEX Board of Directors

- Adopted a new ADEX Mission Statement.

“Develop clinical licensure examinations for dental professionals”

- Appointed Ms. Pat Connolly-Atkins, RDH, MA as the new Dental Hygiene Examination Chair.

Changes to the ADEX Dental Examination:

- Made changes which allow the "Buffalo Model" CIF format to be delivered this year at schools who request it. This will be at CDCA sites this year with CITA's future use to be determined after further study of the logistics.
- Developed a procedure by which a candidate can perform an "Indirect Pulp Cap", where indicated, starting with the 2017 Examination.

Changes to the ADEX Dental Hygiene Examination:

- Extended the Examination time from 90 minutes to 120 minutes
- Manual revisions in multiple area to improve the clarity of information to candidates.
- Definition of calculus in the detection exercise redefined.
- Changes to the scoring rubric and point values for the 2017 Examination Cycle.
- No major changes in the content or criteria of the examination.

ADEX House of Representatives:

- Approved Bylaw changes that will change the membership of the House of Representatives and developed bylaws concerning a conflict of interest.
- Approved the Dental and Dental Hygiene Examinations as recommended by the Examination Committees and the Board of Directors.

Presentations to the House of Representatives from the following:

Dr. Guy Champagne, "Patient Centered Curriculum Integrated Format Examination."

Dr. William Pappas, "ADEX Quality Assurance Site Visits."

Mr. Alex Vandiver, CEO, CDCA, Mr. Michael Zeder, CDCA and Dr. Chip McVea, President of CITA "ADEX Dental Examination Score Portal."

2016 ADEX House of Representatives: The 12th ADEX House of Representatives Meeting is scheduled for Sunday, August 7, 2016, at the Doubletree Hotel, Rosemont, IL.

OTHER ISSUES

Board Approved:

OREGON BOARD OF DENTISTRY
1500 SW 1ST AVENUE, SUITE 770
PORTLAND, OR 97201
(971) 673-3200

Dental Hygiene
Request for Approval of Restorative Curriculum

Dental Hygiene Program

Dental Hygiene CE Course

Name of Institution/Program: Pima Medical Institute- Seattle

Name of Program Director: Melisa McCannel

Address: 9709 Third Avenue NE

City: Seattle

State: Wa

Zip code: 98115

Telephone: 206-529-6692

Date Institution/Program adopted/revised current Curriculum: 2012

Any changes to the course curriculum must have prior approval from the Board. Please provide the Board with adequate notice so that approval can be obtained before any changes to the curriculum are implemented.

Program Director's Signature: 

Date:



RECEIVED

NOV 17 2015

Oregon Board of Dentistry

November 13, 2015

Oregon Board of Dentistry,

Please accept the enclosed documentation that shows that graduates from Pima Medical Institute Dental Hygiene Program are sufficiently qualified and meet and surpass the minimum requirements of an accredited restorative hygiene program. We received full accreditation from CODA in May of 2014.

If there is any information that I have unintentionally overlooked, please accept my apologies and allow me the opportunity to resubmit.

Respectfully,

Melisa McCannel, RDH, BS
Dental Hygiene Program Director
p: 206-529-6692
f: 206-522-5807
e: mmccannel@pmi.edu

RICHARD L. LUEBKE, SR
Founder 1972-2008

RICHARD L. LUEBKE, JR
Chief Executive Officer

FRED FREEDMAN
President/Chief Operating Officer

LIBY LENTZ
Vice President/Secretary

MICHAEL NIGGL
Vice President

RICHARD ALMEROTH
Chief Financial Officer /Treasurer

ALAN CLAY, JR.
Campus Director

CAMPUS LOCATIONS

Albuquerque Campus
4400 Cutler Avenue, NE
Albuquerque, NM 87110
(505) 881-1234

Albuquerque West Campus
8601 Golf Course Road, NW
Albuquerque, NM 87114
(505) 890-4316

Aurora Campus
13750 E. Mississippi Avenue
Aurora, CO 80012
(303) 368-7462

Chula Vista Campus
780 Bay Boulevard, #101
Chula Vista, CA 91910
(619) 425-3200

Colorado Springs Campus
3770 Citadel Drive North
Colorado Springs, CO 80909
(719) 482-7462

Denver Campus
7475 Dakin Street #100
Denver, CO 80221
(303) 426-1800

East Valley Campus
2160 S. Power Road
Mesa, AZ 85209
(480) 898-9898

Houston Campus
10201 Katy Freeway
Houston, TX 77024
(713) 778-0778

Las Vegas Campus
3333 E. Flamingo Road
Las Vegas, NV 89121
(702) 458-9650

Mesa Campus
957 S. Dobson Road
Mesa, AZ 85202
(480) 644-0267

Renton Campus
555 S. Renton Village Place, #400
Renton, WA 98057
(425) 228-9600

Tucson Campus
3350 E. Grant Road
Tucson, AZ 85716
(520) 326-1600

SEATTLE CAMPUS

9709 Third Avenue NE, Suite 400 • Seattle, WA 98115 • (206) 322-6100 • Fax (206) 328-2629 • www.pmi.edu



PIMA MEDICAL INSTITUTE

Dental Hygiene
Program Outline

Semester I (15 Weeks)

Course #	Course	Theory	Lab	Clinical	Credits
CSK 100	Study Skills	15			1.0
PSY 115	Psychology	45			3.0
CCM 121	Communications	15			1.0
BIO 115	Anatomy & Physiology	45	30		4.0
BIO 145	Microbiology & Immunology	45			3.0
RDH 101	Introduction to Dental Hygiene	30			2.0
RDH 186	Dental Anatomy	45			3.0
Semester I Total		240	30		17.0

Semester II (15 Weeks)

Course #	Course	Theory	Lab	Clinical	Credits
SOC 110	Sociology	30			2.0
CHM 125	Chemistry/Biochemistry	45			3.0
BIO 156	Head & Neck Anatomy	45			3.0
RDH 116	Preclinical Dental Hygiene	45			3.0
RDH 120	Preclinical Clinical Dental Hygiene			90	2.0
RDH 211	Radiology	30	45		3.5
Semester II Total		195	45	90	16.5

Semester III (15 Weeks)

Course #	Course	Theory	Lab	Clinical	Credits
RDH 150	Dental Hygiene I	30	15		2.5
RDH 155	Clinical Dental Hygiene I			120	2.5
RDH 215	Biomaterials	15	45		2.5
RDH 218	Periodontics	45			3.0
RDH 260	Pharmacology for Dental Hygiene	45			3.0
Semester III Total		135	60	120	13.5

Semester IV (15 Weeks)

Course #	Course	Theory	Lab	Clinical	Credits
RDH 175	Dental Hygiene II	30	15		2.5
RDH 180	Clinical Dental Hygiene II			150	3.0
RDH 209	Nutrition & Cariology	30			2.0
RDH 214	Patient/Pain Management	30	45		3.5
RDH 220	General/Oral Pathology	45			3.0
Semester IV Total		135	60	150	14.0

Semester V (15 Weeks)

Course #	Course	Theory	Lab	Clinical	Credits
RDH 200	Dental Hygiene III	30	15		2.5
RDH 205	Clinical Dental Hygiene III			180	4.0
RDH 251	Treatment of Special Needs Patient Seminar	45			3.0
RDH 259	Community & Public Dental Health	45			3.0
RDH 266	Restorative Lab*	15	75		3.5
Semester V Total		135	90	180	16.0

Semester VI (15 Weeks)

Course #	Course	Theory	Lab	Clinical	Credits
RDH 226	Review of Dental Hygiene	45			3.0
RDH 271	Dental Health Promotions	45			3.0
RDH 280	Dental Hygiene IV			180	4.0
RDH 285	Restorative Clinic*			60	1.0
RDH 290	Principles of Dental Hygiene Practice	45			3.0
Semester VI Total		135	0	240	14.0
PROGRAM TOTALS		975	285	780	91.0

*Represents the Seattle

Total Hours: 1890 960 Theory/210 Lab/720 Clinical Total Credits: 86.5
 Total Hours*: 2040 975 Theory/285 Lab/780 Clinical Total Credits*: 91.0
 Total Weeks: 90 weeks

Definition of Credit: 1 Credit = 15 Lecture Hours/30 Lab Hours/45 Extern Hours

PIMA MEDICAL INSTITUTE

Dental Hygiene Semester I: RDH 186 Dental Anatomy Course Outline

- I. Overview of the Cell
 - A. Cell membrane
 - B. Organelles
 - C. Cell division
 - D. Extracellular materials
 - E. Intercellular junctions

- II. Basic Tissues
 - A. Epithelial tissue
 - B. Basement membrane
 - C. Connective tissue
 - D. Specialized connective tissue
 - 1. Cartilage
 - 2. Nerve tissue

- III. Prenatal Development
 - A. Preimplantation period
 - B. Embryonic period
 - C. Fetal period

- IV. Development of the Face
 - A. Stomodeum and oral cavity formation
 - B. Mandibular arch and lower face formation
 - C. Frontonasal process and upper face formation
 - D. Maxillary process and midface formation

- V. Development of the Neck
 - A. Primitive Pharynx Formation
 - B. Branchial Apparatus Formation

- VI. Development of Orofacial Structures
 - A. Palatal development
 - 1. Primary palate formation
 - 2. Secondary palate formation
 - 3. Completion of palate
 - 4. Developmental disturbances of the palate and related tissues
 - B. Nasal cavity and septum development
 - C. Tongue development
 - 1. Body and base of tongue formation
 - 2. Completion of tongue formation
 - 3. Developmental disturbances of the tongue

- VII. Tooth Development and Eruption
 - A. Tooth development stages
 - 1. Initiation
 - 2. Bud
 - 3. Cap

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Dental Hygiene Semester I: RDH 186 Dental Anatomy Course Outline

- 4. Bell
 - 5. Apposition and maturation stages
 - 6. Developmental disturbances during stages of tooth development
 - B. Root development
 - C. Tooth eruption
- VIII. Oral Mucosa
- A. Classification of Oral Mucosa
 - 1. Lining mucosa
 - 2. Masticatory mucosa
 - 3. Specialized mucosa
 - B. Epithelium of the oral mucosa
 - 1. Nonkeratinized stratified squamous epithelium
 - 2. Orthokeratinized stratified squamous epithelium
 - 3. Parakeratinized stratified squamous epithelium
 - C. Lamina propria of oral mucosa
 - D. Regional differences in oral mucosa
 - E. Tongue-striated muscle surrounded by oral mucosa
 - F. Pigmentation of the oral mucosa
 - G. Turnover time, repair, and aging of the oral mucosa
- IX. Gingival and Dentogingival Junctional Tissues
- A. Gingival tissues
 - 1. Types of gingiva
 - 2. Clinical appearance of gingival tissue
 - 3. Histological features of gingival tissue
 - B. Dentogingival junctional tissues
 - 1. Sulcular epithelium
 - 2. Junctional epithelium
 - C. Histological features of dentogingival junctional tissues
 - D. Development of the dentogingival junctional tissues
 - E. Turnover time, repair, and aging of the dentogingival junctional tissues
- X. Head and Neck Structures
- A. Glands
 - 1. Salivary glands
 - a. Histology
 - b. Major types
 - c. Development
 - 2. Thyroid gland
 - a. Histology
 - b. Development
 - 3. Lymphatics
 - a. Histology
 - B. Nasal cavity
 - 1. Histology
 - C. Paranasal sinuses
 - 1. Histology

PIMA MEDICAL INSTITUTE

Dental Hygiene
Semester I: RDH 186 Dental Anatomy
Course Outline

XI. Enamel

- A. Apposition of the enamel matrix
- B. Maturation of the enamel matrix
- C. Components of mature enamel
 - 1. Enamel rods
 - 2. Lines of retzius
 - 3. Enamel spindles, tufts, and lamellae

XII. Dentin and Pulp

- A. Dentin
 - 1. Apposition of the dentin matrix
 - 2. Maturation of the dentin matrix
 - 3. Components of mature dentin
 - 4. Types of dentin
 - 5. Microscopic features of mature dentin
- B. Pulp
 - 1. Anatomy
 - 2. Microscopic features
 - 3. Microscopic zones

XIII. Periodontium Tissues: Cementum, Alveolar Bone, Periodontal Ligament

- A. Cementum
 - 1. Development
 - 2. Microscopic appearance
 - 3. Repair
 - 4. Types
- B. Alveolar bone
 - 1. Anatomy of the jaw bones
 - 2. Maxilla development
 - 3. Mandible development
- C. Periodontal ligament (PDL)
 - 1. Components
 - 2. Cells
 - 3. Fiber groups

DENTAL ANATOMY

I. Basic Terminology for Tooth Anatomy

- A. Terminology for parts of the tooth
 - 1. Four tissues
 - 2. Anatomic vs. clinical crown and root
- B. Terminology for tooth surfaces
 - 1. Outer
 - 2. Inner
 - 3. Biting
 - 4. Differentiation of approximating surfaces
 - 5. Divisions of crown or root

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Dental Hygiene Semester I: RDH 186 Dental Anatomy Course Outline

6. Tooth surface junctions
 7. Crown-to-root ratio
 - C. Terminology for tooth morphology
 1. Morphology of an anatomic crown
 - a. Bulges and ridges
 - b. Depressions and grooves
 2. External morphology of the anatomic root
 3. Relative size
 4. Cervical line (CEJ) curvature
 - D. Terminology related to ideal alignment of teeth
 1. Sulcular groove
 2. Height of contour
 3. Contact areas
 4. Embrasure spaces
 - E. Terminology describing ideal occlusion
- II. Morphology of the Permanent Incisors
- A. Function
 - B. Morphology
 - C. Class traits for all Incisors
 - D. Arch traits that distinguish maxillary from mandibular incisors
 - E. Maxillary incisor type traits
 - F. Mandibular incisor type traits
- III. Morphology of the Permanent Canines
- A. Function
 - B. Class traits for all canines
 - C. Arch traits that distinguish maxillary from mandibular canines
 - D. Variations in canine teeth
- IV. Morphology of Premolars
- A. Function
 - B. Class traits for all premolars
 - C. Arch traits that distinguish maxillary from mandibular premolars
 - D. Type traits that differentiate maxillary first from maxillary second premolars
 - E. Type traits that differentiate mandibular first from mandibular second premolars
 - F. Variations in premolar teeth
- V. Morphology of Permanent Molars
- A. Function
 - B. Class traits for all molars
 - C. Arch traits that distinguish maxillary from mandibular molars
 - D. Type traits that differentiate maxillary first from maxillary second molars
 - E. Type traits that differentiate mandibular first from mandibular second molars
 - F. Maxillary and mandibular third molar type traits
- VI. Primary and Mixed Dentition
- A. Background information

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Dental Hygiene Semester I: RDH 186 Dental Anatomy Course Outline

1. Function of primary dentition
- B. Developmental data for primary and secondary dentition
 1. Tooth emergence times
 2. Crown and root development for primary and secondary dentition
 3. Order of emergence for primary and secondary dentition
- C. Dentition traits of all primary teeth
- D. Class and type traits of primary teeth
- E. Pulp cavities of primary teeth

VII. Dental Anomalies

- A. Anodontia
- B. Supernumerary teeth
- C. Abnormal tooth morphology
 1. Abnormal crown morphology
 2. Abnormal root morphology
- D. Anomalies in tooth position
- E. Reactions to injury after tooth eruption

PIMA MEDICAL INSTITUTE
Dental Hygiene
Semester III: RDH 215 Biomaterials (Seattle)
Course Outline

- I. Goal of Course
 - A. Role of dental hygienist
 - B. Historical perspective

- II. Quality Control
 - A. Agencies responsible for standards
 - B. Material hazards in dental office
 - C. Chemical safety
 - D. Acute and chronic toxicity
 - E. Personal chemical protection
 - F. Control of chemical spills
 - G. General storing of chemicals
 - H. Disposal of chemicals
 - I. OSHA
 - J. MSDS

- III. Oral Environment and Patient Considerations
 - A. Factors that oral environment challenging for dental materials
 - B. Key terms and definitions

- IV. Classification of Dental Materials
 - A. Classification by longevity
 - B. Classification by location
 - C. Classification by use

- V. Physical Properties of Dental Materials
 - A. Physical structure: Solids and liquids
 - B. Application
 - C. Composition
 - D. Reaction
 - E. Manipulation

- VI. Impression Materials
 - A. Purpose
 - B. Categories
 - a. Elastic impression materials
 - i. Characteristics
 - b. Inelastic impression materials
 - i. Characteristics
 - C. Impression tray selection
 - D. Criteria for sound impressions
 - E. Procedure for alginate impression
 - F. Disinfecting impressions
 - G. Bite registration materials

- VII. Dental Waxes

PIMA MEDICAL INSTITUTE
Dental Hygiene
Semester III: RDH 215 Biomaterials (Seattle)
Course Outline

- A. Composition and properties
 - B. Classification
 - C. Manipulation
 - D. Wax bit registration
- VIII. Gypsum Products
- A. Properties and Behaviors
 - B. Classification
 - C. Manipulation
 - D. Mixing gypsum products
 - E. Pouring models
 - F. Trimming models
- IX. Preventive Oral Appliances
- A. Types and uses
 - B. Procedure for fabrication of sports guard and night guard
- X. Tooth Whitening
- A. Types of stains
 - B. How bleaching works
 - C. Types of bleaching
 - D. Contraindications
 - E. Potential side effects
 - F. Procedure for fabrication custom bleaching trays
 - G. Clinical procedures and related patient education
- XI. Dental Amalgam
- A. Historical perspective
 - B. Composition
 - C. Setting transformation and reactions
 - D. Tarnish, corrosion, and creep
 - E. Handling characteristics and manipulation
 - F. Placement and condensation
 - G. Mercury safety procedures and debate
- XII. Dental Composites
- A. Components
 - B. Polymerization
 - C. Classification
 - D. Physical properties
 - E. Clinical handling
 - F. Light cure vs. chemical cure
- XIII. Other Direct Esthetic Restorations
- A. Glass ionomers
 - B. Hybrid ionomers
 - C. Compomers

PIMA MEDICAL INSTITUTE
Dental Hygiene
Semester III: RDH 215 Biomaterials (Seattle)
Course Outline

XIV. Bonding

- A. Basic principles of bonding
- B. Clinical applications of bonding
- C. Procedures

XV. Abrasion, Finishing, and Polishing

- A. Factors of abrasion
- B. Materials used in abrasion
- C. Purpose and indications of amalgam and composite polishing
- D. Serviceable vs. non-serviceable restorations
- E. Materials required for finishing and polishing procedure for amalgam and composites
- F. Finishing, polishing, and margination procedures for amalgam and composites

XVI. Indirect Esthetic Restorations

- A. Porcelain
- B. Porcelain-metal restorations
- C. All ceramic restorations
- D. CAC/CAM
- E. Shading Taking

XVII. Casting Alloys: Composition, Benefits, Limitations

- A. Noble vs. non-noble metals
- B. Base metals
- C. Lost waxing technique
- D. Biocompatibility
- E. Solders

XVIII. Surgical Dressings, Dental Cements, and Intermediary Materials

- A. Uses
- B. Properties
- C. Components
- D. Types
- E. Manipulation
- F. Procedures for mixing of ZOE cement
- G. Procedures for mixing and placement of surgical dressings

XIX. Provisional Restorations

- A. Purpose
- B. Indications
- C. Uses
- D. Types
- E. Criteria for provisional coverage
- F. Properties and applications of provisional materials
- G. Procedure of Cavit™ and IRM placement

XX. Polymers in Prosthetic Dentistry

- A. Types and procedures
- B. Review of polymer formation and properties

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Dental Hygiene
Semester III: RDH 215 Biomaterials (Seattle)
Course Outline

- C. Acrylic resins
- D. Denture liners
- E. Acrylic teeth
- F. Characterization of dentures
- G. Review of in-office and home care of dentures

XXI. Specialty Materials Indications and Applications

- A. Pulp therapy materials and procedures
- B. Apicoectomy
- C. Rubber dams
- D. Components and materials of dental implants
- E. Periodontal dressing placement, removal, and related patient education
- F. Dental sutures
 - a. Placement
 - b. Removal

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Dental Hygiene Semester V RDH 266 Restorative Lab Course Outline

- I. Functional Anatomical Forms of Natural Teeth
 - A. Adult
 - B. Child
 - C. Oral cavity factors affecting short/long term outcomes for restorations

- II. Restorative Appointments
 - A. Sequence
 - B. Rationale

- III. Field Isolation
 - A. Techniques and rationale
 - B. Rubber dam placement

- IV. Restorative Instruments and Equipment
 - A. Identification
 - B. Applications (uses)

- V. Restorative/Expanded Function/Preventive Materials
 - A. Terminology
 - B. Physical properties
 - C. Mechanical properties
 - D. Manipulation and/or placement
 - 1. bases
 - 2. liners
 - 3. resins
 - 4. varnishes
 - 5. cements
 - E. Matrix and wedge selection/application
 - 1. adaption
 - 2. contour
 - 3. contact

- VI. Restorative Handling Considerations/Techniques
 - A. Amalgam
 - B. Mercury

- VII. Restorative Skills
 - A. Place
 - 1. amalgam
 - 2. glass ionomer
 - 3. composite
 - 4. provisional
 - B. Carve
 - 1. amalgam
 - 2. glass ionomer
 - 3. composite
 - 4. provisional

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**Dental Hygiene
Semester V
RDH 266 Restorative Lab
Course Outline**

- C. Finish
 - 1. amalgam
 - 2. glass ionomer
 - 3. composite
 - 4. provisional
- D. Polish
 - 1. amalgam
 - 2. glass ionomer
 - 3. composite
 - 4. provisional

- VIII. Clinical Skills and Considerations
 - A. Four-handed instrumentation techniques
 - B. Overhang removal techniques
 - C. Traumatic restorative treatment
 - D. Interim therapeutic restoration
 - E. Self-assessment
 - 1. expanded function
 - 2. plan for improvement
 - F. Compliance with state laws

- IX. Mock Board Exam
 - A. Regional examination board criteria (75%)

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Dental Hygiene Semester VI RDH 285 Restorative Clinic Course Outline

- I. Functional Anatomical Forms of Natural Teeth
 - A. Adult
 - B. Child

- II. Patient Management Considerations
 - A. Pre-appointment team conference
 - 1. dentist
 - 2. lead restorative instructor
 - 3. patient status
 - a. overall health
 - b. oral health assessment
 - c. pain control methodologies
 - B. Communication and assessment
 - 1. treatment needs & procedures
 - 2. informed consent
 - 3. professional principles
 - C. Documentation
 - 1. legal guidelines
 - 2. ethical guidelines

- III. Treatment Plan Development
 - A. Comprehensive
 - B. Individualized prioritization and sequencing

- IV. Treatment Preparation
 - A. GV Black's caries classifications
 - 1. identify
 - 2. classify
 - B. Clinic
 - 1. infection control
 - 2. restorative armamentarium
 - 3. other instruments/equipment
 - 4. hazardous waste handling techniques

- V. Treatment Plan Implementation
 - A. Field isolation
 - 1. need
 - 2. method
 - 3. execute
 - B. Matrix system
 - 1. need
 - 2. type
 - 3. execute
 - C. Cements, bases, liners, varnishes, sealers
 - 1. evaluation
 - 2. justification (of type)
 - D. Posterior amalgam restorations

PIMA MEDICAL INSTITUTE

**Dental Hygiene
Semester VI
RDH 285 Restorative Clinic
Course Outline**

1. place
 2. carve
 3. finish
- E. Composite or glass ionomer restorations/anterior and posterior
1. place
 2. finish
 3. polish
- VI. Clinic Setting Assistance
- A. Four-handed technique
 - B. Restorative materials
 1. mixing
 2. placing
- VII. Mock Board Exam
- A. Regional examination board criteria (85%)

DENTAL HYGIENE - STUDENT

<i>Restorative Student Kit - #7062</i>		<i>Henry Schein</i>		
ITEM DESCRIPTION	Schein #	QTY	EA COST	EXT
5 FS/CS MOUTH MIRROR	SCH-9125	1	\$4.03	\$4.03
6 MIRROR HANDLE	SCH-0509	1	\$7.21	\$7.21
12 PROBE/23 EXPLORER	101-3149	1	\$0.00	\$0.00
317 COTTON & DRESSING PLIERS	100-3313	1	\$0.00	\$0.00
LITTAUER SCISSORS 5-1/2"	100-5115	1	\$0.00	\$0.00
5-1/2" KELLY HEMOSTATS CURVED	100-7878	1	\$0.00	\$0.00
AMALGAM WELL	SCH-2828	1	\$6.09	\$6.09
AMALGAM CARRIER DE #34	100-0749	1	\$0.00	\$0.00
17 EXCAVATOR	SCH-2850	1	\$14.55	\$14.55
DYCAL PLACEMENT INSTRUMNT	SCH-2125	1	\$13.64	\$13.64
GOLDSTEIN FLEXITHIN XTS #3MINI HU-FRIEDY	600-5102	1	\$0.00	\$0.00
1/2 HOLLENBACK CARVER 6HD	SCH-1129	1	\$15.71	\$15.71
1/2 CLEOID-DISCOID CARVER	101-5522	1	\$0.00	\$0.00
7 BLACK GOLD FOIL KNIFE	SCK-0485	1	\$16.56	\$16.56
Goldstein Flexithin XTS #1 Hu Friedy <i>DELETED</i>	SCH-6885	1	\$20.26	\$20.26
1/2 BLACK PLUGGER	100-0892	1	\$0.00	\$0.00
SMITH PLUGGER <i>DELETED 1-16-15</i>	100-4101	1	\$0.00	\$0.00
TOFFLEMIRE MATRX RETAINR	SCH-0068	1	\$16.43	\$16.43
RUBBER DAM CLAMP #W8A	900-4550	1	\$0.00	\$0.00
RUBBER DAM CLAMP #212	SCH-2315	1	\$6.17	\$6.17
CEMENT SPATULA #24	SCH-2171	1	\$2.78	\$2.78
MATRIX BANDS TOFF .0015#1 12pk	100-3556	6	\$0.00	\$0.00
MATRIX BANDS TOFF .0015#2 12pk	SCH-9308	6	\$0.39	\$2.34
PKT-3R TAPERED CONTOURING	600-0020	1	\$0.00	\$0.00
COMPOSI-TIGHT SOFT-FACE 3D-RING 2PK	300-0052	2	\$0.00	\$0.00
8 WILAND CARVER	600-3930	1	\$0.00	\$0.00
CUSTOM CASS 16INST W/4CLP	SCK-6953	1	\$127.53	\$127.53
			Sub Total	\$0.00
<i>COMPOSITE PLUGGER</i>				
	Vendor		Kilgore/ACADENTAL	
	Vendor		Garrison	
Composi-Tight Soft-Face 3D-ring 2pk	3D500	0	\$65.00	\$65.00
Composi-Tight 3D Thin Tine G-ring 3pk <i>DELETED</i>	3D400	0	\$50.00	\$50.00
			Kit Total	\$0.00
Revised 11/25/2013 R Fugiel				

Board Approved:

OREGON BOARD OF DENTISTRY
1500 SW 1ST AVENUE, SUITE 770
PORTLAND, OR 97201
(971) 673-3200

Fax: 2 pgs
RECEIVED

NOV 18 2015

**Dental Hygiene
Request for Approval of Restorative Curriculum**

Dental Hygiene Program

Dental Hygiene CE Course

Oregon Board
of Dentistry

Name of Institution/Program:

Name of Program Director:

Address:

City:

State:

Zip code:

Telephone:

Date Institution/Program adopted/revised current Curriculum:

Any changes to the course curriculum must have prior approval from the Board. Please provide the Board with adequate notice so that approval can be obtained before any changes to the curriculum are implemented.

Program Director's Signature: _____

Josette Beach

Date:



11-02-2015

To: State of Oregon Board of Dentistry
From: Josette Beach, Director-Dental Sciences, Portland Community College
RE: Approval of Revised Restorative Dental Hygiene Curriculum (Embedded in DH Program)

The Portland Community College Dental Hygiene Program is requesting approval of revisions to its embedded restorative dentistry curriculum taught to dental hygiene students prior to graduation. These revisions have been brought about by a collaborative project that will begin January 4, 2016 between the PCC DH Program and OHSU School of Dentistry.

The PCC Restorative Curriculum previously approved by the OBD remains unchanged:

DH 113	Dental Anatomy Lecture: (2) credit hours (20 clock hours)
DH 113L	Dental Anatomy Lab: (1) credit hour (30 clock hours)
DH 230	Dental Materials: (1) credit hour Lecture (10 hrs.), (1) credit Lab (30 clock hrs)
DH 240	Intro to 4-Handed Dentistry: (1) credit hour Lecture (10 hrs.), (1) credit Lab (60 clock hrs)
DH 241	DH Restorative Dentistry I: (2) credit hour Lecture (20 hrs.), (2) credit Lab (60 clock hrs)
DH 242	DH Restorative Dentistry II: (2) credit hour Lecture (20 hrs.), (2) credit Lab (60 clock hrs)
DH 243	DH Restorative Dentistry III: (1) credit hour Lab (30 clock hours)* Pt. Care at PCC, ck'd by PCC Dentist
DH 244	DH Restorative Dentistry IV: (1) credit hour Lab (30 clock hours)**
DH 245	DH Restorative Dentistry V: (1) credit hour Lab (30 clock hours)**

The revisions to the PCC Restorative Curriculum are:

** DH 244 and 245: Pt Care (placement of restorations) to be completed at OHSU School of Dentistry under the direct supervision of a PCC Instructor. Final restoration placed to be approved/checked by Dentist/OHSU School of Dentistry Faculty.

Current Affiliation agreements exist between OHSU School of Dentistry and Portland Community College.

I can be reached at 971 722-4235 or by email at jbeach@pcc.edu, should you need additional information.

Sincerely,

A handwritten signature in cursive script that reads "Josette Beach".

Director, Dental Sciences
Portland Community College

Tab 7 Request Approval to take the Western Regional Examining Board (WREB) Dental Examination – Silvia Amaya-Pajares, D.D.S., M.S.

Dr. Amaya-Pajares is a foreign trained dentist who was recently hired as an Assistant Professor by Oregon Health and Sciences University, School of Dentistry. Dr. Amaya-Pajares would like to apply for a faculty license, however, Dr. Amaya-Pajares would not qualify for this license unless she successfully passes a clinical examination recognized by the Board.

Based on WREB's Proof of Qualifications, for Dr. Amaya-Pajares to be eligible to sit for the WREB examination, WREB requires that the state board verify that the candidate is eligible to take the WREB exam.

Dr. Amaya-Pajares is requesting the Board submit a letter to WREB authorizing her to take the examination.

WREB - Proof of Qualification

Proof of qualification is required to be eligible to take the WREB exam. Candidates may be enrolled in an exam prior to providing this document; however, the proof of qualification must be received in the WREB office by the final deadline date. Candidates who do not provide the proof of qualification by this date will be cancelled from the exam and no refund will be given. An email notice of clinical schedules will be emailed approximately four weeks prior to the first day of the exam. Candidates will receive their schedules only after proof of qualification is received.

The appropriate document must be submitted in English. Choose **one** of the following documents to be submitted:

- A photocopy of candidate diploma showing a DDS or DMD degree from an ADA accredited dental school. **If not printed in English, an official translation is required.** Diplomas in Latin must be translated. *Post graduate certificates are not acceptable.*
- An original letter on school letterhead from an ADA accredited dental school stating that candidate received a DDS or DMD from that school. The letter must include the date the DDS or DMD was earned.
- A photocopy of candidate's official transcript from an ADA accredited dental school listing a DDS or DMD and the date earned. *Unofficial copies are not acceptable.*
- If candidate is a **foreign-trained graduate** or a **graduate of a non-accredited dental school**, the state board where the candidate is seeking licensure must provide an original letter. The letter must have the state seal affixed, and must verify that the candidate **is eligible to take the WREB exam.** See our **List of States Accepting WREB** for state board contact information.
- If candidate is a **senior dental student** in their final semester (does not apply to post-graduate studies), they can provide a completed **Certification for Graduating Seniors Form**. The form must be an original signed by the school dean with the school seal affixed and mailed to WREB.

Teresa Haynes

From: Silvia Amaya Pajares [amayas@ohsu.edu]
Sent: Thursday, December 03, 2015 3:04 PM
To: Teresa Haynes
Subject: letter for WREB dental exam

Hello Teresa,

I am a foreign-trained dentist and I just started to work at OHSU as an Assistant Professor at the Department of Restorative Dentistry.

I have studied a Certificate and MS in Operative Dentistry at the University of North Carolina – Chapel Hill and I graduated from this program in 2014. I need to get a faculty license at the State of Oregon and to be able to complete this as far as I know I need to pass a clinical examination recognized by the board. I would like to take WREB dental exam and in order to register for this exam I need a letter from the State Board. Please, let me know how can I get this letter.

Thanks,

Silvia Amaya-Pajares, D.D.S, M.S.

Assistant Professor
Department of Restorative Dentistry
OHSU School of Dentistry
2730 SW Moody Ave
Portland, OR 97201
Tel: 503 346-9922



OREGON
HEALTH & SCIENCE
UNIVERSITY

Ethics and Boundaries Essay Examination

A Tool for the Regulator's Toolkit!

- **No charge to agency board;** \$1,500 fee to the licensee/applicant covers all costs
- Supports agency's mission of "**public protection**"
- Assesses a sanctioned licensee's comprehension of ethical and boundary issues
- Offers independent third-party evaluation
- Provides follow-up to E&B educational coursework
- Aids boards in reducing costs and adjudication slow downs
- Delivered at national computerized testing centers throughout the U.S. using "On-Demand" scheduling with exam dates available six (6) days a week

EBAS currently offers three (3) forms of the E&B Essay Exam: 1) a general healthcare form (addresses broader spectrum of ethical/boundary issues so as to be applicable to the many and varied professions included in the overall healthcare industry); 2) a chiropractic form; & 3) a form for the numerous regulated professions outside the healthcare industry.

A 4th form is being developed for use by veterinary medicine boards.

"The Ethics and Boundaries Assessment Services, LLC (EBAS) Essay Examination provides a stellar program for evaluation of a licensee's understanding of the action(s) which precipitated their discipline. The essays work well as an appraisal of the moral compass of the licensed professional. The scoring of the essays has exemplary rigors ensuring reliability because of a comprehensive grader training process."

William J. Rademacher, DC
Former Member, Illinois Medical Licensing Board



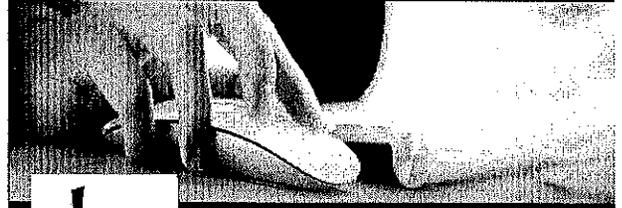
Dr. Judi Gerstung, Executive Director
jgerstung@ebas.org
901 54th Avenue, Greeley, CO 80633
1-888-676-3227 (EBAS)
1-970-775-3729 (Mobile)

www.ebas.org



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Ethics and Boundaries Essay Examination



Mission Statement

The purpose of the Ethics and Boundaries Assessment Services, LLC (EBAS) is to provide post-licensure appraisal of the moral compass of ethically-challenged professionals. EBAS primarily serves as an agency dedicated to assisting regulatory/licensing agencies in their evaluation of a licensee's understanding of ethical and boundary issues relevant in their professional workplace environment.

Ethics and Boundaries *Essay Examination*

Ethics and Boundaries Assessment Services, LLC (EBAS), was established in 2013 to address the post-licensure testing needs of regulated professions concerning ethical and/or boundary issues. In 2015, EBAS expanded their outreach to include educational institutions and malpractice insurance carriers.

EBAS provides a tool that requires the individual to demonstrate an understanding of appropriate professional protocols and judgments involving the protection of the public.

Successful completion of the essay exam requires the examinee to compose a response to scenarios, one from each of the Test Plan topic areas. Scenarios cover a variety of professional settings on ethical/boundary issues and are not written to be profession specific.

The E&B Test Plan is based on licensing input from regulatory and other agencies regarding the importance of understanding ethical and boundary issues.

When should an agency use the E&B Exam?

- ◆ When the boundary between the licensee and clients/patients or staff/employees has been violated or blurred.
- ◆ When the licensee has stepped over the line with respect to fraudulent or sub-standard practices.
- ◆ When the licensee has demonstrated unprofessional conduct, including drug and alcohol abuse.

What does the E&B Exam measure?

The E&B Test Plan includes the following areas:

- ◆ **Boundary Violations** (licensee with client/patient/staff including harassment concerns - both verbal and non-verbal)
- ◆ **Fraud** (fraudulent billing/coding; falsification or alteration of any documents; performing unwarranted services)
- ◆ **Professional Standards** (quality assurance issues; negligent performance of duties; safety concerns; improper diagnoses and/or treatments; improper client/patient management; improper records and documentation)
- ◆ **Unprofessional Conduct** (inappropriate behavior; prescription forgery; aiding and abetting unlicensed activity; practicing with revoked/suspended license)
- ◆ **Substance Abuse** (drug and alcohol misconduct or violations)

Why an essay exam?

- ◆ Essays allow in-depth evaluations of a licensee's understanding of complex interactions within the professional workplace environment.

When/where is the E&B Exam administered?

- ◆ E&B is delivered at computerized testing centers throughout the United States.
- ◆ Exam appointments are available on-demand, six days per week.
- ◆ Each examinee receives five (5) essay scenarios and is allowed up to 60 minutes to complete each essay.

What makes the E&B Exam reliable?

- ◆ Each essay is scored by multiple trained graders with regulatory experience.
- ◆ Graders receive ongoing training in scenario writing, content analysis, use of scoring criteria, and mock grading with calibration.

What makes the E&B Exam valid?

- ◆ Scenarios for essays are derived from realistic ethics and boundary situations.
- ◆ Most graders have addressed ethical and boundary issues in a licensing/regulatory context.

How is the E&B Exam scored?

- ◆ Trained graders score each essay, using a secure website, and assign points to each required essay component:
 - I) Introductory Statements
 - II) Consequences
 - III) Public Protection
 - IV) Solutions
- ◆ Graders are trained to focus on content and expression of ideas; however, licensees are encouraged to write using complete sentences when composing essay responses,
- ◆ Graders do not see the name or state of the examinee, nor do they grade examinees from their own states.
- ◆ The score report indicates the strengths and weaknesses of each component response and its contribution to the final point total for each of the five essays.
- ◆ EBAS sends a copy of the E&B score report to the authorizing agency and to the examinee.

Who are the graders?

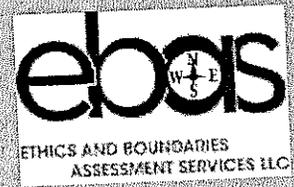
- ◆ Graders are professionals with licensing/regulatory experience, including board members, legal counsel and executive directors.
- ◆ EBAS requires graders to complete a multi-disciplinary Agency Orientation/Calibration Workshop.
- ◆ If interested in attending a Grader Calibration Workshop, please send your email request to jgerstung@ebas.org.

*Join off
from China NY1*

English

**ETHICS AND
BOUNDARIES
ESSAY EXAMINATION**

Post-1500
Take Tests
6 days per week
Computer Area
offered -
5 Hr Test



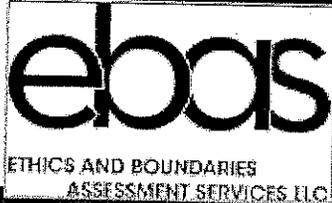
Register Agency
Get e-mail
Back

Computerized *2 to weeks
for results*
Assessment Tool
**Providing Solutions for
Regulatory Boards**

Dr. Judi Gerstung, Executive Director
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jgerstung@ebas.org

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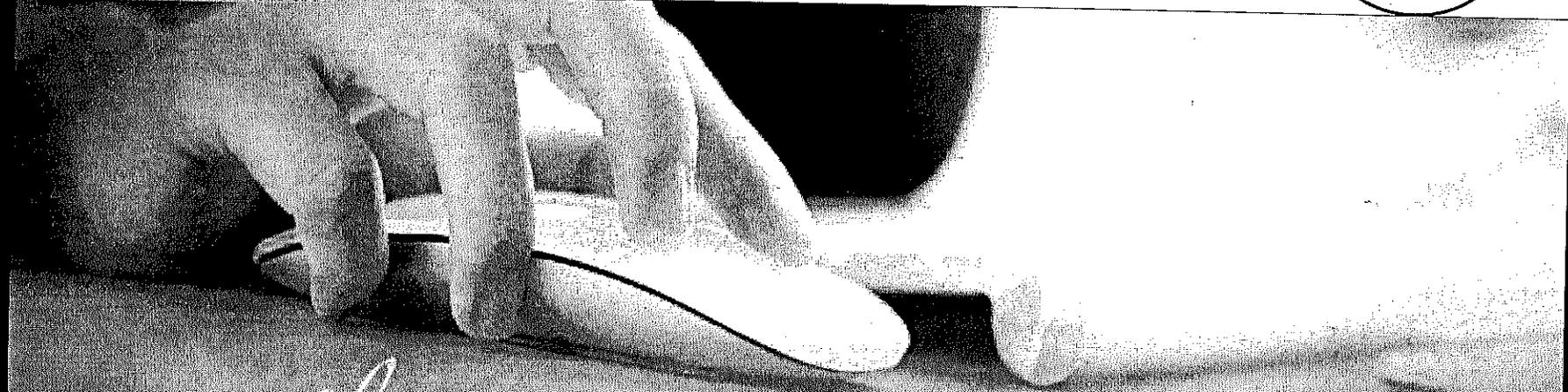
[Application Info](#)

[Schedule Your Exam](#)

[Exam Prep](#)

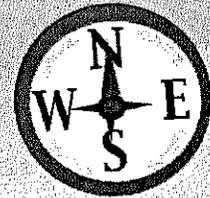
[Score Your Exam](#)

[Agency Info](#)



Welcome Ethics and Boundaries Assessment Services LLC

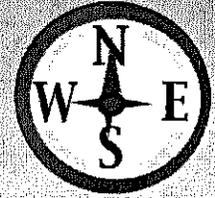
How Effective are Your Agency's Disciplinary Measures?



- Are your current procedures providing you with the best information to make a decision as to whether or not the licensee really **“GETS IT”** or are you still relying on your **gut feeling?**
- Does the licensee fully understand the **consequences** of ethical/boundary violations?
- Does the licensee understand what **solutions** are needed?

*Without Assessment as part of your Disciplinary Orders...
is your agency truly serving & protecting the public?*

What Does EBAS Provide?



- A tool that assesses the “moral compass” of the ethically-challenged professional
- A validated, reliable exam that crosses all professions
- A calibrated, and now, *interprofessional* grader training
- A means of furthering the goal of all regulatory jurisdictions:

Protection of the public!!

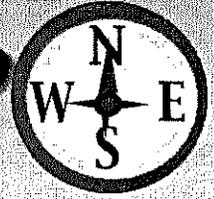
WHY to Use...



- **Offers more insight** into ethical attitudes and thought processes
- **Provides better evaluation** of complex interactions required to work in an ethically appropriate manner
- **Demands accountability** for public and health safety concerns within professional environment
- **Gives agencies** an additional item in their “toolbox” of disciplinary orders

What Does the Exam Cost?

(No Cost to Regulatory Agency)



- **\$1,500** per initial exam administration includes all costs:
 - processing the application
 - seat time at computerized test center
 - essay grading (including grader training and calibration)
 - post-exam review
 - mailing of transcripts to licensee and board
- **\$300** per retake area

Are There Guidelines for Writing Disciplinary Orders?



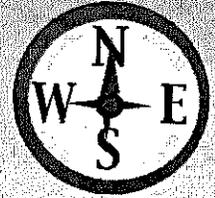
The following information is provided to assist you in advising your sanctioned licensees of the application procedures for EBAS. EBAS advises inclusion of these guidelines in your disciplinary orders:

- Specify agency requirements:
 - “Licensee must **take and pass** all 5 topic areas of the EBAS Essay Examination **within 6, 9, or 12 months** of the date of these disciplinary orders.”
- Provide website location for accessing the EBAS

Application Form:

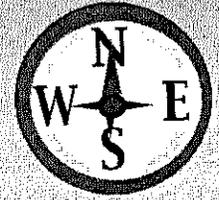
- Enter www.ebas.org in the web address line (URL) of an internet browser (Internet Explorer, Chrome, Firefox, Safari) to access the EBAS website.

How Is the Exam Delivered?



- Launched its new assessment tool for use by **inter-professional** regulatory agencies in January 2014.
- Utilizes **computerized** testing centers throughout the United States (Int'l sites are also available).
- Currently offered in an “**On-Demand**” format and administered **6 times per week** vs. 6 times/year (as from 2011-2013).
- Each licensee receives **five (5)** unique essay scenarios – **60 minutes per essay** with stratified random selection from pool of scenarios in each of the topic areas.

What Are the Scenario Topic/Focus Areas?



- **Boundary Violations** (Licensee with Client/Patient; Licensee with Staff, including Harassment Concerns);
- **Fraud** (Fraudulent Billing/Coding; Falsification or Alteration of any Documents; Performing Unwarranted Services);
- **Professional Standards** (Quality Assurance Issues; Negligent Performance of Duties; Safety Concerns; Improper Diagnoses and/or Treatments; Improper Client/Patient Management);
- **Office Protocols** (Fabricated/Incomplete Records or Documentation; Failure to Release Records; Improper Billing Procedures);
- **Unprofessional Conduct** (Inappropriate Behavior; Substance Abuse; Prescription Forgery; Aiding/Abetting Unlicensed Activity; Practicing with Revoked/Suspended License).

How Is the Essay Response Formatted?



- Required Essay Components (component text boxes have specified response directions with unlimited typing space):
 - **Personal Opinion Statements:** Referring to the given scenario and its assigned focus, present several clearly stated opinions about potential issues and concerns. **PLEASE NOTE:** Limit this component to opinion statements only. You will have the opportunity to provide “EXAMPLES/EXPLANATIONS” for your opinions in the next component.
 - **Examples & Explanations:** Expand and support **each** of your Introductory Opinion Statements with several thorough and well-developed examples and explanations.
 - **Consequences:** Referring back to the given scenario and its assigned focus, discuss several consequences to include, when applicable: client/patient, staff, licensee, profession, and/or other public health/safety issues.
 - **Solutions:** Referring back to the given scenario and its assigned focus, discuss several solutions that reflect the professional responsibilities and actions needed on the part of the licensee involved to resolve the relevant ethical/ boundary issues and concerns.
- **Content and expression of ideas are more heavily weighted in scoring than grammar, punctuation, or spelling.**

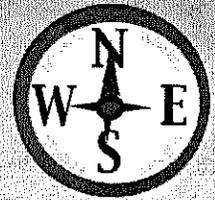
More Information?



For specifics regarding the EBAS Essay Examination format, please review the EBAS website at www.ebas.org

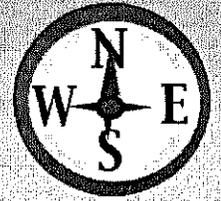
- Exam Prep:
 - Test Plan
 - Essay Exam Format
 - Essay Writing Exercise
 - Resource List
- Score Your Exam:
 - Scoring Criteria

Who Grades the Essays?



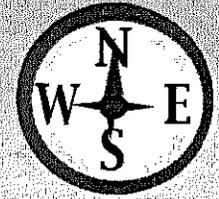
- Graders are trained professionals who have addressed ethics and boundaries issues in a licensing/regulatory context.
- EBAS held its first **inter-professional** Grader Calibration Workshop in February 2014 including representatives from the following boards:
 - Medical doctors, osteopaths, physician assistants, chiropractors, psychologists, pharmacists, massage therapists, social workers, marriage and family therapists, and cosmetologists.

What Establishes Exam Reliability and Validity?



- Scenarios for essays are derived from realistic ethical and boundary situations.
- Graders are regulatory professionals that receive training in scenario writing, scenario content analysis, scoring, and mock grading with calibration – prior to participating on the graders panel. Graders receive additional follow-up scoring calibration – when indicated.

How Is Grader Bias Reduced?



- Licensee identification is not disclosed to graders.
- Graders do not grade licensees from their own state (EBAS creates “firewall”).
- All essays are delivered in random order to graders to ensure that responses from each examinee are not rated sequentially.
- **Content and expression of ideas are more heavily weighted in scoring than grammar, punctuation, or spelling.**

What is the Score Report?



- Both examinee and agency receive a copy of the score report.
- The report indicates the strengths and weaknesses of each component response and its contribution to the final point total for each of the 5 essays.
- Exam provides informative evaluation; not designed to be punitive.

Sample Score Analysis Report

	Boundary Violations	Fraud	Professional Standards	Office Protocols	Unprofessional Conduct
Introductory Opinion Statements	3.2	2.3	2.6	1.5	2.8
Examples/ Explanations	2.7	1.5	3.0	2.7	3.3
Consequences	3.7	3.5	4.0	2.6	3.0
Solutions	2.7	2.0	2.3	2.7	3.2
TOTAL	12	9*	12	10*	12

- Total scores are rounded to the nearest whole number.
- Licensees will NOT receive a score at the testing center at the end of their examination.
- Essays are batched (monthly or bi-monthly as needed) for delivery to the grading panel. As soon as a grading event is complete (graders have one week to score), essays undergo a thorough post-exam/panel review process. Upon finalization of the scores, the Score Report is sent to both the licensee and their state board.
- It may take anywhere from two (2) to six (6) weeks from the time a licensee takes their exam to receipt of their score report. Licensees need to factor in this period of time when scheduling their exam and especially when considering their sanctioning deadlines.

* Indicates a failing score

What Are the Pass/Fail Statistics?

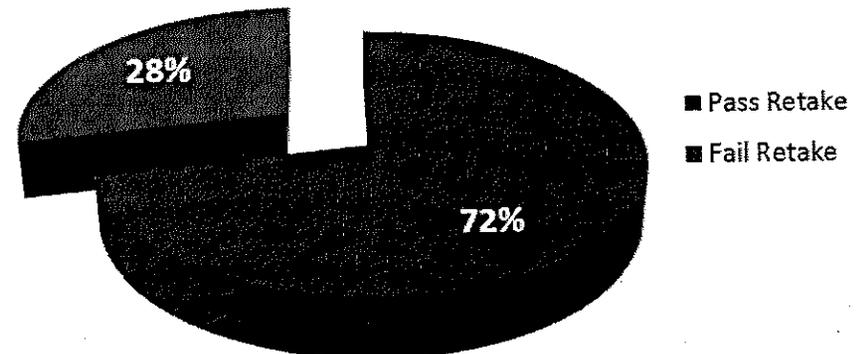


Pass/Fail Percentages
for First Time Examinees



2011-2015

Pass/Fail Percentages
for Examinees Retaking Exam



Essay Exams from Jan – Dec 2014

How can EBAS Help You EXPEDITE Your Disciplinary Cases?

- Cuts costs and case adjudication slow-downs;
- EBAS assessments provide a quicker path to settlement using a 5 topic essay examination;
- EBAS offers a tool to assess a licensee's comprehension of ethical and boundary issues;
- EBAS supports your agency's mission: **Public Protection**



*How do your
Consent Orders measure up?
www.ebas.org*

How Does a Board Get Started?



- Arrange for teleconference/webinar presentation at your Board meeting;
- Register your agency with EBAS by selecting the menu “AGENCY INFO” at www.ebas.org; then click on the tab “Steps to Register”:
 - Provide **ALL** information requested on the application form.
 - This will ensure prompt processing of all aspects of a sanctioned licensee’s application to include completion of the automated/electronic authorization form: “**E&B Examination Agency Authorization and Score Report Request**”
 - A link to access the Agency Authorization and Score Report Request form will be emailed to you by EBAS upon receipt and verification of a licensee’s application and fees.

THANK YOU!

Any Questions?

Please contact:

**Dr. Judi Gerstung
Executive Director, EBAS
970-775-3729 or 888-676-3227
jgerstung@ebas.org**



**ETHICS AND BOUNDARIES
ASSESSMENT SERVICES LLC**

Oregon Board of Dentistry
Online License Renewal

Continuing Education Confirmation

Complete the statement below for the renewal of your License. Failure to answer the question will result in your License not being renewed.

Continuing Education Confirmation

Continuing Education Confirmation

A. I have completed, or will complete by 9/30/2015, the 36 hours of continuing education required for licensure period 10/1/2013 to 9/30/2015, including THREE (3) hours related to medical emergencies in the dental office: Yes No

If NO, provide details below. Checking NO will not prevent renewal of your License:

B. Pursuant to OAR 818-012-0030(18), I certify that effective January 1, 2015 I have maintained at a minimum a current and valid Health Care Provider BLS/CPR certification. Yes No

My certificate will expire on:

C. I have completed, or will complete by 9/30/2015, the TWO (2) hours of infection control continuing education required for licensure period 10/1/2013 to 9/30/2015. Yes No

Continuing Education in Cultural Competency

Have you taken CE in Cultural Competency since your last renewal? Yes No I don't remember

If Yes, how many hours was it?

If Yes, was the course approved or recommended by Oregon Health Authority's Office of Equity and Inclusion? Yes No I don't remember

If Yes, what was the name of the course?

Do you feel this course improved your effectiveness in improving the health of a targeted population? Yes No Not Sure

Submit and Proceed to Next Step

Proposed change on Question on License Renewal – Cultural Competency

Continuing Education (CE) in Cultural Competency is not a required CE subject, however, Licensees who take CE in Cultural Competence can count those hours towards their CE requirements.

Pursuant to ORS 676.850 the Oregon Board of Dentistry is required to report to the Oregon Health Authority if a licensee has completed a course(s) in Cultural Competency.

Pursuant to OAR 943-090-0010 “Cultural competence” means a life-long process of examining values and beliefs and developing and applying an inclusive approach to health care practice in a manner that recognizes the context and complexities of provider-patient communication and interaction and preserves the dignity of individuals, families and communities.

Please complete the following questions regarding Cultural Competency:

Have you taken CE in Cultural Competency since your last renewal: Yes No

If yes, how many hours was it?

If yes, was the course(s) approved or recommended by the Oregon Health Authority’s Office of Equity and Inclusion? Yes No Unknown

If yes, what was the name of the course(s)?

Do you feel this course(s) improved your effectiveness in improving the health of a targeted population? Yes No

NEWSLETTERS
&
ARTICLES OF
INTEREST

The Bulletin

Dentists adopting drill-and-fill alternative

Off-label use of silver fluoride promoted by Redmond's Advantage Dental

By [Kathleen McLaughlin](#) / The Bulletin

Published Dec 3, 2015 at 12:04AM

Preschoolers, elderly people and others who are ill-suited to go under a dentist's drill have an alternative that proponents say will stop their tooth decay quickly, painlessly and cheaply.

A subsidiary of Advantage Dental of Redmond has been marketing since last spring a silver fluoride product called Advantage Arrest, which the U.S. Food and Drug Administration approved to treat dental sensitivity. Its real purpose, however, is to stop tooth decay, and it's about to become even easier for dentists in Oregon and across the country to use it.

The American Dental Association approved a new billing code that can be used for silver fluoride treatments starting in January, said Gary Allen, dental director for Advantage, which is a statewide network of clinics that treats 340,000 Oregon Health Plan members.

Also starting Jan. 1, OHP, which is the state's version of Medicaid, will cover silver fluoride treatment for cavities up to two times per year.

Advantage is already using silver fluoride, which the FDA approved in August 2014. Before then, Advantage used a controversial compound called silver nitrate in conjunction with fluoride varnish. Both compounds are applied in tiny drops to the decayed area to stop infection and, dentists hope, avoid the need for a filling.

"It's new, it's revolutionary, it changes the way dentistry is practiced," said Mike Shirtcliff, president and founder of Advantage.

Shirtcliff acknowledges that there was not much current research to support the use of silver nitrate. That's why he joined forces with University of Washington oral health professor Peter Milgrom to push through approval of silver fluoride.

Silver, which is the antimicrobial agent, comes at a slightly higher concentration in silver fluoride, which has been used and studied extensively in Asia and other places around the world, said Milgrom, director of the Northwest Center to Reduce Oral Health Disparities at UW.

He specializes in working with fearful or otherwise difficult-to-treat patients.

Advantage and Milgrom formed a small business, won a grant to support their own research and received FDA approval for silver fluoride as a medical device.

The next step, Milgrom said, is to conduct further research that would support FDA approval of silver fluoride as a drug, which would be marketed directly for treatment of cavities. That's a much more expensive and

rigorous process, he said.

Gaining approval for silver fluoride to this point took seven years, Milgrom said. He estimates that he donated \$500,000 of his time, and Shirtcliff said Advantage invested \$1 million of time and cash.

Advantage Arrest is such an inexpensive product, Shirtcliff said he doesn't expect it to become a moneymaker.

Advantage Arrest comes in a small bottle that costs \$125. A single drop can treat more than one cavity.

Shirtcliff said he took on the project so that Advantage could get access to silver fluoride. If silver fluoride begins to generate substantial revenue, he said it will go toward developing more products that fight infection rather than rebuild teeth. "We're looking at (cavities) as a chronic disease," Shirtcliff said. "We're taking a medical approach, not a restorative approach."

Like the controversial silver nitrate, silver fluoride leaves a black crust on the place of decay. The discoloration can be mitigated or covered up, Milgrom said.

The silver compound can also damage tissue if misapplied. That's one reason silver nitrate was controversial when in 2013 Advantage asked the Oregon Board of Dentistry to allow it to be applied by dental assistants and hygienists. The board declined.

Dental assistants and hygienists are allowed to administer fluoride, and that includes silver fluoride, said Stephen Prisby, executive director of the dentistry board. Prisby noted that silver nitrate and silver fluoride, also called silver diamine fluoride, are different compounds.

The off-label use of silver fluoride for cavity treatment is already gaining interest in dentistry, Milgrom said. The University of California San Francisco School of Dentistry studied the effectiveness and developed a protocol, which will be published in January in the Journal of the California Dental Association. The UCSF program is recommending silver fluoride for people at extreme risk of developing cavities, who are challenging to treat because of medical or behavioral problems, who have too many cavities to address in one visit, or whose cases are too difficult for a dental-school clinic.

The UCSF study found that one round of silver fluoride doesn't have a substantial effect on tooth decay, but that "annual reapplication results in remarkable success."

The authors said longer studies are needed to determine whether the arrest and prevention of decay can be maintained after two to three years and with decreasing treatment.

Milgrom began using silver fluoride in the late 1990s after reviewing papers from Japan and China. "I started smuggling it into the U.S. and using it," he said. "I take care of fearful and mentally ill people. These people are real hard to work with."

Milgrom said one of his patients is a 40-year-old who was treated for oral cancer with radiation, and as a side effect developed tooth decay in every part of his mouth. The silver fluoride left dark spots around his gum line, which is where cancer patients are most susceptible to decay.

"He hasn't gotten one new cavity," Milgrom said.

— Reporter: 541-617-7860, kmclaughlin@bendbulletin.com

ADEA Snapshot of Dental Education

2015-2016

AMERICAN DENTAL EDUCATION ASSOCIATION
adea.org/snapshot

Introduction

The American Dental Education Association (ADEA) is The Voice of Dental Education. Its members include all 76 U.S. and Canadian dental schools, over 800 allied and advanced dental education programs, 66 corporations and more than 20,000 individuals. The mission of ADEA is to lead institutions and individuals in the dental education community to address contemporary issues influencing education, research and the delivery of oral health care for the overall health and safety of the public.

ADEA is committed to conducting research into contemporary and emerging issues that are likely to impact decisions in the dental education and policy-making communities. Each year, ADEA collects data on topics of particular interest to dental school deans, program directors, faculty, students, residents and fellows. The resulting **ADEA Snapshot of Dental Education** presents findings on discrete subject areas to help the ADEA membership and related stakeholders better understand the academic dental profession and its role in health and health care.

The information in this report is taken from data compiled by ADEA, the American Dental Association and other sources. The associated online resources are updated regularly and are available for download at: adea.org/snapshot.

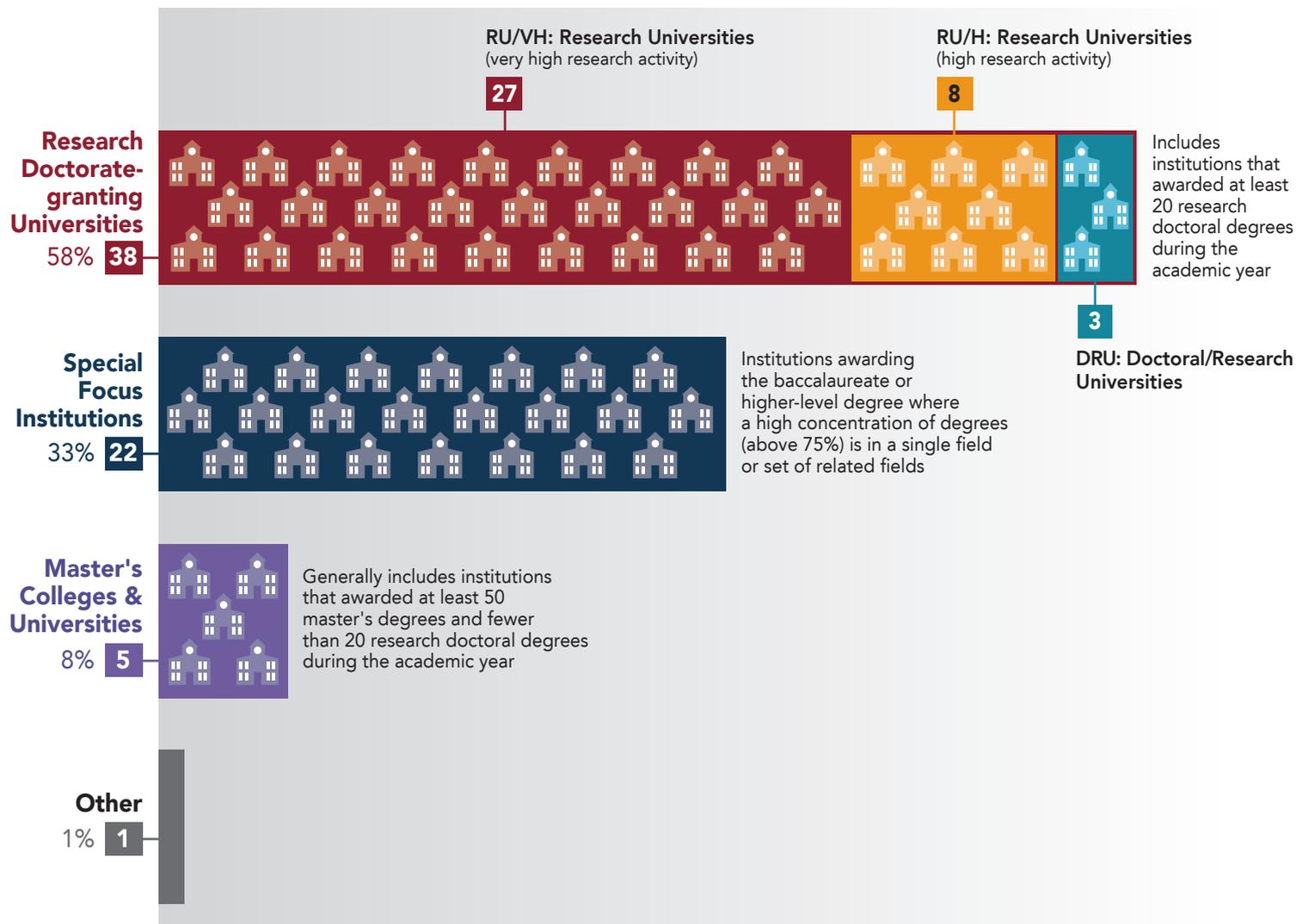
ORDERS

Additional copies are available from:
American Dental Education Association
655 K Street, NW, Suite 800
Washington, DC 20001
202-289-7201

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Carnegie Classifications of U.S. Dental Schools' Parent Institutions

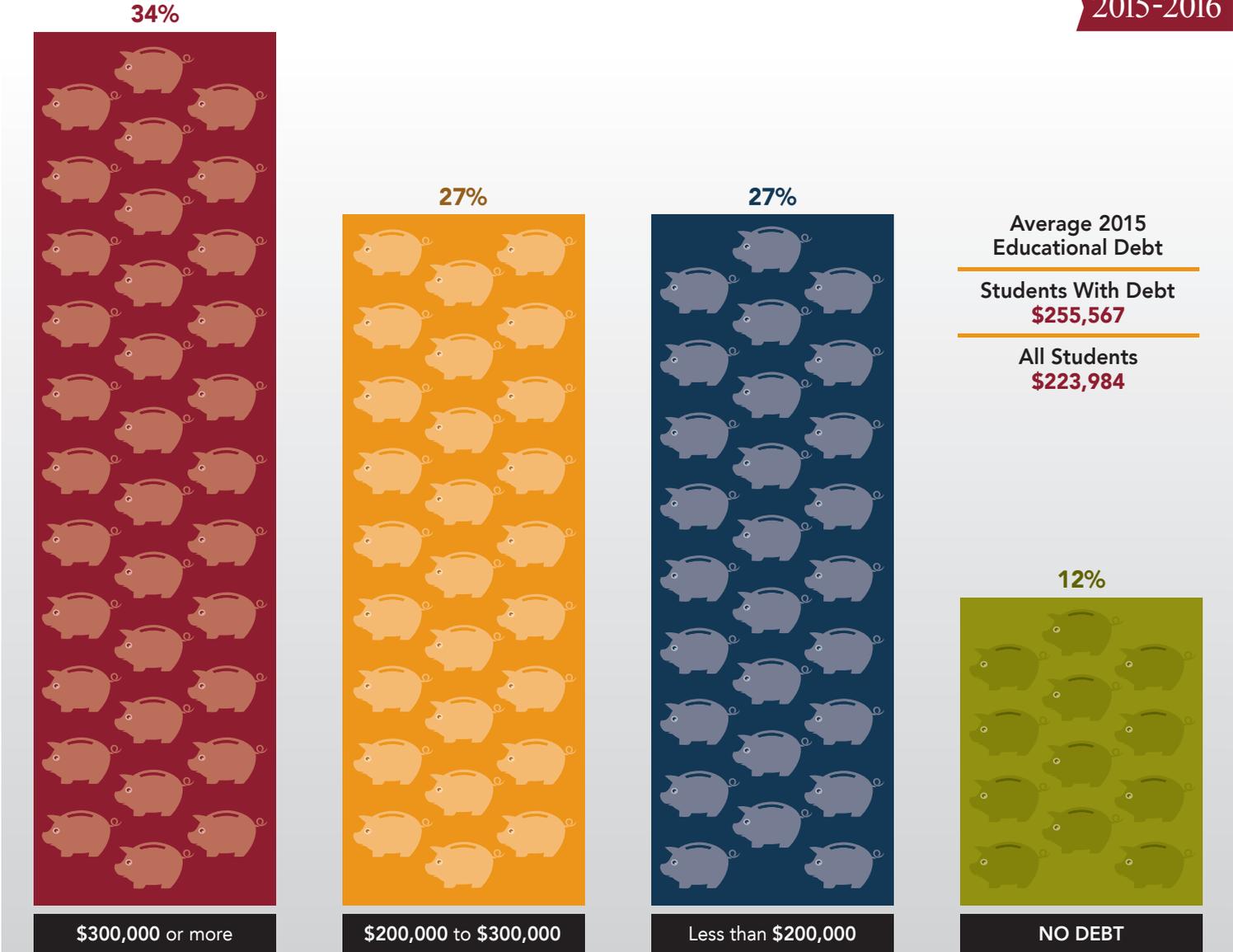


Note: Carnegie Classification, Basic Classification, 2010

Source: Carnegie Foundation for the Advancement of Teaching (2011). The Carnegie Classification of Institutions of Higher Education, 2010 edition Menlo Park, CA: Author.

Total Educational Debt, 2015 Graduating Class

Total educational debt is the sum of college debt and dental school debt.



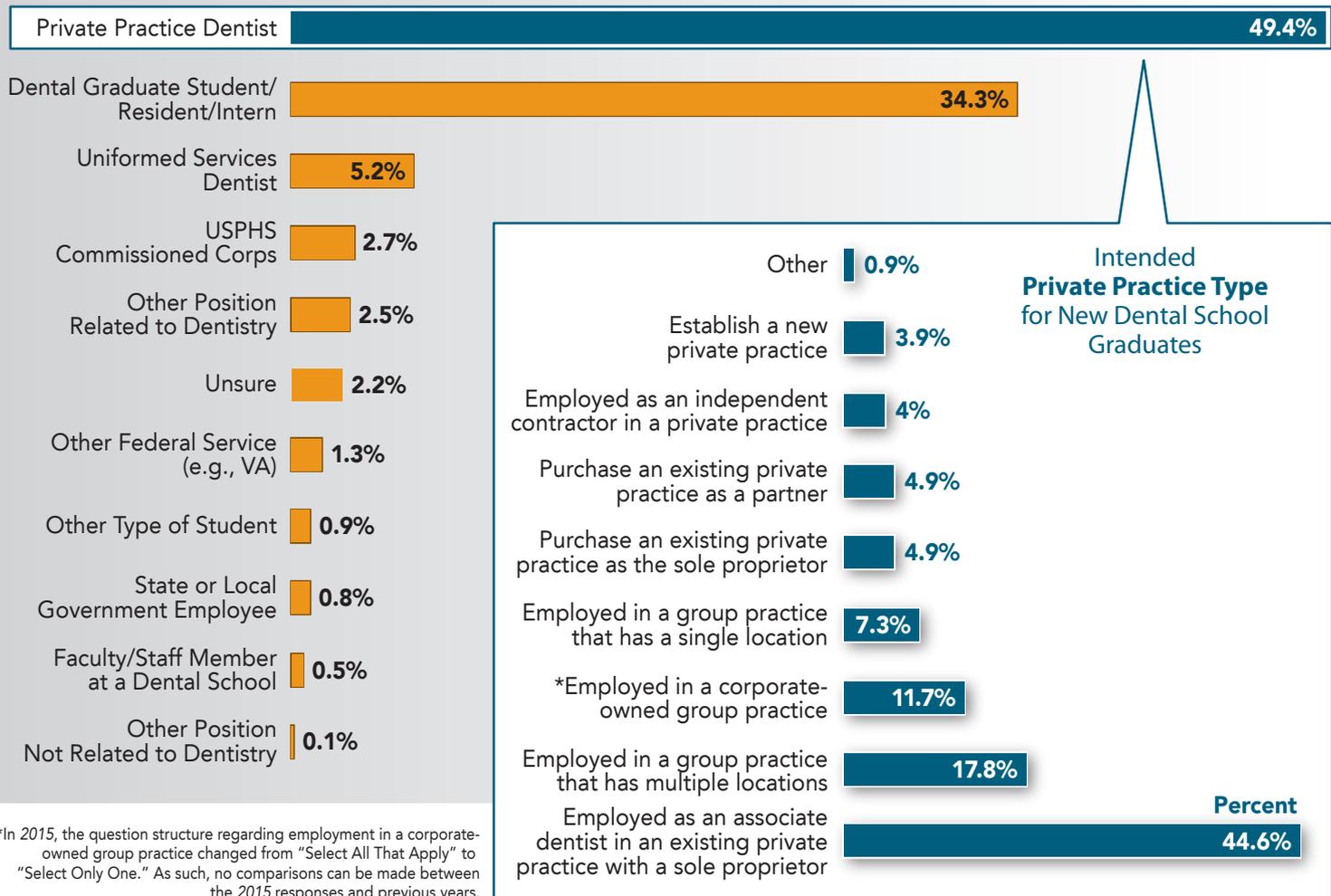
Source: American Dental Education Association, Survey of Dental School Seniors, 2015 Graduating Class

Where Do They Go From Here?

Intended professional activities and practice options, 2015 dental school graduating class

Intended **Primary Professional Activity** for New Dental School Graduates

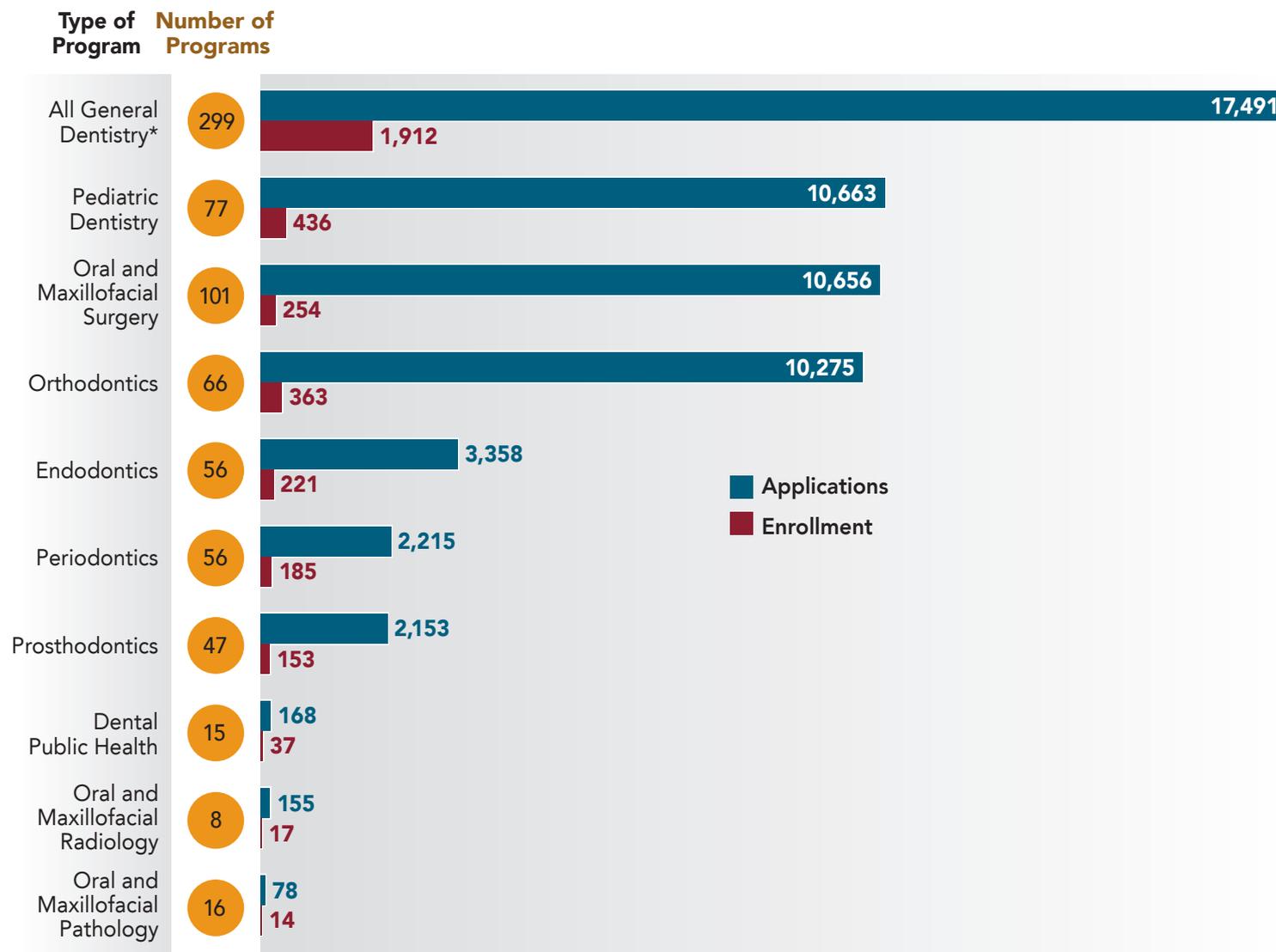
Percent



*In 2015, the question structure regarding employment in a corporate-owned group practice changed from "Select All That Apply" to "Select Only One." As such, no comparisons can be made between the 2015 responses and previous years.

Number of Applications and First-Year Enrollment for Advanced Dental Education Programs

2014-15 academic year. Application figures represent the total number of applications submitted by all programs, and counts applicants more than once if they applied to multiple programs.

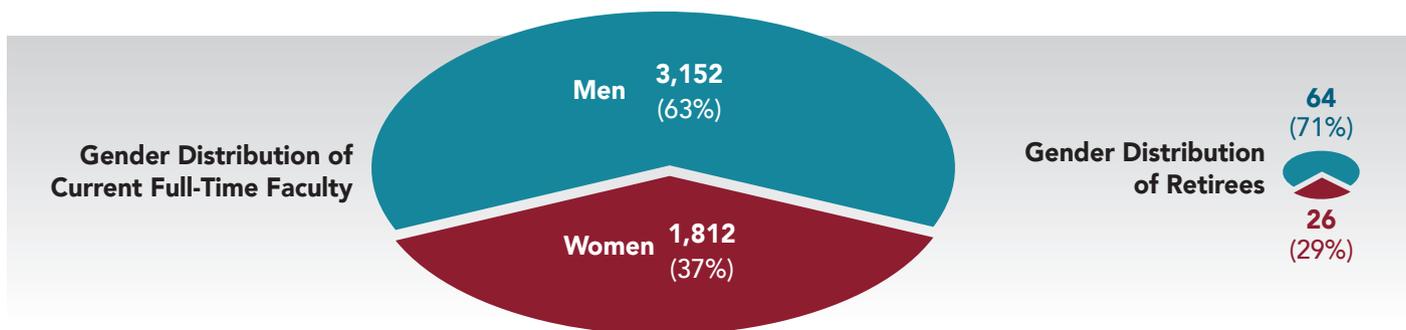
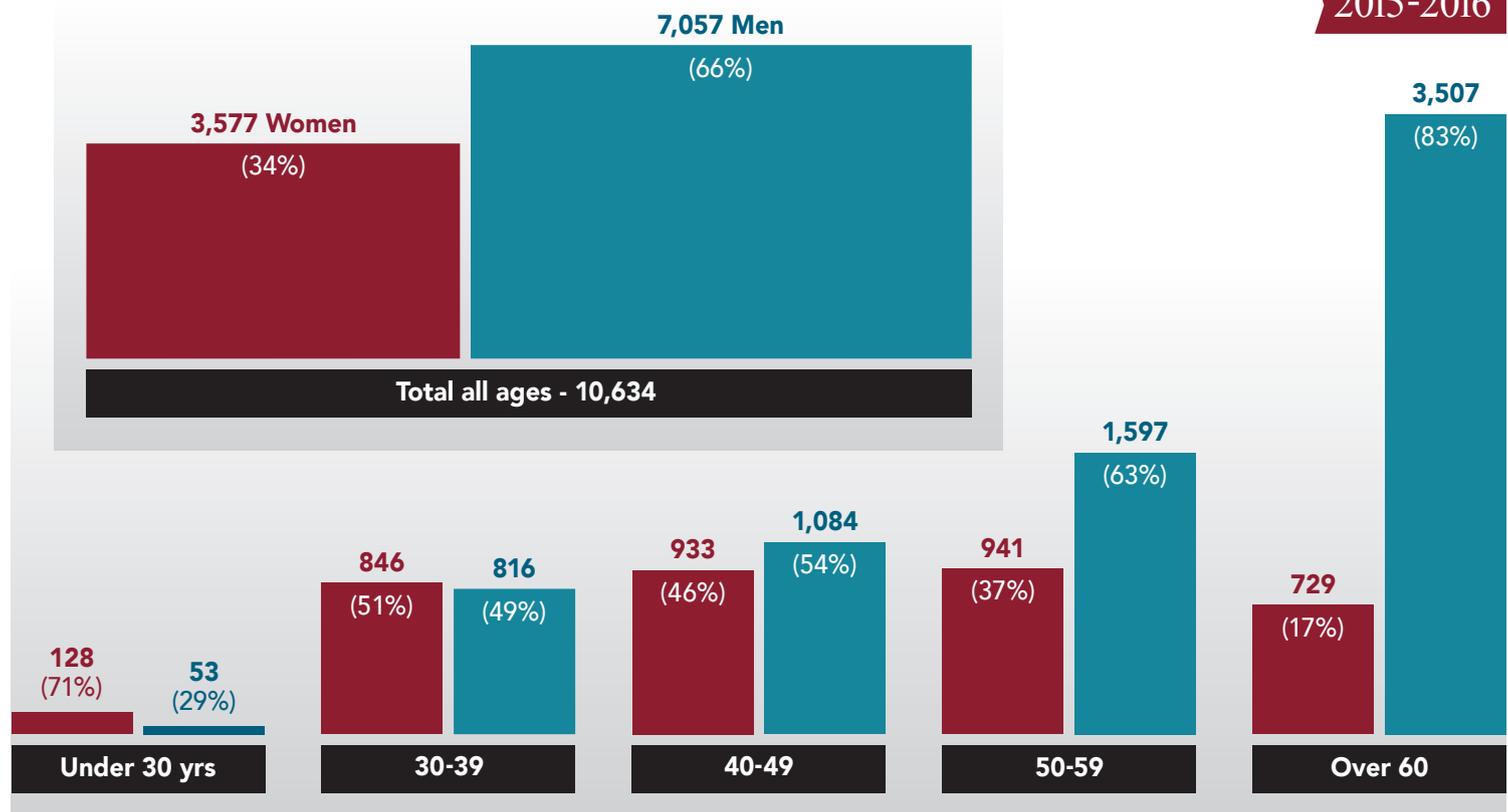


*All General Dentistry includes General Practice Residency, Advanced Education in General Dentistry, Dental Anesthesiology, Oral Medicine, and Orofacial Pain.
Source: American Dental Association, Health Policy Institute, 2014-15 Survey of Advanced Dental Education

Gender Diversity in Dental School Faculty

Faculty by age and gender, 2013-14 academic year

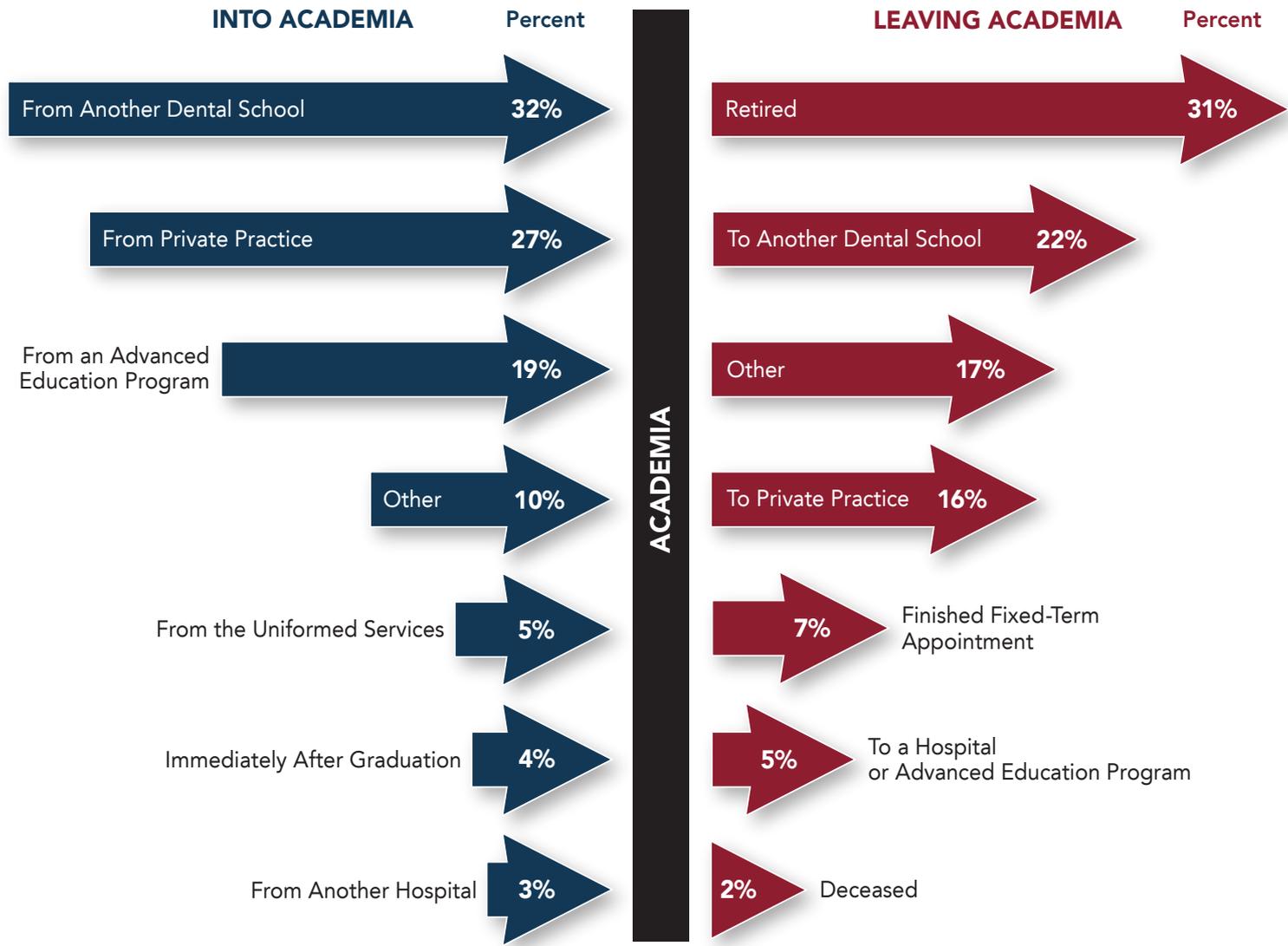
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2015-2016



Note: Faculty included are full time and part time unless otherwise indicated; voluntary faculty are not included.
Source: American Dental Education Association, Survey of Dental School Faculty, 2013-14

Entry to and Separation From Academic Life, Full-Time Faculty

2013-14 academic year



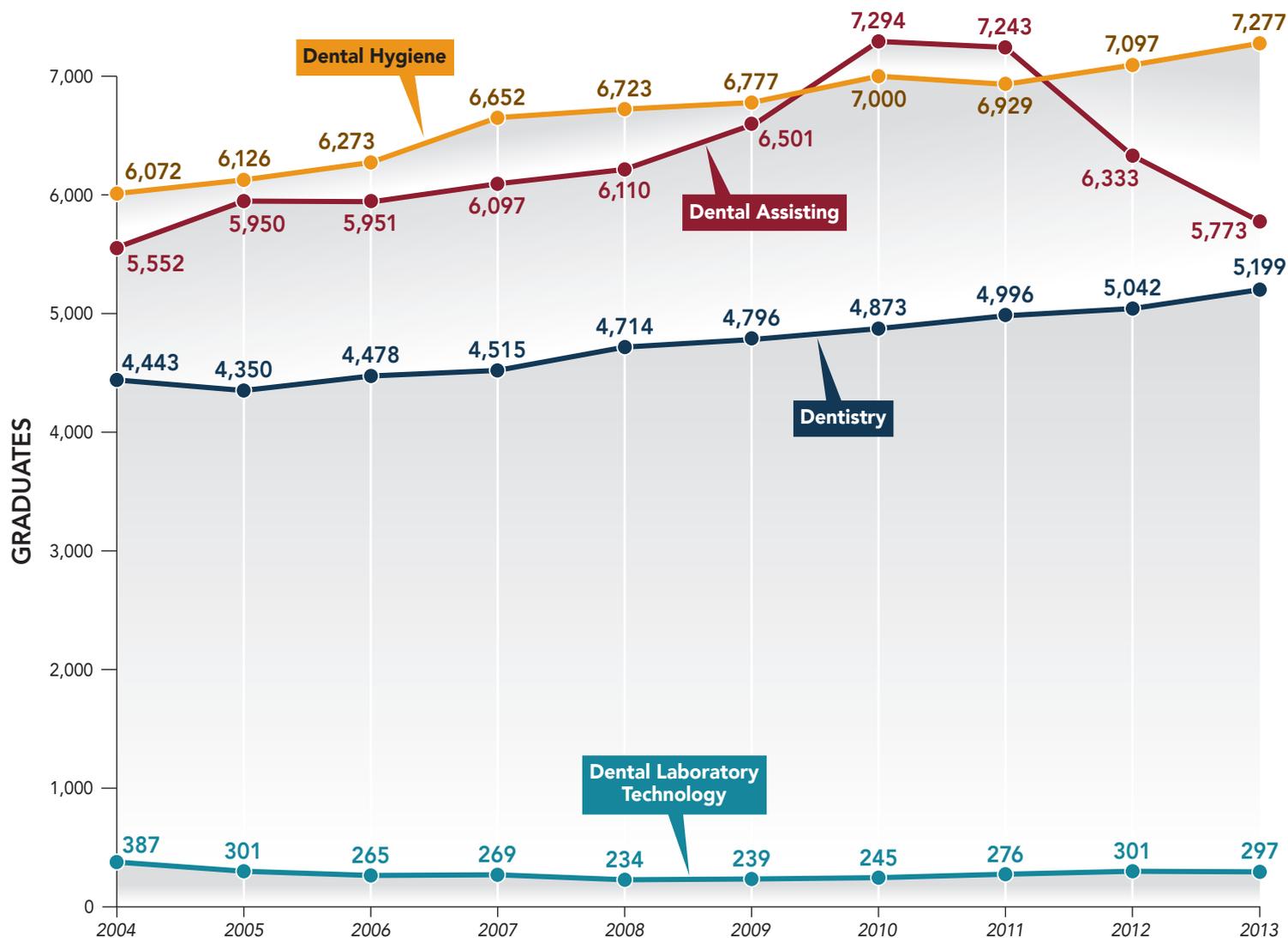
Source: American Dental Education Association, Survey of Dental School Faculty, 2013-14

Graduates of Accredited Dental and Allied Dental Education Programs

2003-04 to 2012-13 academic years

ADEA
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of Dental
Education

2015-2016

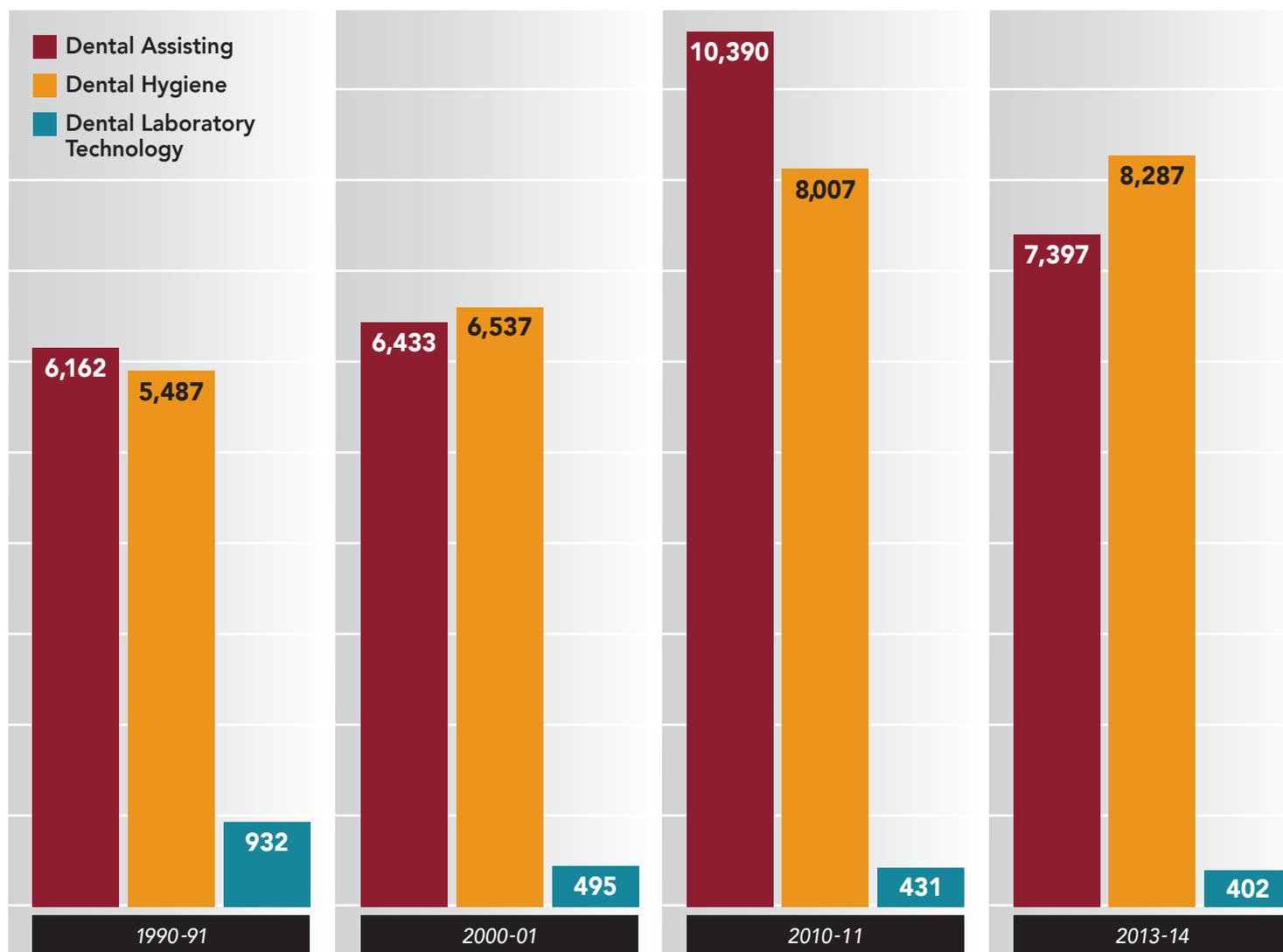


Source: American Dental Association, Health Policy Institute, Surveys of Dental Hygiene Education Programs, Surveys of Dental Assisting Education Programs, Surveys of Dental Laboratory Technology Education Programs, and Surveys of Dental Education.

First-Year Enrollment in Accredited Allied Dental Education Programs

1990-2014

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Education
2015-2016



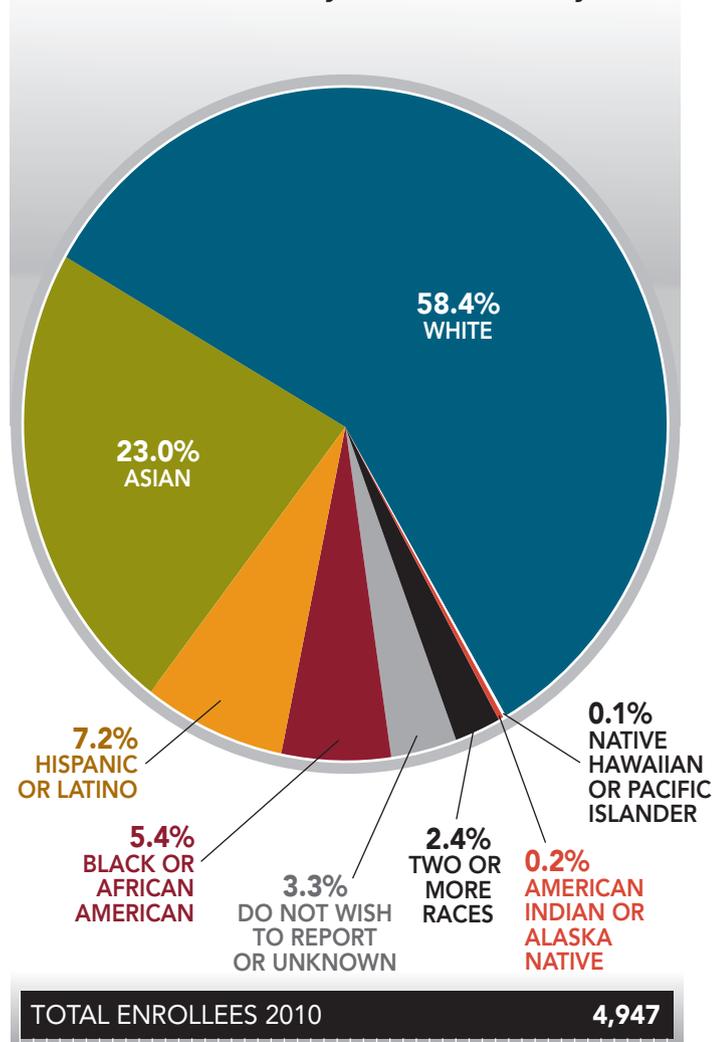
Source: American Dental Association, Health Policy Institute, Surveys of Dental Hygiene Education Programs, Surveys of Dental Assisting Education Programs, and Surveys of Dental Laboratory Technology Education Programs

Dental School Enrollees by Race and Ethnicity

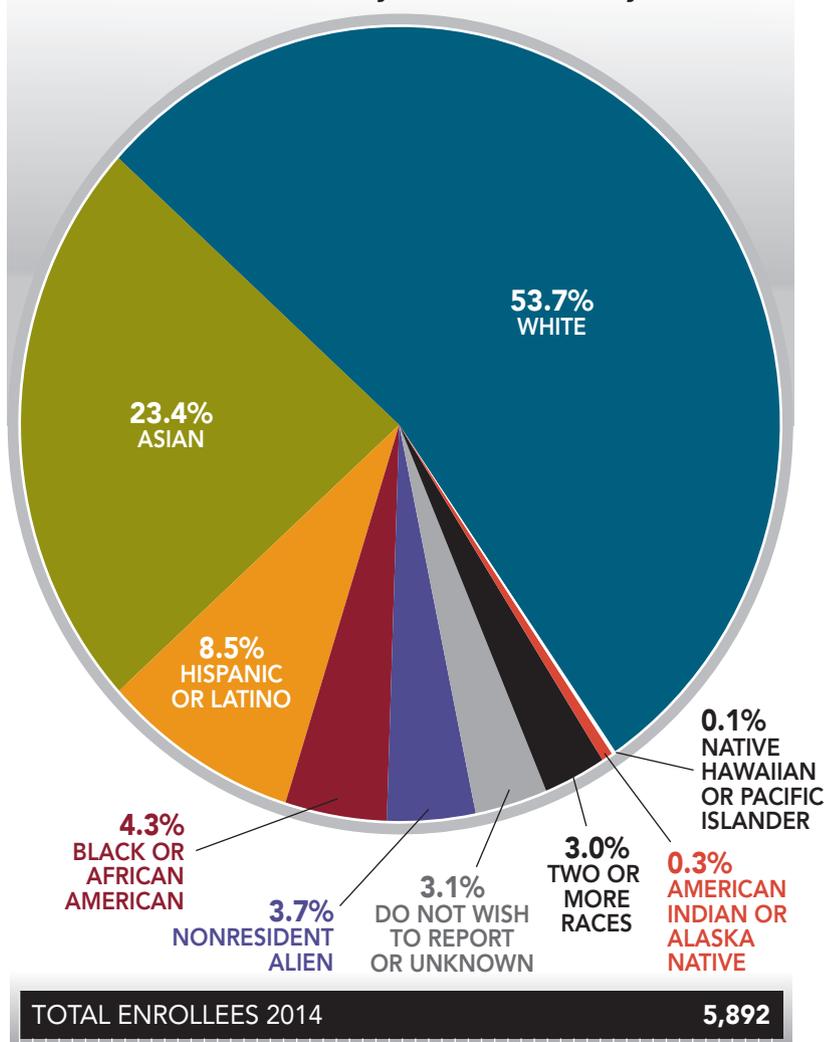
2010 and 2014

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2015-2016

2010 Enrollees by Race and Ethnicity



2014 Enrollees by Race and Ethnicity

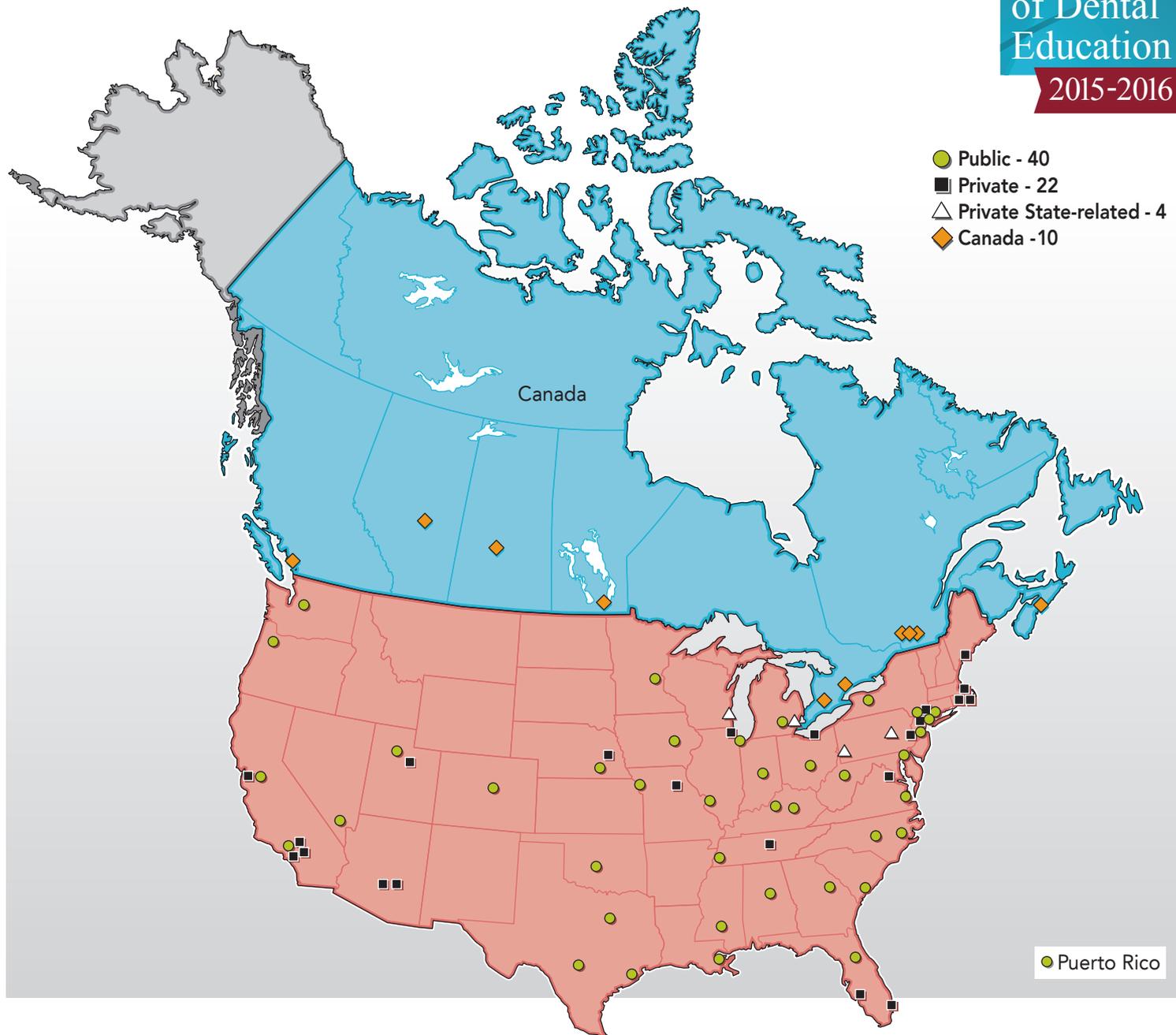


Source: American Dental Education Association, U.S. Dental School Applicants and Enrollees, 2010 and 2014 Entering Classes
ADEA adheres to the revised federal guidelines for collecting and reporting race and ethnicity. Percentages may add up to more than 100% due to rounding.

Distribution of Dental Schools in North America

ADEA
Snapshot
of Dental
Education

2015-2016

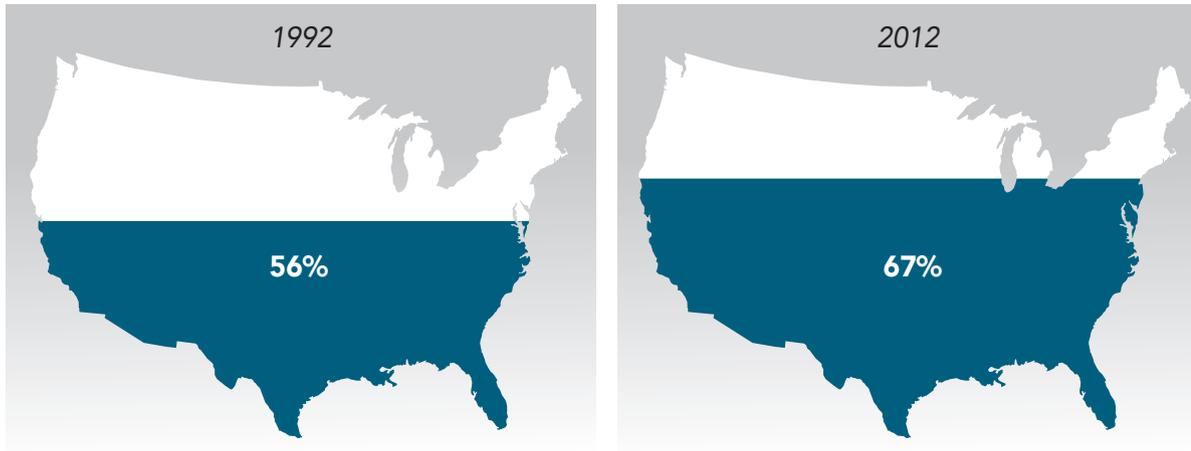


Source: American Dental Education Association

What a Difference a Generation Makes

Over the course of just one generation, two areas in particular demonstrate significant improvements in both the oral health of the public and the ability of dental education to not only adapt, but also lead by example in new health care workforce models.

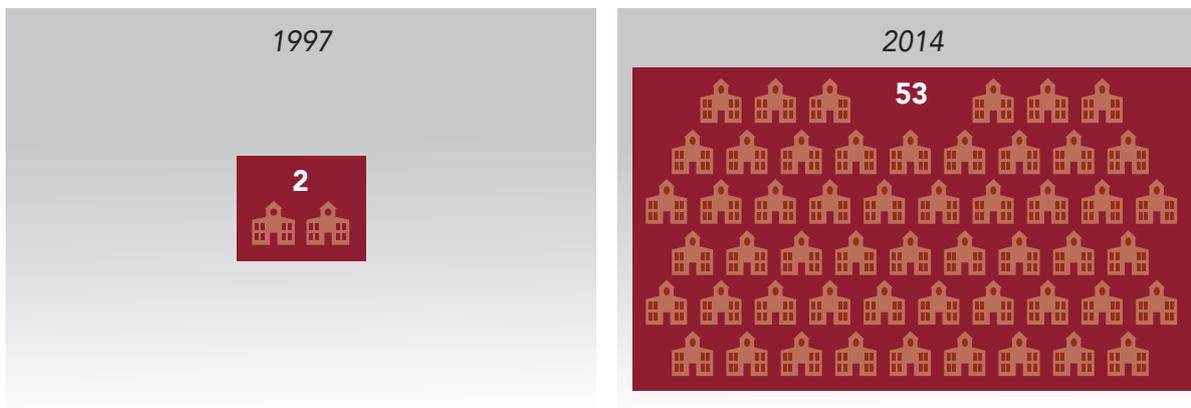
Percentage of U.S. population receiving fluoridated water



The number of U.S. communities with fluoridated water increased 11 percentage points over a 20-year period, allowing millions more American children and adults to reduce their chance of dental caries. With over 3 million patient visits at academic dental institutions annually, dental educators and clinics are uniquely situated to provide accurate information to students, patients and their communities about the benefits of optimal community water fluoridation.

Source: Centers for Disease Control and Prevention, Fluoridation Growth by Population, U.S., 1940-2012. <http://www.cdc.gov/fluoridation/statistics/fsgrowth.htm>

Number of dental schools with active interprofessional education programs



Dentistry is now recognized as an integral and integrated part of the interprofessional health care team. The marked increase in formal interprofessional education programs at dental schools in less than 20 years demonstrates the commitment of academic dentistry to prepare students, residents and fellows for a future in collaborative care.

Source: Palatta A, Cook BJ, Anderson EL, Valachovic RW. 20 Years Beyond the Crossroads: The Path to Interprofessional Education at U.S. Dental Schools. J Dent Educ 2015; 79:982-996, Table 6.

Dentistry exemplifies the most prominent trends in health care delivery and is well positioned to improve the health of the public.

1. We see a significant portion of the population—500,000,000 dental patient encounters annually.
2. The oral–systemic connection is fundamental to overall health.
3. Dentistry already embodies team-based care in the relationship between dentists and allied personnel.
4. The dental profession arguably represents the most respected preventive model in health care, including fluoridation as one of the most celebrated public health successes of modern time.

ADEA Snapshot of Dental Education

2015-2016

ADEA | THE VOICE OF
DENTAL EDUCATION

655 K Street, NW, Suite 800
Washington, DC 20001
202-289-7201

adea.org/snapshot

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

H7113	GAIL MARGARET JOHNSON, R.D.H.	10/22/2015
H7114	SARAH LYNN BOROWIAK, R.D.H.	10/22/2015
H7115	TIA M GLANDING, R.D.H.	10/22/2015
H7116	CALLY MARIE GRANT, R.D.H.	10/29/2015
H7117	SHANNON MICHIKO SAKATA, R.D.H.	10/29/2015
H7118	VANESSA R PLUNKETT, R.D.H.	10/29/2015
H7119	ADAM M MERRITT, R.D.H.	11/6/2015
H7120	BINA MISTRY, R.D.H.	11/10/2015
H7121	JACQUE'LINE MARIE MENDIOLA, R.D.H.	11/18/2015
H7122	MELISSA KAYE ALLEMAND, R.D.H.	11/18/2015
H7123	KYNA L CHILDS, R.D.H.	11/18/2015
H7124	SABRINA ROSE ANDRUS, R.D.H.	11/18/2015
H7125	ALESIA MARIE GREENE, R.D.H.	12/3/2015
H7126	SARAH A ROSS, R.D.H.	12/3/2015
H7127	DANIELLE MARIE DESHAYES, R.D.H.	12/3/2015
H7128	CORINNE MAUREEN SMITH, R.D.H.	12/4/2015
H7129	ANGELA M HERMANSEN, R.D.H.	12/7/2015

DENTISTS

D10366	JASMINE J CHA, D.D.S.	10/23/2015
D10367	MARK S CUSHING, D.D.S.	10/23/2015
D10368	IRAJ H KASIMI, D.M.D.	10/29/2015
D10369	LAUREN S BUSCH, D.D.S.	10/29/2015
D10371	JOHN K SULLIVAN, D.D.S.	11/6/2015
D10372	MELISSA M RAMSEY, D.D.S.	11/18/2015
D10373	LIN ZHU, D.D.S.	11/18/2015
D10374	CHARLES DANIEL KNECHTEL, D.D.S.	11/18/2015
D10375	DANA NGUYEN SCHMIDL, D.D.S.	11/19/2015
D10376	RARES N DECA, D.M.D.	12/3/2015
D10377	BEATRICE E DECA, D.M.D.	12/3/2015
D10378	LAUREN M WEBER, D.D.S.	12/3/2015
D10379	CRAIG ROSS ELGIN, D.M.D.	12/3/2015
D10380	ELIZABETH A MILLER, D.D.S.	12/3/2015
D10381	ALISHA J JAMES, D.D.S.	12/3/2015
D10382	JUNGHUN JI, D.D.S.	12/7/2015
D10383	CONG VO, D.D.S.	12/7/2015
D10366	JASMINE J CHA, D.D.S.	10/23/2015

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