

PUBLIC PACKET

**OREGON BOARD
OF
DENTISTRY**

**BOARD MEETING
FEBRUARY 27, 2015**



COMMITTEE REPORTS

Nothing to report under this tab

APPROVAL OF MINUTES

**OREGON BOARD OF DENTISTRY
MINUTES
December 19, 2014**

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

STAFF PRESENT: Patrick D. Braatz, 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)
William Herzog, D.M.D., Consultant (portion of meeting)
Michelle Lawrence, D.M.D., Consultant (portion of meeting)
Stephen Prisby, Office Manager (portion of meeting)
Lisa Warwick, Office Specialist (portion of meeting)

ALSO PRESENT: Lori Lindley, Sr. Assistant Attorney General

VISITORS PRESENT: Steve Duffin, D.D.S., Shoreview Dental; Scott Hansen, D.M.D., ODA; Lynn Ironside, R.D.H, ODHA; Christina Swartz, ODA; Heidi Jo Grubbs, R.D.H.; Alex Shebiel, Lindsay Hart, ODHA; Pamela Lynch, R.D.H.; Norman Auzins, D.D.S.; Kim Wright, D.M.D.; Bruce HORN, D.D.S., WREB; Mike Shirtcliff, D.D.S., Advantage Dental; Mary Harrison, ODA; Russell A Lieblich, D.M.D., OSOMS

Call to Order: The meeting was called to order by the President at 7:30 a.m. at the Board office; 1500 SW 1st Ave., Suite 770, Portland, Oregon.

NEW BUSINESS

MINUTES

Dr. Hongo moved and Mr. Harvey seconded that the minutes of the October 17, 2014 Board meeting be approved as presented. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

Mr. Harvey moved and Dr. Hongo seconded that the minutes of the November 12, 2014 Board meeting be approved as amended. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

ASSOCIATION REPORTS

Oregon Dental Association

No one was present.

Oregon Dental Hygienists' Association

Alex Shebiel stated that the ODHA had just completed their Legislative Days in Salem and added that they appreciate the Board's support to move things through.

Oregon Dental Assistants Association

Mary Harrison stated there was nothing to report.

COMMITTEE AND LIAISON REPORTS

WREB Liaison Report

Dr. Hongo had nothing to report.

AADB Liaison Report

Dr. Hongo had nothing to report.

ADEX Liaison Report

Dr. Hongo stated that there were ADEX Meetings in Rosemont, Illinois November 7 - 9. Dr. Guy Champagne will become the new chief Executive Officer. Changes to the exam include eliminating the three criteria to a pass/fail exam. A Pilot Exam in Buffalo New York where the Exam in the school will calibrate the examiners to approve tooth selection in advance for the students.

NERB Liaison Report

Dr. Smith stated that NERB is meeting in January. Dr. Hongo, Dr. Underhill, Dr. Fine, Mr. Morris and Mr. Harvey will be attending.

Anesthesia Committee Meeting Report

Dr. Smith stated that the committee met on August 27th and continued on with those agenda items on November 12, 2014 and that the Anesthesia committee recommended that the following rules be submitted to the Rules Oversight Committee as amended by the Anesthesia Committee for further review: 818-026-0010, 818-026-0030, 818-026-0040, 818-026-0050, 818-026-0060, 818-026-0065, 818-026-0070, 818-026-0080, 818-026-0110.

Upon review of the Anesthesia meeting recommendations with the Board, the Board voted to send the suggestions to the Rules Oversight Committee.

818-026-0010

Mr. Morris moved and Dr. Underhill seconded to send this to the Rules Oversight Committee. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

818-026-0030

Dr. Hongo moved Mr. Harvey seconded to send this to the Rules Oversight Committee. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

818-026-0040

Mr. Harvey moved Dr. Fine seconded to send this to the Rules Oversight Committee. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

818-026-0050

Dr. Beck moved and Mr. Harvey seconded to send this to the Rules Oversight Committee. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

818-026-0060 (8)(a) page 7

Dr. Smith moved and Dr. Beck seconded that this rule be sent back to the Anesthesia Committee for rewording that would incorporate Dr. Auzins recommendations as submitted pg 17 of 28 on anesthesia minutes. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

818-026-0060 to clarify Language in the Rule 1b

Dr Fine moved an clarify language and Mr. Harvey seconded that the Board send this to the Rules Oversight Committee with the exception of edits to 8(a)(going back to the Anesthesia Committee). The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

818-026-0065

Dr. Hongo moved and Mr. Harvey seconded that the Board send this to the Rules Oversight Committee with the exception of edits to 8(a) (going back to the Anesthesia Committee). The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

818-026-0070

Dr. Hongo moved and Mr. Harvey seconded that the Board send this to the Rules Oversight Committee with the exception of edits to 8(a) (going back to the Anesthesia Committee).. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

818-026-0110

Mr. Harvey moved and Dr. Beck seconded that the Board send this to the Rules Oversight Committee. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

818-026-0080

Mr. Morris moved and Dr. Smith seconded that the Board to send this to the Rules Oversight Committee as proposed.

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Dr. Smith moved and Dr. Beck seconded that the Board amend the motion of the proposed language to remove references to a Dental Hygienist who uses Nitrous Oxide as well as direct the Rules Committee to expand it to allow for further revision. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye. Dr. Fine was opposed.

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

Mr. Morris moved and Dr. Smith seconded that the Board send 818-026-0080 to the Rules Oversight Committee as amended. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye. Dr. Fine was opposed

Licensing, Standards and Competency Committee Meeting Report

Dr. Underhill stated that the committee met December 18, 2014. Dr. Underhill stated that the committee discussed silver diamine fluoride and its uses. The committee came to the conclusion that Silver Diamine Fluoride falls under the umbrella of Fluoride use and no there is no need to change anything in order to allow for its use.

Dr. Beck moved and Dr. Underhill seconded that the Board adopt that interpretation. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

818-042-0040

Dr. Fine moved and Dr. Beck seconded to send this rule to the Rules Oversight Committee. The rules amendment allows for placing of cords subgingivally. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

818-042-0070

Dr. Underhill moved and Dr. Beck seconded to send this rule to the Rules Oversight Committee. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

818-042-0090

Mr. Harvey moved and Dr. Underhill seconded. The motion passed with Mr. Harvey, Dr. Beck, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye. Ms. Martinez was opposed.

Mr. Morris excused himself temporarily from the meeting at 10:02 a.m.

EXECUTIVE DIRECTOR'S REPORT

Budget Status Report

Mr. Braatz stated that he had attached the latest budget report for the 2013 - 2015 Biennium. The report, which is from July 1, 2013 through October 31, 2014, shows revenue of \$1,849,465.30 and

expenditures of \$1,655,778.38. Mr. Braatz stated that he believed the was performing as expected and that if Board members had questions on that he'd be happy to discuss them.

Customer Service Survey Report

Mr. Braatz stated that he had included a copy of the OBD State Legislatively Mandated Customer Service Survey with results from July 1, 2014 through November 30, 2014. The results of the survey show that the OBD continues to receive positive comments from the majority of those that return the surveys. The booklet containing the written comments that are on the survey forms, which staff has reviewed, are available on the table for Board members to review

Board and Staff Speaking Engagements

Friday, November 14, 2014 - Dr. Paul Kleinstub, Dental Director/Chief Investigator made a presentation to the ODHA Annual Conference at the Sheraton PDX.

Facebook

Mr. Braatz stated that a recent discussion by the Executive Directors of the Health Regulated Licensing Boards about Facebook pages, prompted him to ask Office Manager, Stephen Prisby, to work with Sr. Assistant Attorney General, Lori Lindley, to look at some of the Legal ramifications of having a Facebook Page and what other Boards or Commissions are doing. Mr. Braatz stated that he would recommend to the Board that this memo be referred to the OBD Communications Committee for review and recommendation back to the Board regarding the fact that the OBD may wish to discontinue its' Facebook page because of many legal hurdles that have recently been presented to the Board.

Dr. Fine moved and Dr. Beck seconded to send this matter to the Communication Committee. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

OBD Budget 2015 – 2017 Update

Mr. Braatz stated that the Governor recently submitted the 2015 – 2017 Biennial Budget included as a part of the State Budget is the OBD Budget and stated the he had attached documents that show that based on his appeal the Governor is recommending that we have the authority and funding to add an additional Fulltime Dental Investigator to the OBD beginning July 1, 2015. This position and the OBD budget will require a \$75.00 per License renewal fee increase for Dentists and Dental Hygienists effective July 1, 2015.

Jurisprudence Exam Update

Mr. Braatz stated that the revision of the Jurisprudence Examination has been completed and that all of the members of the Workgroup have submitted their recommendations, changes, etc. Mr. Braatz added that the OBD Jurisprudence Examination has been revised and that staff would begin using the new examination starting January 1, 2015.

Staff Changes

Mr. Braatz stated that Lisa Warwick, Office Specialist 2, has submitted her letter of resignation effective December 26, 2014. Her last day in the office will be December 23rd. Ms. Warwick will be transferring to a promotional position at DHS. Mr. Braatz added that Ms. Warwick has been with the OBD for over 10 years and has been a tremendous asset and outstanding employee, breaking us into the electronic Board Agenda Book as just one of the many accomplishments during her tenure with the OBD. We will work with the Oregon Medical Board's HR Manager and together we will begin the recruitment process for a new Office Specialist 2. We will look to hire during the duration, a temporary employee to assist with some of the clerical duties of this

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position. I will answer any questions about the hiring process. Mr. Braatz presented a plaque to Ms. Warwick thanking her for her time with the Board.

OBD Disciplinary Protocols

Mr. Braatz stated that the Evaluators had requested that the OBD might want to review some of the current OBD Disciplinary Protocols that have been previously established. Mr. Braatz stated that he would recommend to the Board that this matter be referred to the OBD Enforcement and Discipline Committee for a review and recommendation back to the Board.

Dr. Hongo moved and Dr. Harvey seconded that they send protocols to the Enforcement and Discipline Committee. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

Discussion on Strategic Planning Session

Mr. Braatz stated that he is still attempting to plan the Strategic Planning session for the Board, potentially for a weekend following a Board meeting.

Newsletter

Mr. Braatz stated that it was again time to consider another newsletter and that articles are welcome from Board Members.

UNFINISHED BUSINESS

CORRESPONDENCE

The Board received a letter from Mr. James Tarrant, Executive Director AABD

Sent a letter thanking Patrick Braatz.

The Board received a letter from DeeAnn Ashcroft, Dental Hygiene Program Directors, Carrington College

Thanked both Patrick Braatz and Teresa Haynes for their time presenting to the hygiene students at Carrington.

The Board received a letter from Robert E. Varner, DMD, President American Association of Orthodontists

The Board directed Mr. Braatz to respond stating that we have heard their concern and will keep an eye on the matter.

The Board received an email from J. Andrew Baxter, DDS

The Board directed Mr. Braatz to respond stating that we have heard their concern and will keep an eye on the matter.

The Board received a letter from Erik M. Richmond, DMD

The letter was regarding the proposed changes to the anesthesia rules.

The Board received a letter from Russell A. Lieblick, DMD, Oregon Oral and Maxillofacial Surgeons

The letter was regarding the proposed changes to the anesthesia rules.

The Board received a letter from Steven Beadnell, DMD, Sunset Oral and Maxillofacial Surgery

The letter was regarding the proposed changes to the anesthesia rules.

The Board received a letter from Normund Auzins, DDS

The letter was regarding the proposed changes to the anesthesia rules.

OTHER BUSINESS

Lane Community College EPP CE Course Approval

Dr. Underhill moved and Mr. Harvey seconded that the Board approve the course as presented. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Dr. Smith and Dr. Underhill voting aye.

Presentation by Bruce Horn, D.D.S. of WREB

Dr. Horn presented to the board regarding WREB and the updates and changes to the organization.

Presentation by Kim Wright, D.M.D., - Study Club Proposal

The Board was in support of development of curriculum that was multiple times per year as they do not want doctors held up due to lack of course offerings. They directed Dr. Wright to contact Mr. Wayson as the point of contact for the Board for further cooperation.

Mr. Morris returned to the meeting at 11:00 a.m.

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

PERSONAL APPEARANCES AND COMPLIANCE ISSUES

Licensees appeared pursuant to their Consent Orders in case numbers **2005-0117 and 2008-0013**.

LICENSING ISSUES

OPEN SESSION: The Board returned to Open Session.

CONSENT AGENDA

2015-0091, 2015-0074, 2015-0095 and 2015-0066 Dr. Smith moved and Mr. Harvey seconded that the above referenced cases be closed with No Further Action per the staff recommendations. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

COMPLETED CASES

2013-0188, 2013-0211, 2015-0059, 2013-0154, 2013-0200, 2014-0098, 2015-0065, 2013-0061, 2014-0032, 2015-0004, 2014-0037, 2014-0063, 2014-0034, 2014-0014, 2013-0198, 2013-0206, 2014-0010, 2015-0058, 2015-0002, 2014-0055, 2014-0021, 2014-0073, 2015-0044, 2014-0042, 2014-0234 and 2014-0195. Dr. Smith moved and Mr. Harvey seconded that the above referenced cases be closed with a finding of No Violation of the Dental Practice Act or No Further Action per the Board recommendations. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye. Dr. Fine and Dr. Schwindt recused themselves on case 2015-0002. Dr. Schwindt recused himself on cases 2013-0061 and 2013-0188. Dr. Hongo recused herself on case 2013-0154.

2014-0028

Dr. Beck moved and Mr. Harvey seconded that the Board close the matter with a **STRONGLY** worded Letter of Concern addressing the issue of ensuring that patient record copies are provided within 14 days of receipt of a written request and that heat sterilizing devices are tested for proper function on a weekly basis with a biological monitoring system. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris and Dr. Underhill voting aye. Dr. Smith recused herself.

2014-0011

Ms. Martinez moved and Dr. Smith seconded that the Board recommend a **Strong Letter of Concern** suggesting the Board presented recordkeeping class would be of benefit to attend at next year's dental convention. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

2015-0069

Dr. Underhill moved and Dr. Hongo seconded that the Board close the matter with a Letter of Concern reminding the Licensee that patients who respond and pay for advertised specials are paid in full for all the services rendered in the advertisement; and reminding the Licensee that all sterilization equipment is to be tested on a weekly basis. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

2015-0064 Harewood, Lillian G., D.M.D.

Dr. Fine moved and Mr. Harvey seconded that the Board recommended following the Board protocol and Issue the Licensee a Notice of Proposed Disciplinary Action and offer a Consent Order incorporating a reprimand and civil penalty of \$2,000.00. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

2014-0035 Harper, Gerald A., D.D.S.

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

2015-0077

Mr. Harvey moved and Dr. Hongo seconded that the Board close the matter with a Letter of
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Concern reminding the Licensee that it is the Licensee's responsibility to ensure compliance with regulatory bodies seeking to perform their duties at facilities under the Licensee's control. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

2014-0006

Dr. Beck moved and Dr. Smith seconded that the Board close the matter with a Letter of Concern addressing the issue of ensuring that when treatment complications are diagnosed and evident on radiographs, the information is documented in the patient records, and that when medication is prescribed, the dosage and amount is documented in the patient records. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

2013-0210 Pier, Shauna L., D.D.S.

Ms. Martinez moved and Dr. Beck seconded that the Board move to issue a Notice of Proposed Disciplinary Action and offer the Licensee a Consent Order in which the Licensee would agree to be reprimanded and pay a civil penalty of \$1000.00 and agree to complete 20 hours of continuing education in the next four months for the 2009-2011 licensing period. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

2015-0063 Pierce, Dana P., R.D.H.

Dr. Underhill moved and Dr. Hongo seconded that the Board recommended following the Board protocol and Issue the Licensee a Notice of Proposed Disciplinary Action and offer a Consent Order incorporating a reprimand and civil penalty of \$2,500.00. The motion passed with Mr. Harvey, Dr. Beck, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye. Ms. Martinez recused herself.

2013-0157 Schmidt, Richard C., D.M.D.

Dr. Fine 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 per Board protocols. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

2015-0049 Shishkin, Igor, D.D.S.

Dr. Hongo moved and Mr. Harvey 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 \$10,000.00 civil penalty. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

2014-0033

Mr. Harvey moved and Dr. Hongo seconded that the Board close the matter with a **STRONGLY** worded Letter of Concern addressing the issue of ensuring that when treatment is provided, the treatment is documented in the patient records and that heat sterilizing devices are tested for proper function on a weekly basis. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

2014-0041

Dr. Beck moved and Dr. Hongo seconded that the Board close the matter with a Letter of Concern

addressing the issue of ensuring that following the extraction of teeth every effort is made to verify the complete removal of all tooth structure. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

2015-0088

Ms. Martinez moved and Dr. Hongo seconded that the Board close the matter with a Letter of Concern addressing the issue of ensuring that patient instructions reflect the current guidelines for maximum recommended medication dosages. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye. Dr. Fine recused herself.

2014-0012

Dr. Underhill moved and Dr. Hongo seconded that the Board close the matter with a STRONGLY Worded Letter of Concern reminding the Licensee to ensure that he at all times maintains a current Health Care Provider BLS/CPR certificate. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

2014-0030 Turley, Brandon L., D.M.D.

Dr. Fine moved and Dr. Beck seconded that the Board move to issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order in which Licensee would agree to be reprimanded and attend within 6 months a Board approved 3 hour class in clinical documentation. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

2014-0229

Dr. Hongo moved and Mr. Harvey seconded that the Board move the Board accept Licensee's Oregon dental license resignation and close the case with no further action. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

PREVIOUS CASES REQUIRING BOARD ACTION

2010-0026

Mr. Harvey moved and Dr. Smith seconded that the Board move to grant Licensee's request, relieve him from the terms of the Board's Voluntary Diversion Agreement and his Health Professionals' Services Program contract with Reliant Behavioral Health. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

2013-0019 Starr, Duane T., D.M.D.

Ms. Martinez moved and Dr. Hongo seconded that the Board move to accept Licensee's proposal and offer a Consent Order incorporating a reprimand, a \$2500.00 civil penalty, 16 hours of Board approved community service to be completed within six months, and three hours of Board approved continuing education in record keeping to be completed within six months. The motion passed with Mr. Harvey, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye. Dr. Beck recused himself.

2015-0003 Tanner, Nathan M., D.M.D.

Dr. Beck moved and Dr. Hongo seconded that the Board accept Licensee's offer of a Consent Order incorporating a reprimand, a \$5,000.00 civil penalty, and 80 hours of community service to be completed between January 1, 2015 and January 1, 2016, and to make a personal appearance before the Board at the first scheduled Board meeting after the effective date of the Consent Order. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

2013-0119 Smith, Grant M., D.D.S.

Mr. Morris moved and Dr. Smith seconded that the Board move, following confirmation that the hair analysis is negative, to reinstate Licensee's Oregon dental license providing he agree to a Consent Order incorporating a reprimand; 40 hours of community service to be completed within one year; for a period of five years, Licensee is prohibited from having a DEA certificate, is required to only practice in a group practice, and be prohibited from ordering, storing, inventorying or having unilateral access to Scheduled controlled drugs; and agree to the Board's protocols to support his recovery and protect the public, including in enrollment with the State's Health Professionals' Services Program; and endorse the release of the investigative report to the DEA. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

LICENSURE AND EXAMINATION

Ratification of Licenses Issued

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

DENTAL HYGIENE

H6862	SALLY RENAE REHLING, R.D.H.	10/13/2014
H6863	MICHELLE E FORD, R.D.H.	10/13/2014
H6864	JILL JENSEN, R.D.H.	10/13/2014
H6865	MERIMA HODZIC, R.D.H.	10/13/2014
H6866	HEIDI L WALKER, R.D.H.	10/13/2014
H6867	NICOLE MARILYN KEANONA PIKINI, R.D.H.	10/13/2014
H6868	LEIGH BERNADETTE LEMHOUSE, R.D.H.	10/13/2014
H6869	HEATHER C BUTLER, R.D.H.	10/13/2014
H6870	HANNAH ROSE SMITH, R.D.H.	10/14/2014
H6871	HEIDI SOHN AN, R.D.H.	10/21/2014
H6872	ABIGAIL RENEE KOOS-HENDERSON, R.D.H.	10/21/2014
H6873	ALMA DENISE VERA, R.D.H.	10/21/2014
H6874	KYLIE R LIABRAATEN, R.D.H.	10/21/2014
H6875	GEORGIE RUTH BARRETT, R.D.H.	10/23/2014
H6876	BONNIE LEE LABER, R.D.H.	10/23/2014
H6877	IRINA V ARCHER, R.D.H.	10/23/2014
H6878	RACHELLE T TRAN, R.D.H.	10/29/2014

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H6879	BETTY A VONGNATH, R.D.H.	10/29/2014
H6880	SHAUNA A WEIL, R.D.H.	10/29/2014
H6881	HANNAH BABETTE RICH, R.D.H.	11/4/2014
H6882	EMILEE M THOMAS, R.D.H.	11/4/2014
H6883	RACHEL S HUNTLEY, R.D.H.	11/4/2014
H6884	SUZANNE ELIZABETH MOORE, R.D.H.	11/4/2014
H6885	CHARIS BLAKELY NAFFIN, R.D.H.	11/11/2014
H6886	KATHRYN JOANNE CRACKEL, R.D.H.	11/11/2014
H6887	JOANNA MARIE MORI, R.D.H.	11/12/2014
H6888	SUZETTE MARIE HANSON, R.D.H.	11/12/2014
H6889	MONALI KANTIBHAI PATEL, R.D.H.	11/12/2014
H6890	HANNAH J BEARDSHEAR, R.D.H.	11/12/2014
H6892	BETHANY R HAMMOND, R.D.H.	11/18/2014
H6893	LEE ANN B MATHUS, R.D.H.	11/20/2014
H6894	KIMBERLY DAWN CAMPBELL, R.D.H.	11/20/2014
H6895	JULIA A MARTIN, R.D.H.	11/20/2014
H6896	BERNITA B CHASE, R.D.H.	12/3/2014
H6897	NIKKI D ROGERS, R.D.H.	12/3/2014
H6898	ALISON E NOBLE, R.D.H.	12/3/2014
H6899	ARIELLE ELEANOR PARKER, R.D.H.	12/3/2014
H6900	LARISA D CERBU, R.D.H.	12/9/2014

Dentists

D10151	ROBERT I STOCKTON, D.D.S.	10/21/2014
D10152	SAMATA KONA, D.D.S.	10/21/2014
D10153	MAHDAD NASSIRI, D.D.S.	10/21/2014
D10154	DAVID R VASQUEZ, D.D.S.	10/21/2014
D10155	BARBARA JANE FOX, D.D.S.	10/23/2014
D10156	CATHRINE ELIZABETH MARTELL, D.M.D.	10/23/2014
D10157	NICHOLAS DAVID ANDROS, D.D.S.	10/23/2014
D10158	JAIME J NORTON, D.M.D.	10/23/2014
D10159	LAVANYA BIKKI, D.D.S.	10/29/2014
D10160	SONG HYON KIM, D.D.S.	10/30/2014
D10161	SUZANNE R MEGENITY, D.D.S.	11/4/2014
D10162	SCOTT DAVID WINOKUR, D.D.S.	11/12/2014
D10163	SHAO-CHIU CHEN, D.M.D.	11/13/2014
D10164	UAN CONG NGUYEN, D.M.D.	11/13/2014
D10165	ELIZABETH ANH SMITH, D.D.S.	12/3/2014
D10166	PATRA V ALATSIS, D.M.D.	12/3/2014
D10167	ELLY B KIM, D.D.S.	12/3/2014
D10168	JULIA A JAVARONE, D.D.S.	12/3/2014
D10170	ELLIE E SONG, D.D.S.	12/9/2014

Periodontic Specialty

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

Reinstatement of Licensee – J. Ritacca, D.D.S.

Dr. Underhill moved and Dr. Hongo seconded that the Board reinstate Licensee's license without any further examination. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

Reinstatement of Licensee J. Pearson, D.M.D.

Dr. Fine moved and Dr. Beck seconded that the Board reinstate Licensee's license without any further examination. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

Define Study Club

Mr. Harvey moved and Dr. Hongo seconded that the board send to the Rules Oversight Committee, the task of discussing and defining what a study club is for the Board. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

Specialty Examination

Dr. Hongo moved and Dr. Beck seconded that the Board as presented. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

Executive Session Recordings

Dr. Smith moved and Dr. Hongo seconded that the Board start a trial period of 6 months in which there would be no electronic recordings of Executive sessions, just written minutes. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith and Dr. Underhill voting aye.

EXECUTIVE SESSION: The Board entered into Executive Session pursuant to ORS 192.660(2)(i), to conduct the annual review and evaluation of the Executive Director. No final action will be taken in Executive Session.

EXCEPTIONAL PERFORMANCE LEAVE WITH PAY

Dr. Hongo moved and Dr. Fine seconded that the Board grant Mr. Braatz 40 hours of exceptional performance leave with pay. The motion passed with Mr. Harvey, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Dr. Smith and Dr. Underhill voting aye. Mr. Morris voted nay.

Announcements

No announcements

Adjournment

The meeting was adjourned at 1:22 p.m. Dr. Schwindt stated that the next Board meeting would take place February 27, 2015.

Approved by the Board on February 27, 2015.

Brandon Schwindt, D.M.D.
President

DRAFT

OREGON BOARD OF DENTISTRY
Special Board Meeting Minutes
February 17, 2015

MEMBERS PRESENT: Brandon Schwindt, D.M.D., President
Alton Harvey, Sr., Vice-President
Todd Beck, D.M.D.
Jonna E. Hongo, D.M.D.
James Morris
Amy B. Fine, D.M.D. (via Telephone)
Julie Ann Smith, D.D.S., M.D. (via Telephone)
Yadira Martinez, R.D.H.

STAFF PRESENT: Stephen Prisby, Interim Executive Director
Paul Kleinstub, Dental Director/Chief Investigator

ALSO PRESENT Lori Lindley, Sr. Assistant Attorney General

VISITORS PRESENT: Enrique Sama, DAS-HR Executive Recruiter

Call to Order: The meeting was called to order by the President at 7:00 p.m. at the Board office; 1500 SW 1st Ave., Suite 770, Portland, Oregon.

Dr. Schwindt thanked Enrique Sama for joining the meeting via teleconference. Mr. Sama proceeded to initiate a discussion with the board on past recruitments and options for the Board regarding the search for the next permanent executive director.

Dr. Hongo moved and Alton Harvey seconded to accept the January 28, 2015 Special Teleconference Board Meeting minutes as presented. The motion passed with Mr. Harvey, Dr. Hongo, Dr. Beck, Dr. Fine, Ms. Martinez and Dr. Smith voting aye.

Mr. Morris joined the meeting at 7:15 p.m.

Dr. Hongo moved and Dr. Beck seconded that the Board create a steering committee, and an interview committee of the board, to help determine the best candidates for the Executive Director position and that the full board review the final top 3 candidates. The motion passed with Mr. Harvey, Dr. Beck, Dr. Fine, Dr. Hongo, Dr. Smith, Ms. Martinez and Mr. Morris voting aye.

Mr. Harvey moved and Dr. Hongo seconded that the OBD staff move forward with creating a blog for the OBD website, and retain possession of the OBD Facebook page, but keep it unpublished. The motion passed with Mr. Harvey, Dr. Beck, Dr. Fine, Dr. Hongo, Dr. Smith, Ms. Martinez and Mr. Morris voting aye.

ADJOURNMENT

The meeting was adjourned at 7:56 p.m.

Approved by the Board on February 27, 2015.

Brandon Schwindt, DMD
President

DRAFT

ASSOCIATION REPORTS

Nothing to report under this tab

**Oregon Board of Dentistry
Committee and Liaison Assignments
May 2014 - April 2015**

STANDING COMMITTEES

Communications

Purpose: To enhance communications to all constituencies

Committee:

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

Subcommittees:

- Newsletter – Todd Beck, D.M.D., Editor

Dental Hygiene

Purpose: To review issues related to Dental Hygiene

Committee:

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

Enforcement and Discipline

Purpose: To improve the discipline process

Committee:

Julie Ann Smith, D.D.S., M.D.- Chair
Vacant, R.D.H.
James Morris

Subcommittees:

Evaluators

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

Licensing, Standards and Competency

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

Committee:

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

Rules Oversight

Purpose: To review and refine OBD rules

Committee:

Todd Beck, D.M.D., Chair	Jill M. Price, D.M.D., ODA Rep.
Alton Harvey, Sr.	Lynn Ironside, R.D.H., ODHA Rep.
Yadira Martinez, R.D.H.	Bonnie Marshall, CDA, EFDA, EFODA, MADAA, ODAA Rep.

LIAISONS

American Assoc. of Dental Administrators (AADA) — Patrick D. Braatz, Executive Director

American Assoc. of Dental Boards (AADB)

- Administrator Liaison – Patrick D. Braatz, Executive Director
- Board Attorneys' Roundtable – Lori Lindley, SAAG - Board Counsel
- Dental Liaison – Jonna Hongo, D.M.D.
- Hygiene Liaison – Yadira Martinez, R.D.H..

American Board of Dental Examiners (ADEX)

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

North East Regional Board (NERB) Steering Committee

- Julie Ann Smith, D.D.S, M.D.
- Vacant, RDH.
- Jill Mason, M.P.H., R.D.H., E.P.P.

Oregon Dental Association – Brandon Schwindt, D.M.D.

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

Oregon Dental Assistants Association – Brandon Schwindt, D.M.D.

Western Regional Exam Board (WREB)

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

OTHER

Administrative Workgroup

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

Committee:

Brandon Schwindt, D.M.D, Chair
Yadira Martinez, R.D.H..
Alton Harvey, Sr.

Subcommittee:

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

- Brandon Schwindt, D.M.D.
- Alton Harvey, Sr.
- Jonna Hongo, D.M.D.

Anesthesia

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

Committee:

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

*Not Selected by the OBD

**EXECUTIVE
DIRECTORS
REPORT**

EXECUTIVE DIRECTOR'S REPORT

February 27, 2015

Board Member and Staff Member Update

Patrick Braatz submitted his resignation on January 26, 2015, with his last day February 6, 2015. There was a motion which was affirmed by the Board, that I be the Interim Executive Director, effective February 7, 2015. The recruitment and search process for the permanent Executive Director has started with open discussions at a Special Board Meeting held on February 17, 2015. There will be more information available at the Board meeting.

We will have more information regarding the newest Board Member, who is now scheduled to appear before the Senate Rules Committee for confirmation on February 26, 2015. The Office Specialist candidate has been selected and is going through a background check as this report was being completed. I hope to introduce them both at the next meeting.

Due to the recent transition with the governor, we anticipate a greater workload on our administrative staff to update forms, applications, letterhead, website and other documents that have any reference to the former governor.

OBD Budget Status Report

Attached is the latest budget report for the 2013 - 2015 Biennium. This report, which is from July 1, 2013 through January 31, 2015, shows revenue of \$2,030,864.81 and expenditures of \$1,944,300.29. The Budget is performing as projected. If Board members have questions on this budget report format, please feel free to ask me.

Attachment #1 NO ACTION IS REQUIRED

Customer Service Survey

Attached is a chart which shows the OBD State Legislatively Mandated Customer Service Survey Results from July 1, 2014 – November 30, 2014.

The results of the survey show that the OBD continues to receive positive comments from the majority of those that return the surveys. The booklet containing the written comments that are on the survey forms, which staff has reviewed, are available on the table for Board members to review. **Attachment #2 NO ACTION IS REQUIRED**

Board and Staff Speaking Engagements

Teresa Haynes and Patrick Braatz made a License Application Presentation to the graduating Dental Hygiene Students at the ODS/Dental Hygiene Program in La Grande on Tuesday, January 13, 2015.

Patrick Braatz made a presentation to Advantage Dental in Redmond on January 29, 2015.

Patrick Braatz made a presentation to the Lane County Dental Society on January 30, 2015.

Teresa Haynes and Patrick Braatz made a License Application Presentation to the graduating Dental Hygiene Students at OIT in Klamath Falls on Monday, February 2, 2015.

Teresa Haynes made a License Application Presentation to the graduating Dental Hygiene Students at Chemeketa in Salem on Wednesday, February 18, 2015.

Alton Harvey, Sr., Board Vice-President; Clair Clark- DAS Budget Analyst; Dr. Paul Kleinstub and Stephen Prisby, Interim Executive Director were scheduled to present the OBD 2015-2017 Budget to the Joint Ways and Means Subcommittee on Education on February 19, 2015. Attached please find a copy of this presentation **Attachment #3 NO ACTION REQUIRED**

Dr. Paul Kleinstub made a presentation to the Junior Dental Students at OHSU on Wednesday, February 25, 2015.

2015 Dental License Renewal

Approximately 1,827 post card notices were mailed to Oregon Licensed dentists for the March 31, 2015 Renewal Cycle. I will provide an update to the Board on the number who have renewed at the Board Meeting.

AADB & AADA Mid-Year Meeting

I do not plan to attend the American Association of Dental Administrators (AADA) Meeting to be held Sunday April 26, 2015 and the American Association of Dental Boards (AADB) Meeting to be held Sunday, April 26-27, 2015 in Chicago, IL. Senior Assistant Attorney General Lori Lindley will be attending the Board Attorneys' Roundtable Meeting that is held in conjunction with the AADB Meeting and Dr. Jonna Hongo and Yadira Martinez, R.D.H., E.P.P. who are the Dental and Dental Hygiene Liaisons, are already authorized to attend the AADB meeting.

Protocols

Attached are the current Board Protocols for handling discipline. In previous discussions, it was suggested that the Board either convene an Enforcement and Discipline Committee to review the protocols or the Board itself can make policy changes regarding discipline protocols. **Attachment #4 BOARD ACTION REQUESTED**

Legislative Update

I attached bills that have been introduced. I would like the Board of be aware of the potential legislation that could impact the Board and our licensees. **Attachment #5 DISCUSS**

HPSP REPORT

Attached is the Reliant Behavioral Health, LLC Health Professionals' Services Program (HPSP) Satisfaction Report. **Attachment #6 NO ACTION IS REQUIRED**

Facebook Page and Blog

At the Special Board Meeting on February 17, 2015 the board directed staff to develop an OBD blog and work out the details for that, and keep the Facebook page in possession of the OBD, but unpublished.



BOARD OF DENTISTRY
Fund 3400 BOARD OF DENTISTRY
For the Month of JANUARY 2015

REVENUES

<u>Budget Obj</u>	<u>Budget Obj Title</u>	<u>Monthly Activity</u>	<u>Biennium to Date Activity</u>	<u>Financial Plan</u>	<u>Unobligated Plan</u>	<u>Monthly Avg to Date</u>	<u>Monthly Avg to Spend</u>
0205	OTHER BUSINESS LICENSES	127,650.00	1,885,632.00	2,376,611.00	490,979.00	99,243.79	98,195.80
0210	OTHER NONBUSINESS LICENSES AND FEES	0.00	8,250.00	15,772.00	7,522.00	434.21	1,504.40
0410	CHARGES FOR SERVICES	1,081.50	12,831.00	0.00	-12,831.00	675.32	-2,566.20
0505	FINES AND FORFEITS	5,000.00	85,500.00	136,085.00	50,585.00	4,500.00	10,117.00
0605	INTEREST AND INVESTMENTS	198.55	6,225.18	7,890.00	1,664.82	327.64	332.96
0975	OTHER REVENUE	904.57	32,426.63	24,447.00	-7,979.63	1,706.66	-1,595.93
		134,834.62	2,030,864.81	2,560,805.00	529,940.19	106,887.62	105,988.04

TRANSFER OUT

<u>Budget Obj</u>	<u>Budget Obj Title</u>	<u>Monthly Activity</u>	<u>Biennium to Date Activity</u>	<u>Financial Plan</u>	<u>Unobligated Plan</u>	<u>Monthly Avg to Date</u>	<u>Monthly Avg to Spend</u>
2443	TRANSFER OUT TO OREGON HEALTH AUTHORITY	1,350.00	109,255.00	215,500.00	106,245.00	5,750.26	21,249.00
		1,350.00	109,255.00	215,500.00	106,245.00	5,750.26	21,249.00

PERSONAL SERVICES

<u>Budget Obj</u>	<u>Budget Obj Title</u>	<u>Monthly Activity</u>	<u>Biennium to Date Activity</u>	<u>Financial Plan</u>	<u>Unobligated Plan</u>	<u>Monthly Avg to Date</u>	<u>Monthly Avg to Spend</u>
3110	CLASS/UNCLASS SALARY & PER DIEM	37,757.00	726,574.88	940,701.00	214,126.12	36,240.78	42,825.22
3160	TEMPORARY APPOINTMENTS	0.00	0.00	15,434.00	15,434.00	0.00	3,066.80
3170	OVERTIME PAYMENTS	1,056.47	7,702.03	13,384.00	5,681.97	405.37	1,136.39
3180	SHIFT DIFFERENTIAL	10.31	130.50	114.00	-16.50	6.87	-3.30
3210	ERB ASSESSMENT	6.60	155.10	212.00	56.90	8.16	11.38
3220	PUBLIC EMPLOYEES' RETIREMENT SYSTEM	5,350.86	104,913.19	133,173.00	28,259.81	5,521.75	5,651.96
3221	PENSION BOND CONTRIBUTION	2,290.05	44,807.04	52,001.00	7,193.96	2,358.27	1,438.79
3230	SOCIAL SECURITY TAX	2,915.81	55,332.44	73,795.00	18,462.56	2,912.23	3,692.51
3250	WORKERS' COMPENSATION ASSESSMENT	15.97	389.12	434.00	44.88	20.48	8.98
3260	MASS TRANSIT	205.06	4,046.98	5,414.00	1,367.02	213.00	273.40
3270	FLEXIBLE BENEFITS	7,488.29	162,202.72	209,350.00	47,147.28	8,536.99	9,429.46
		57,096.22	1,106,254.00	1,444,012.00	337,758.00	58,223.89	67,551.60

SERVICES and SUPPLIES

<u>Budget Obj</u>	<u>Budget Obj Title</u>	<u>Monthly Activity</u>	<u>Biennium to Date Activity</u>	<u>Financial Plan</u>	<u>Unobligated Plan</u>	<u>Monthly Avg to Date</u>	<u>Monthly Avg to Spend</u>
4100	INSTATE TRAVEL	1,428.34	43,545.28	55,994.00	12,448.72	2,291.86	2,489.74
4125	OUT-OF-STATE TRAVEL	2,241.20	32,289.79	23,487.00	-8,802.79	1,699.46	-1,760.56
4150	EMPLOYEE TRAINING	0.00	6,595.00	8,877.00	2,282.00	347.11	456.40
4175	OFFICE EXPENSES	1,822.04	73,772.53	86,657.00	12,884.47	3,862.76	2,576.89

Budget Obj	Budget Obj Title	Monthly Activity	Biennium to Date Activity	Financial Plan	Unobligated Plan	Monthly Avg to Date	Monthly Avg to Spend
4200	TELECOMM/TECH SVC AND SUPPLIES	1,193.83	21,616.99	26,077.00	4,460.01	1,137.74	892.00
4225	STATE GOVERNMENT SERVICE CHARGES	-1,692.55	70,025.25	75,916.00	5,890.75	3,685.54	1,176.15
4250	DATA PROCESSING	39.74	3,730.14	4,702.00	971.86	196.32	194.37
4275	PUBLICITY & PUBLICATIONS	1,125.62	21,247.89	22,866.00	1,618.11	1,118.31	323.62
4300	PROFESSIONAL SERVICES	10,423.50	129,997.70	104,922.00	-25,075.70	6,841.98	-5,015.14
4315	IT PROFESSIONAL SERVICES	0.00	19,045.00	22,503.00	3,458.00	1,002.37	691.60
4325	ATTORNEY GENERAL LEGAL FEES	12,814.80	124,592.13	176,916.00	52,323.87	6,557.48	10,464.77
4400	DUES AND SUBSCRIPTIONS	59.95	9,908.80	10,888.00	979.20	521.52	195.84
4425	FACILITIES RENT & TAXES	6,277.92	139,213.80	152,950.00	13,736.20	7,327.04	2,747.24
4475	FACILITIES MAINTENANCE	0.00	5,154.95	877.00	-4,277.95	271.31	-855.59
4575	AGENCY PROGRAM RELATED SVCS & SUPP	818.97	88,337.78	104,286.00	15,948.22	4,649.36	3,189.64
4650	OTHER SERVICES AND SUPPLIES	1,005.45	39,212.18	48,577.00	7,364.82	2,063.80	1,472.96
4700	EXPENDABLE PROPERTY \$250-\$5000	0.00	2,980.66	1,782.00	-1,198.68	156.88	-239.73
4715	IT EXPENDABLE PROPERTY	0.00	6,780.42	6,411.00	-369.42	356.86	-73.88
		37,558.91	838,046.29	932,688.00	94,641.71	44,107.70	18,928.34

SPECIAL PAYMENTS

Budget Obj	Budget Obj Title	Monthly Activity	Biennium to Date Activity	Financial Plan	Unobligated Plan	Monthly Avg to Date	Monthly Avg to Spend
6443	DIST TO OREGON HEALTH AUTHORITY	0.00	142,651.00	230,216.00	87,565.00	7,507.95	17,513.00
		0.00	142,651.00	230,216.00	87,565.00	7,507.95	17,513.00

SUMMARY TOTALS

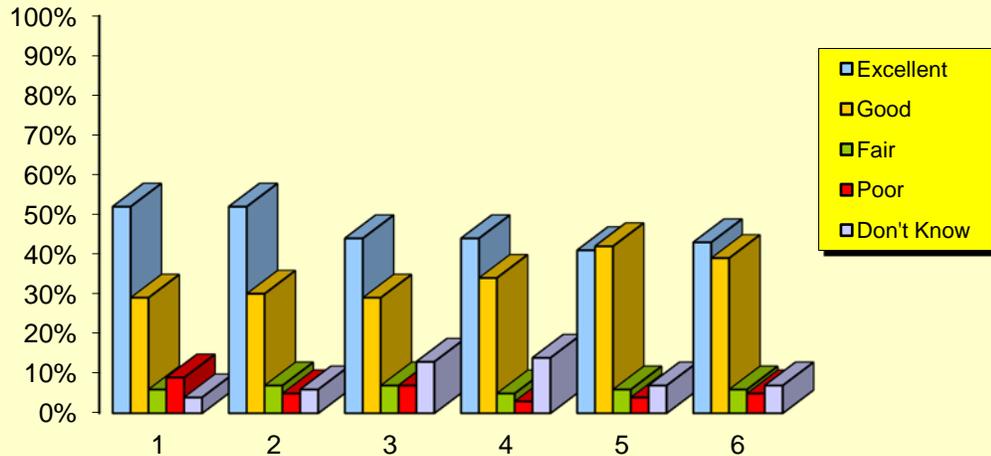
3400
BOARD OF DENTISTRY

		Month Activity	Biennium Activity
REVENUES	REVENUE	134,834.62	2,030,864.81
	Total	134,834.62	2,030,864.81
TRANSFER OUT	TRANSFER OUT	1,350.00	109,255.00
	Total	1,350.00	109,255.00
SPECIAL PAYMENTS	SPECIAL PAYMENTS	0.00	142,651.00
	Total	0.00	142,651.00
EXPENDITURES	PERSONAL SERVICES	57,096.22	1,108,254.00
	SERVICES AND SUPPLIES	37,558.91	838,046.29
	Total	94,655.13	1,944,300.29

Oregon Board of Dentistry

Customer Service Survey

July 1, 2014 - November 30, 2014



- 1 How do you rate the timeliness of the services provided by the OBD?
E= 52% G= 29% F= 6% P= 9% DK= 4%
- 2 How do you rate the ability of the OBD to provide services correctly the first time?
E= 52% G= 30% F= 7% P= 5% DK= 6%
- 3 How do you rate the helpfulness of the OBD?
E= 44% G= 29% F= 7% P= 7% DK= 13%
- 4 How do you rate the knowledge and expertise of the OBD?
E= 44% G= 34% F= 5% P= 3% DK= 14%
- 5 How do you rate the availability of information at the OBD?
E= 41% G= 42% F= 6% P= 4% DK= 7%
- 6 How do you rate the overall quality of services provided by the OBD?
E= 43% G= 39% F= 6% P= 5% DK= 7%

OREGON BOARD OF DENTISTRY
2015 - 2017 BUDGET PRESENTATION

Joint Ways and Means Subcommittee on Education
February 19, 2015

Presented by:
Stephen Prisby, Interim Executive Director
Alton Harvey, Sr., OBD Vice-President
Paul H. Kleinstub, DDS, Dental Director/Chief Investigator

**OREGON BOARD OF DENTISTRY
2015-2017 Budget Presentation**

Joint Way and Means Subcommittee on Education

AGENCY OVERVIEW

The Board of Dentistry was established in 1887 to regulate the practice of Dentistry. In 1946, Dental Hygiene was established as a licensed profession in Oregon and added to the purview of the Board.

There are ten members appointed to this policymaking Board and seven permanent full-time staff. The ten Board members include six dentists, one of whom must be a specialist, two dental hygienists and two public members. Members of the Board are appointed by the Governor and confirmed by the Senate.

The Board's highest priorities are the enforcement, monitoring, licensing and examination of Dentists and Dental Hygienists in Oregon.

The Board's identified goal is to protect the public from unsafe, incompetent or fraudulent practitioners; encourage licensees to practice safely and competently in the best interests of their patients; and educate the public on acceptable and appropriate dental practices.

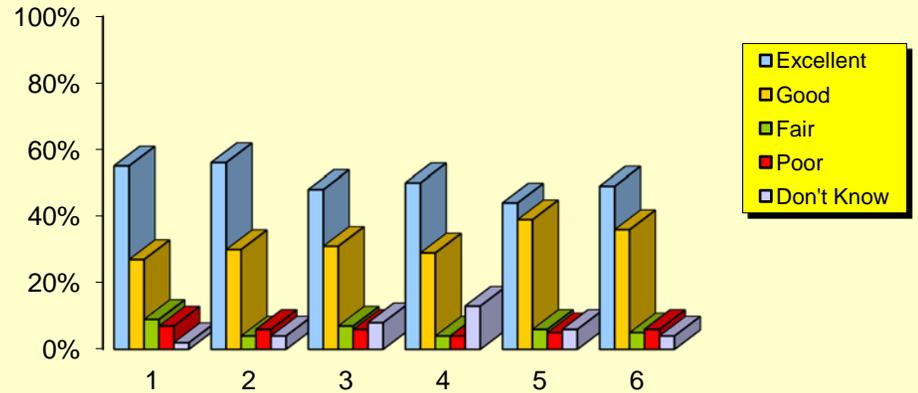
The Board is supported solely from application and license renewal fees, permit fees, miscellaneous receipts, penalty fees for late renewals and civil penalties. 95% of this revenue is from licensee and permit fees. The Board last raised fees in 2009.

AGENCY PERFORMANCE OVERVIEW

**OREGON BOARD OF DENTISTRY
ANNUAL PERFORMANCE PROGRESS REPORT 2014**

Performance Measure Definition	2014 Goal	2014 Performance
#1 Percent of licensees in compliance with continuing education requirements	100%	100%
#2 Average time from receipt of a new complaint to completed investigation (ready to be submitted to the Board)	3.5 months	Cases opened and investigations completed during the period 7/1/2013 through 6/30/2014. 10.0 months
#3 Average Number of working days for the receipt of completed paperwork to issuance of license (new or renewal)	7 Days	7 Days
#4 Agency Overall Satisfaction – Percent of customers rating their overall satisfaction with the agency above average or excellent.	85% Positive Response	85% Positive Response
#5 Board Best Practices – Percent of total of best practices met by Board.	100%	100%

Oregon Board of Dentistry Customer Service Survey July 1, 2013 - June 30, 2014



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

E= 55% G= 27% F= 9% P= 7% DK= 2%

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

E= 56% G= 30% F= 4% P= 6% DK= 4%

3 How do you rate the helpfulness of the OBD?

E= 48% G= 31% F= 7% P= 6% DK= 8%

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

E= 50% G= 29% F= 4% P= 4% DK= 13%

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

E= 44% G= 39% F= 6% P= 5% DK= 6%

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

E= 49% G= 36% F= 5% P= 6% DK= 4%

PROGRAM PRIORITIES

The Board's three major areas of service are:

- **Licensing and Examination**

The Board licenses dentists and dental hygienists, conducts examination for eight different specialties, establishes standards for the use of anesthesia in dental offices, issues four levels of anesthesia permits, and certifies dental assistants. Background checks are conducted on all new applicants. As described previously, applicants must pass a written national examination; a clinical examination conducted by a dental testing agency recognized by the Board, and passes the Board's Jurisprudence examination. 15% of all licensees renewing their licenses each year are audited for compliance with the Board's Continuing Education requirements.

There are currently approximately 3804 licensed dentists and 4226 licensed dental hygienists. We anticipate issuing about 800 new licenses this biennium almost equally divided between dentists and dental hygienists. However, this increase does not translate into a lot more practitioners available to serve the public because of retirements, licenses that are allowed to lapse for any number of reasons and practitioners moving out of state. The Board offers licensure through examination; by credential; and for dental specialists, the ability to be examined by the Board in the particular specialty and then the license is limited to that special area of expertise; i.e., Oral and Maxillofacial Surgery, or Pediatric Dentistry. Applicants for a general dental license or a dental hygiene license must pass a written examination, called the "National Boards," which is conducted by the American Dental Association, Commission on Dental Education. Applicants must also pass a clinical examination conducted by any state or regional testing agency.

The table below shows the historical and projected workload for the agency in this activity.

Licensing and Examination Workload	2003-05 Actual	2005-07 Actual	2007-09 Actual	2009-11 Actual	2011-13 Actual	2013 – 2015 Est.
Licenses Issued:						
Dental	311	350	355	305	340	360
Dental Hygiene	294	335	375	434	450	550
Total New Licenses Issued:	616	685	731	739	790	910
Licenses Renewed:						
Dental	3254	3300	3325	3389	3400	3556
Dental Hygiene	3180	3265	3386	3613	3700	3684
Total Licenses Renewed:	6434	6595	6712	7002	7100	7240
Specialty Examinations Conducted	9	5	3	3	3	3
Candidates Examined	7	5	3	5	3	3
Anesthesia Permits Issued/Renewed	3795	3969	3750	4359	4400	4534
Dental Assistants Certified	1751	2260	2449	2638	2650	2500
Dental Assisting Instructor Permits Issued/Renewed	102	124	106	110	125	83
Limited Access Dental Hygiene Permits Issued/Renewed	59	67	84	171	300	40

- Enforcement and Monitoring

The Board conducts investigations of complaints filed with the Board alleging unacceptable patient care or other issues ranging from unprofessional conduct, improper prescribing practices, substance abuse, unauthorized use of auxiliaries, advertising or disciplinary action in another state. The majority of cases involve allegations of unacceptable patient care. Investigations are also conducted based on reports of malpractice claims that are submitted by insurance companies. Disciplinary actions are reported to the National Practitioners Data Bank and to the Healthcare Integrity and Protection Data Bank. Licensees under disciplinary sanction are actively monitored to assure their compliance with the terms of their Order including licensees with substance abuse issues who have long-term treatment and recovery needs.

There are usually 50 licensees being monitored on a regular basis. During calendar year 2014 the Board received 249 complaints closed 228 case investigations. Disposition of those cases are shown in the table below:

Dismissed	125	55%
Letter of Concern	63	28%
Disciplinary Actions	40	18%

Disciplinary actions in 2014 included:

- Revocation – 0
- Voluntary resignation – 0
- Suspension – 2
- Restrictions on practice – 1
- Reprimand – 29
- Civil Penalty/Restitution – 13
- Education/Training – 9
- Evaluation/Treatment Monitoring – 0

(There is typically more than one type of discipline incorporated in a disciplinary action; i.e. reprimand, civil penalty and community service is the standard discipline for working without a current license or allowing a person to perform duties for which they do not hold the appropriate license or permit.)

- Administration

Administrative activities include implementation of Board policy, communication and collaboration with the professional associations, the School of Dentistry and other educational programs, related licensing agencies such as the Board of Pharmacy, the Board of Medical Examiners and the Board of Denture Technology in addition to State Boards of Dentistry in other states. Administration also includes legislative activities, budget development and monitoring, and staffing. A major component of Administration is carrying out the Board's primary goal of communicating with licensees and the public. This includes maintenance of a web site, production of two newsletters per year, and scheduling and presenting information to students, licensees and the public about the Board and its activities.

Agency plans for accomplishment of its goals for 2015-2017 include:

- Continue to promote and encourage participation in the Statewide HPSP diversion program for licensees with substance abuse addictions.
- Continue to promote and encourage participation in the volunteer Dentist/Dental Hygienist program to increase access to quality dental care.
- Continue to use OBD/OAGD Mentoring Program as one avenue to resolve disciplinary cases.
- Continue to promote the Oregon Prescription Drug Monitoring Program to all licensees.
- Review Specialty Examination process to assure exams are valid and reliable.
- Utilize the website, newsletter and personal presentations to communicate Board policies and expectations.
- Refine On-line renewal process.
- Fully implement use of electronic forms of Payments.
- Continue to collect data on the ethnic and racial makeup of licensees and work with policy makers, educators, and students to encourage a representative diversity in the dental workforce.
- Refine participation in the Health Care Workforce Initiative project to address the issues of health care workforce shortages and access to care.
- Continue the implementation of more electronic media for communication and Board functions.

POLICY OPTION PACKAGES:

Package 100 Increase in O/S Travel Limitation for National Meetings

\$30,000

- The purpose of this package is to rectify and accounting issue that was presented by the OBD Accountants at the Department of Administrative Services.

How Achieved: National Organizations have in the past reimbursed the OBD for travel expenses and per diem for staff and board members and the money was recorded as a return of expenses, the accountants have now required since this is an ongoing expense and reimbursement that it should be budgeted as a revenue and expense item.

Staffing Impact: None

Services and Supplies: Increased by \$30,000.00

Revenue Source: National Organizations that Reimburse the OBD for travel expenses and per diem.

Package 101 Dental Health Investigator Position

\$273,481

- The purpose of this package is to allow the Board to hire an additional 1.0 FTE Dental Investigator. For the past 20 years the Board has hired independent contractor dental consultant investigators on a part-time basis to assist with the investigation of dental cases, this process has simply not been able to keep up with the number of complaints as well as the complexity of those complaints. The current Board Dental Investigator who is the Chief Investigator has been with the Board for 24 years and is expected to retire within the next few years and a new person will need to be brought in and be trained so that a seasoned dental investigator will be available.

How Achieved: The Oregon Board of Dentistry will promulgate rules to raise fees effective July 1, 2015: Dental License fees will be increased from \$315.00 to \$390.00 and Dental Hygiene License Fees will be increased from \$155.00 to \$230.00

Staffing Impact: 1.0 FTE increased.

Services and Supplies: None

Revenue Source: License Fees for Dentists and Dental Hygienists will be increased by \$75.00 per licensee.

Package 103 Fee Increase

\$586,260.00

- The purpose of this package is to provide for the funding to cover the cost of hiring an additional Dental Investigator.

How Achieved: The Oregon Board of Dentistry will promulgate rules to raise fees effective July 1, 2015: Dental License fees will be increased from \$315.00 to \$390.00 and Dental Hygiene License Fees will be increased from \$155.00 to \$230.00.

Staffing Impact: None

Services and Supplies: None

Revenue Source: License Fees for Dentists and Dental Hygienists will be increased by \$75.00 per licensee.

AGENCY CHALLENGES For 2015 – 2017 and Beyond:

- Reducing the complaint investigation backlog.
- Filling the vacant Executive Director position.
- Filling the new full time dentist investigator position with a competent candidate and then training that new individual.
- Fulfilling the already scheduled Board outreach events.
- Staffing changes within the next few years – (four of the seven positions are within retirement).

STANDARD PROTOCOLS FOR GENERAL CONSENT ORDERS

CIVIL PENALTIES

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

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

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

RESTITUTION PAYMENTS

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

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

REIMBURSEMENT PAYMENTS

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

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

CONTINUING EDUCATION – BOARD ORDERED

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

COMMUNITY SERVICE

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

FALSE CERTIFICATION OF CONTINUING EDUCATION

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

WORKING WITHOUT A CURRENT LICENSE

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

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

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

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

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

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

FAILURE TO CONDUCT WEEKLY BIOLOGICAL TESTING OF STERILIZATION DEVICES

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

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

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

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

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

STANDARD PROTOCOLS FOR CONSENT ORDERS SPECIFICALLY RELATED TO ALCOHOL ABUSE

ALCOHOL

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

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

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

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

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

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

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

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

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

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

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

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

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

STANDARD PROTOCOLS FOR CONSENT ORDERS SPECIFICALLY RELATED TO SUBSTANCE ABUSE

DRUGS

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

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

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

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

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

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

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

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

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

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

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

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

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

IF APPROPRIATE –

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

Licensee shall immediately begin using pre-numbered triplicate prescription pads for prescribing controlled substances. Said prescription pads will be provided to the Licensee, at his/her expense, by the Board. Said prescriptions shall be used in their numeric order. Prior to the 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

Stephen Prisby

From: Paul Kleinstub
Sent: Thursday, February 12, 2015 7:42 AM
To: Stephen Prisby
Subject: RE: HB 2972

Oral Health Screening Policy

2003 House Bill 3157, which was passed by the Legislature and signed into law by the Governor, allowed the Oregon Board of Dentistry (OBD) to develop written training and screening protocols so dental hygienists and dental assistants could independently perform Oral Health Screenings in Oregon.

The OBD on January 23, 2004 determined that no additional training was necessary for Oregon Dental Hygienists or Oregon Dental Assistants.

The OBD adopted specific language that must be on any Oral Health Screening Form that would be given to individuals or parents or guardians of minors who would be screened.

The following is the language and would need to be on any Oral Health Screening Form that would be used by any Oregon Dental Hygienist or Dental Assistant in compliance with Oregon Law.

This language was revised on March 1, 2006.

This is an oral health screening for _____.
A screening is just a quick look and does not take the place of a thorough examination by a dentist. Serious oral health problems may be missed in a screening. The person doing the screening may or may not have any dental training. *[Dental Hygienists or Dental Assistants may omit the previous sentence.]*

- No visible signs of oral problems. See your dentist at least yearly.
- Visible signs of oral problems were found. A visit to a dentist is recommended to prevent serious or more costly problems.
- Visible signs or symptoms of serious dental needs were found. An immediate visit to a dentist is recommended.

The Board encourages others who may do Oral Health Screenings to use this language on their screening forms.

If you have questions regarding this Oral Health Screening Policy, please feel free to contact the OBD at (971) 673-3200.

From: Stephen Prisby
Sent: Thursday, February 12, 2015 7:35 AM
To: Paul Kleinstub
Subject: FW: HB 2972

From: KRUSKA Mitch [<mailto:mitch.kruska@state.or.us>]
Sent: Wednesday, February 11, 2015 4:06 PM
To: Stephen Prisby
Subject: HB 2972

Stephen,

I am writing to seek your assistance with the analysis of HB 2972, which creates a new requirement that all schools in the state conduct dental screenings on all students 7 years of age and younger. This would be a new mandate and ODE was hoping you could assist us in identifying what an appropriate screening method would be, who would be potentially qualified to do such a screening, or how would we go about developing a training to get school staff trained to do an appropriate

screening. I understand you are probably not the person who will assist in answering these questions, but I am hoping you will direct me to the person who could assist. Thanks!!

Mitch Kruska-

Director
Education Programs, Secondary Transition & Assessment
Oregon Department of Education
Office of Learning | Student Services Unit
☎ 503.947.5634 | 📠 971-273-9170 | ✉ mitch.kruska@state.or.us

"Ultimately our worth can only be determined by how much we value ourselves"

The Oregon Department of Education is an equal opportunity agency and employer.
Messages to and from this e-mail address may be made available to the public under Oregon law.

House Bill 2972

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

SUMMARY

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

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

Declares emergency, effective on passage.

A BILL FOR AN ACT

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

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

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

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

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

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

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

12 (D) **A school nurse, an employee of an education provider or a person designated by the**
13 **Department of Education to provide dental screening to students who is acting in accordance**
14 **with rules adopted by the board.**

15 (b) **“Education provider” means:**

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

18 (B) **A school district board.**

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

23 (b) **The certification required by this subsection must be provided no later than 120 days**
24 **after the student begins the educational program.**

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

28 (a) **The student submitted certification to a prior education provider; or**

29 (b) **The dental screening is contrary to the religious beliefs of the student or the parent**
30 **or guardian of the student.**

31 (4) **Each education provider shall:**

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

1 (a) Ensure that the requirements of this section are met. Failure by a student to meet
 2 the requirements of this section may not result in a program's or school's prohibiting the
 3 student from attending the program or school, but may result in withholding report cards
 4 or similar actions.

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

7 (c) Provide the parent or guardian of each student with information about:

8 (A) The dental screenings;

9 (B) Further examinations or necessary treatments; and

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

11 (5) The State Board of Education, in consultation with the Oregon Health Policy Board,
 12 shall adopt by rule any standards for the implementation of this section.

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

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

15 **SECTION 3.** The State Board of Education, in consultation with the Oregon Health Policy
 16 Board, may adopt rules or take any action before the operative date specified in section 2
 17 of this 2015 Act that is necessary to enable the board to exercise, on or after the operative
 18 date specified in section 2 of this 2015 Act, all the duties, functions and powers conferred on
 19 the board by section 1 of this 2015 Act.

20 **SECTION 4.** (1) No later than October 1, 2017, each school district shall submit to the
 21 Department of Education a report that identifies the percentage of students required to
 22 submit certification under section 1 of this 2015 Act who did submit certification for the
 23 2016-2017 school year.

24 (2) No later than December 1, 2017, the department shall summarize the reports received
 25 under subsection (1) of this section and submit that summary to the interim legislative
 26 committees on education.

27 **SECTION 5.** ORS 326.580 is amended to read:

28 326.580. (1) As used in this section, "educational institution" means:

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

30 (b) A state agency.

31 (c) A local correctional facility.

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

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

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

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

45 (a) Shall not be required to forward by mail or other means physical items such as original

1 documents or photocopies to a receiving educational institution that also is approved for partic-
2 ipation in the program. This paragraph does not apply to special education records that are specif-
3 ically required by federal law to be physically transferred.

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

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

6 **SECTION 6.** ORS 680.020 is amended to read:

7 680.020. (1) It is unlawful for any person not otherwise authorized by law to practice dental
8 hygiene or purport to be a dental hygienist without a valid license to practice dental hygiene issued
9 by the Oregon Board of Dentistry.

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

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

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

22 (c) Bona fide students of dental hygiene who engage in community-based or clinical studies as
23 an elective or required rotation in a clinical setting located in Oregon during the period of their
24 enrollment and as a part of the course of study in a dental hygiene education program located out-
25 side of Oregon. The program must be accredited by the Commission on Dental Accreditation of the
26 American Dental Association or its successor agency. The community-based or clinical studies must:

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

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

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

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

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

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

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

45 (i) Counselors and health assistants who have been trained in the application of fluoride

1 varnishes to the teeth of children and who apply fluoride varnishes only to the teeth of children
2 enrolled in or receiving services from the Women, Infants and Children Program, the Oregon
3 prekindergarten program or a federal Head Start grant program.

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

6 [(j)] **(k)** Dental hygienists licensed in another state and in good standing, while practicing dental
7 hygiene without compensation for no more than five consecutive days in any 12-month period, pro-
8 vided the dental hygienist submits an application to the [board] **Oregon Board of Dentistry** at least
9 10 days before practicing dental hygiene under this paragraph and the application is approved by
10 the board.

11 **SECTION 7. This 2015 Act being necessary for the immediate preservation of the public**
12 **peace, health and safety, an emergency is declared to exist, and this 2015 Act takes effect**
13 **on its passage.**

Senate Bill 301

Sponsored by Senators GIROD, MONNES ANDERSON (Pre-session filed.)

SUMMARY

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

Specifies which services to be performed by expanded practice dental hygienist must be included in agreement between expanded practice dental hygienist and dentist.

Declares emergency, effective on passage.

A BILL FOR AN ACT

1
2 Relating to expanded practice dental hygienists; creating new provisions; amending ORS 680.205; and
3 declaring an emergency.

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

5 **SECTION 1.** ORS 680.205 is amended to read:

6 680.205. (1) An expanded practice dental hygienist may render all services within the scope of
7 practice of dental hygiene, as defined in ORS 679.010, without the supervision of a dentist and as
8 authorized by the expanded practice dental hygienist permit to:

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

11 (A) Nursing homes as defined in ORS 678.710;

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

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

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

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

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

17 (G) Facilities for persons with developmental disabilities, as those terms are defined in ORS
18 427.005;

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

23 (I) Public and nonprofit community health clinics.

24 (b) Adults who are homebound.

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

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

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

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

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

3 (2) At least once each calendar year, an expanded practice dental hygienist shall refer each
4 patient or resident to a dentist who is available to treat the patient or resident.

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

10 (a) Administering local anesthesia;

11 (b) Administering temporary restorations without excavation; **and**

12 (c) Prescribing prophylactic antibiotics and nonsteroidal anti-inflammatory drugs specified in the
13 agreement[; and].

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

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

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

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

22 **SECTION 2. Section 1 of this 2015 Act applies to agreements entered into on or after the**
23 **effective date of this 2015 Act.**

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

27

Senate Bill 302

Sponsored by Senator GIROD (Pre-session filed.)

SUMMARY

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

Clarifies that practice of dentistry includes prescribing, dispensing and administering prescription drugs for purposes related to dentistry. Defines "dental hygiene" to include prescribing, dispensing and administering prescription drugs for purposes related to dental hygiene.

Declares emergency, effective on passage.

A BILL FOR AN ACT

1
2 Relating to prescription drugs used for purposes related to dentistry; amending ORS 679.010; and
3 declaring an emergency.

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

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

6 679.010. As used in this chapter and ORS 680.010 to 680.205, unless the context requires other-
7 wise:

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

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

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

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

17 (c) **Prescribing, dispensing and administering prescription drugs for the services de-**
18 **scribed in paragraphs (a) and (b) of this subsection.**

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

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

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

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

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

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

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

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

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

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

11 (B) Post-graduate training programs; or

12 (C) Continuing education courses.

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

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

19 (10) “General supervision” means supervision requiring that a dentist authorize the procedures
20 by standing orders, practice agreements or collaboration agreements, but not requiring that a den-
21 tist be present when the authorized procedures are performed. The authorized procedures may also
22 be performed at a place other than the usual place of practice of the dentist.

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

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

28

Senate Bill 474

Sponsored by Senator GELSER (Pre-session filed.)

SUMMARY

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

Allows certain nonprofit charitable corporations to own and operate dental clinics that serve children with special needs.

Declares emergency, effective on passage.

A BILL FOR AN ACT

1
2 Relating to dental business entities for children with special needs; amending ORS 679.020; and de-
3 claring an emergency.

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

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

6 679.020. (1) A person may not practice dentistry without a license.

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

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

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

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

18 (c) Public universities listed in ORS 352.002.

19 (d) Local governments.

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

22 (f) Nonprofit corporations organized under Oregon law to provide dental services to rural areas
23 and medically underserved populations of migrant, rural community or homeless individuals under
24 42 U.S.C. 254b or 254c or health centers qualified under 42 U.S.C. 1396d(l)(2)(B) operating in com-
25 pliance with other applicable state and federal law.

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

30 **(h) Nonprofit charitable corporations as described in section 501(c)(3) of the Internal**
31 **Revenue Code and determined by the Oregon Board of Dentistry as having an existing pro-**

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

1 **gram that provides medical and dental care to medically underserved children with special**
2 **needs.**

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

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

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

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

11 (C) The treatment plan of any dental patient.

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

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

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

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

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

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

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

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

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

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

30 (c) Management of the business aspects of a dental office or clinic that do not include the clin-
31 ical practice of dentistry.

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

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

42

Senate Bill 662

Sponsored by Senator GIROD

SUMMARY

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

Requires that dental instructor's license issued to specialist be restricted to specialty for which applicant completed advanced dental education program.

A BILL FOR AN ACT

1
2 Relating to dental instructor licensing; creating new provisions; and amending ORS 679.115.

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

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

5 679.115. (1) Notwithstanding any other provision of this chapter, the Oregon Board of Dentistry
6 shall issue a dental instructor's license to practice dentistry to any person who furnishes the board
7 with evidence satisfactory to the board that the applicant meets the requirements of subsection (2)
8 of this section.

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

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

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

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

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

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

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

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

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

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

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

31 (4) A person issued a dental instructor's license is restricted to the practice of dentistry for or

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

1 on behalf of Oregon Health and Science University.

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

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

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

10

House Bill 2683

Sponsored by Representative GILLIAM; Representative CLEM (Pre-session filed.)

SUMMARY

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

Requires Oregon Board of Dentistry, upon request of individual who has been disciplined by board, to remove from its website and other publicly accessible print and electronic publications information related to disciplining individual if individual meets certain criteria.

Declares emergency, effective on passage.

A BILL FOR AN ACT

1
2 Relating to dentistry; and declaring an emergency.

3 Whereas the Oregon Board of Dentistry is responsible for the licensure and discipline of dental
4 professionals in this state; and

5 Whereas collaboration between the Oregon Board of Dentistry and other medical professional
6 boards in this state fosters productive and equitable discipline procedures among all medical pro-
7 fessions; and

8 Whereas communication between the Oregon Board of Dentistry and the Legislative Assembly
9 should be encouraged; now, therefore,

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

11 **SECTION 1.** Section 2 of this 2015 Act is added to and made a part of ORS chapter 679.

12 **SECTION 2.** (1) Upon the request of an individual who has been disciplined by the Oregon
13 Board of Dentistry, the board shall remove from its website and other publicly accessible
14 print and electronic publications under the board's control all information related to disci-
15 plining the individual under ORS 679.140 and any findings and conclusions made by the board
16 during the disciplinary proceeding, if:

17 (a) The request is made 10 years or more after the date on which any disciplinary sanc-
18 tion ended;

19 (b) The individual was not disciplined for financially or physically harming a patient;

20 (c) The individual informed the board of the matter for which the individual was disci-
21 plined before the board received information about the matter or otherwise had knowledge
22 of the matter;

23 (d) The individual making the request, if the individual is or was a licensee, otherwise
24 remained in good standing with the board following the imposition of the disciplinary sanc-
25 tion; and

26 (e) The individual fully complied with all disciplinary sanctions imposed by the board.

27 (2) The board shall adopt by rule a process for making a request under this section.

28 **SECTION 3.** As soon as practicable after the effective date of this 2015 Act, the Oregon
29 Board of Dentistry shall:

30 (1) Provide notice to each individual licensed by the board under ORS chapter 679 of the

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

1 **process for making a request described in section 2 of this 2015 Act; and**

2 **(2) Provide public notice of the process for making a request under section 2 of this 2015**
3 **Act.**

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

7

House Bill 2972

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

SUMMARY

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

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

Declares emergency, effective on passage.

A BILL FOR AN ACT

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

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

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

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

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

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

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

12 (D) **A school nurse, an employee of an education provider or a person designated by the**
13 **Department of Education to provide dental screening to students who is acting in accordance**
14 **with rules adopted by the board.**

15 (b) **“Education provider” means:**

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

18 (B) **A school district board.**

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

23 (b) **The certification required by this subsection must be provided no later than 120 days**
24 **after the student begins the educational program.**

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

28 (a) **The student submitted certification to a prior education provider; or**

29 (b) **The dental screening is contrary to the religious beliefs of the student or the parent**
30 **or guardian of the student.**

31 (4) **Each education provider shall:**

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

1 (a) Ensure that the requirements of this section are met. Failure by a student to meet
 2 the requirements of this section may not result in a program's or school's prohibiting the
 3 student from attending the program or school, but may result in withholding report cards
 4 or similar actions.

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

7 (c) Provide the parent or guardian of each student with information about:

8 (A) The dental screenings;

9 (B) Further examinations or necessary treatments; and

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

11 (5) The State Board of Education, in consultation with the Oregon Health Policy Board,
 12 shall adopt by rule any standards for the implementation of this section.

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

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

15 **SECTION 3.** The State Board of Education, in consultation with the Oregon Health Policy
 16 Board, may adopt rules or take any action before the operative date specified in section 2
 17 of this 2015 Act that is necessary to enable the board to exercise, on or after the operative
 18 date specified in section 2 of this 2015 Act, all the duties, functions and powers conferred on
 19 the board by section 1 of this 2015 Act.

20 **SECTION 4.** (1) No later than October 1, 2017, each school district shall submit to the
 21 Department of Education a report that identifies the percentage of students required to
 22 submit certification under section 1 of this 2015 Act who did submit certification for the
 23 2016-2017 school year.

24 (2) No later than December 1, 2017, the department shall summarize the reports received
 25 under subsection (1) of this section and submit that summary to the interim legislative
 26 committees on education.

27 **SECTION 5.** ORS 326.580 is amended to read:

28 326.580. (1) As used in this section, "educational institution" means:

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

30 (b) A state agency.

31 (c) A local correctional facility.

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

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

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

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

45 (a) Shall not be required to forward by mail or other means physical items such as original

1 documents or photocopies to a receiving educational institution that also is approved for partic-
2 ipation in the program. This paragraph does not apply to special education records that are specif-
3 ically required by federal law to be physically transferred.

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

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

6 **SECTION 6.** ORS 680.020 is amended to read:

7 680.020. (1) It is unlawful for any person not otherwise authorized by law to practice dental
8 hygiene or purport to be a dental hygienist without a valid license to practice dental hygiene issued
9 by the Oregon Board of Dentistry.

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

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

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

22 (c) Bona fide students of dental hygiene who engage in community-based or clinical studies as
23 an elective or required rotation in a clinical setting located in Oregon during the period of their
24 enrollment and as a part of the course of study in a dental hygiene education program located out-
25 side of Oregon. The program must be accredited by the Commission on Dental Accreditation of the
26 American Dental Association or its successor agency. The community-based or clinical studies must:

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

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

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

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

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

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

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

45 (i) Counselors and health assistants who have been trained in the application of fluoride

1 varnishes to the teeth of children and who apply fluoride varnishes only to the teeth of children
2 enrolled in or receiving services from the Women, Infants and Children Program, the Oregon
3 prekindergarten program or a federal Head Start grant program.

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

6 [(j)] **(k)** Dental hygienists licensed in another state and in good standing, while practicing dental
7 hygiene without compensation for no more than five consecutive days in any 12-month period, pro-
8 vided the dental hygienist submits an application to the [board] **Oregon Board of Dentistry** at least
9 10 days before practicing dental hygiene under this paragraph and the application is approved by
10 the board.

11 **SECTION 7. This 2015 Act being necessary for the immediate preservation of the public**
12 **peace, health and safety, an emergency is declared to exist, and this 2015 Act takes effect**
13 **on its passage.**

14 _____

House Bill 5014

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

SUMMARY

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

Limits biennial expenditures from fees, moneys or other revenues, including Miscellaneous Receipts, but excluding lottery funds and federal funds, collected or received by Oregon Board of Dentistry.

Declares emergency, effective July 1, 2015.

A BILL FOR AN ACT

1
2 Relating to the financial administration of the Oregon Board of Dentistry; and declaring an emer-
3 gency.

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

5 **SECTION 1. Notwithstanding any other law limiting expenditures, the amount of**
6 **\$3,052,614 is established for the biennium beginning July 1, 2015, as the maximum limit for**
7 **payment of expenses from fees, moneys or other revenues, including Miscellaneous Receipts,**
8 **but excluding lottery funds and federal funds, collected or received by the Oregon Board of**
9 **Dentistry.**

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

13

Note: For budget, see 2015-2017 Biennial Budget

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



Oregon

John A. Kitzhaber, MD, Governor

Board of Nursing
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(971) 673-0685
Fax: (971) 673-0684
Oregon.BN.INFO@state.or.us
www.oregon.gov/OSBN

TO: Oregon State Board of Nursing
FROM: Ruby R. Jason
Executive Director
DATE: 2/2/15
RE: Discussions with Other Regulatory Boards
Regarding Prescriptions of Controlled Substances

- 2/9/15 1155 Wickenhagen
- 2/10/15 1315 RUBY (ASSIST)
WILL GET BACK TO ME

During the public hearings regarding prescriptive authority during the November 2014 Board meeting, there was some discussion about the Board of Nursing (BON) meeting with other Boards to discuss their view of the use of protocols when writing prescriptions for controlled substances.

I invited the Boards of Medicine, Dentistry, and Pharmacy to meet with us to discuss this topic. On December, 22nd, 2014 representatives from these four Boards met at the OSBN building. Sarah Wickenhagen and I represented the BON, Joe Thaler represented the Board of Medicine (BOM), Marcus Watt and Gary Miner represented the Board of Pharmacy (BOP), Harvey Wayson and Paul Kleintraub represented the Board of Dentistry (BOD). Of the representatives attending, Sarah, Joe and Paul are authorized prescribers .

The BON, BOM, and BOP all agreed that the abuse of controlled substances places the public at risk for harm. These Boards have seen an increase in complaints regarding misuse of prescriptive authority (no data currently exists to quantify the increase). The BOD, while acknowledging the information, felt they have not seen an increase. Representatives from the BOP informed the BOD that there is a significant number of patients who get controlled substances from their dentists, then visit their private practitioner, and then obtain more prescriptions from Emergency Department visits.

This began the discussion regarding authorized prescribers utilizing the Prescription Drug Monitoring Program (PDMP) . Joe Thaler, a physician, stated that less than 27% of the authorized prescribers in Oregon access the PDMP prior to writing a prescription for schedule II-IV substances. Other Oregon related information that were discussed:

- There were prescriptions written for over 100,000,000 pills in Oregon in 2013, which equates to about 30 pills for every man, woman and child in the state.
- Oregon leads the nation in the abuse of medications designated as "painkillers"
- The death rate from opioid overdoses has quadrupled between 2002 and 2012.

- Twenty-two states of the Forty –nine states who have a PDMP do have some type of requirement based on patient profile to access the PDMP, Oregon has no requirement for an authorized prescriber to access the PDMP. While no longitudinal data exists to determine if these type of requirements decrease the misuse of these drugs by patients, there is data to support that the number of prescriptions has decreased in states where these requirements are in place.

The group then decided another meeting with more expertise was required. I contacted Rob Bovett who contributed significantly to the effort to get the PDMP legislation passed in Oregon, former Lincoln County District Attorney, and who is currently legal counsel for the Association of Oregon Counties.

A second meeting of the group, including Rob Bovett, was held on January 22, 2015. Rob, still active in policy work particularly peratining to the issue of prescription abuse, presented his agenda for this legislative session (copies will be distributed to the board members during the board meeting).

We discussed the following:

- Rob has worked through the professional organizations to review and gather support for his agenda. Significant pushback from some of the professional organizations has been experienced due to the perceived intrusion of the patient/provider relationship.
- Rob has not previously approached any regulatory board, this has been his first invitation to have a discussion with board staff.
- That there is support at the legislative level for a few of the proposals within the agenda.

The board staff agreed that items 2 through 13 (reference document to be made available to board members) may not be successful as proposed. After much discussion, the group felt that the 1st item on Rob's legislative agenda was something that could possibly be supported by the boards. This item requires the PDMP to be accessed if the patient met specific criteria. The group felt that this could be supported because it:

1. Does not prescribe that a specific prescribing protocol be followed for each and every patient.
2. Provides the authorized prescriber information only, the decision of what to prescribe, how many to prescribe and how often to prescribe is left to the prescriber.

Each Board representative agreed to return to their board to request the following:

1. Does the Board support item# 1 as described in the document? If so,
2. May Rob state to the legislature that the regulatory boards support the concept in item #1?
3. If the Board does not support item #1 does the board want to provide any statements to the legislature regarding the issues of abuse of controlled substances without a specific endorsement to any legislation?

Mandatory Use of Prescription Drug Monitoring Programs FREE

Rebecca L. Haffajee, JD, MPH¹; Anupam B. Jena, MD, PhD^{1,2}; Scott G. Weiner, MD, MPH¹

JAMA. Published online January 26, 2015. doi:10.1001/jama.2014.18514

The United States is in the midst of a prescription opioid overdose and abuse epidemic. The rate of fatal prescription drug overdoses involving opioids almost quadrupled from 1.4 deaths/100,000 people in 1999 to 5.4 deaths/100,000 people in 2011. The rate of emergency department visits involving prescription drug misuse—primarily of opioid, antianxiety, and insomnia medications—more than doubled from 214 visits/100,000 people in 2004 to 458 visits/100,000 people in 2011. Forty-nine states have responded by developing prescription drug monitoring programs (PDMPs), which digitally store controlled substance dispensing information and make those data accessible to prescribers, pharmacies, and law enforcement officials. Although PDMPs are designed to curb opioid overprescribing, prescriber utilization is low. The median PDMP registration rate among licensed prescribers who issue at least 1 controlled-substance prescription is 35%. Furthermore, not all enrolled prescribers regularly use PDMPs.

Consequently, 22 of the 49 states with PDMPs now legally mandate prescribers to query the system before writing for controlled substances with recognized potential for abuse or dependence. These requirements face pushback from prescribers, many of whom consider them to be burdensome incursions into clinical practice. For example, physician and dentist group challenges to the breadth of circumstances proposed for PDMP checks have contributed to a 2-year delay in the final implementation of a legally required mandate in Massachusetts. On the other hand, proponents argue that required PDMP consultation is necessary to change prescribing behavior, citing early evidence from states that have deployed mandates to demonstrate their potential to reduce opioid abuse.

Some studies associate state PDMPs with lower rates of prescription drug abuse and altered prescribing practices, although evidence is mixed and inconclusive. Small (if any) demonstrated effect sizes, a dearth of detailed prescribing data prior to PDMP implementation, and a lack of precision in characterizing interventions in existing studies make attributing significant changes in total opioid prescribing or health outcomes to PDMPs a challenge. Another reason for inconsistent findings may be low and variable prescriber utilization of PDMPs. Prescribers must actually access PDMP data for the systems to have an appreciable effect. In addition, voluntary approaches have self-selection bias: already conscientious opioid prescribers are those likely to use PDMPs.

Clear benefits can derive from increased prescriber participation in PDMPs. When prescribers query the database for a patient's prescription history, they have access to information about the dose, supply, and prescriber of scheduled drugs the patient has filled. With knowledge of this information, practitioners can communicate with patients about their histories, avoid polypharmacy, and refrain from supplying opioids to those who "doctor shop" while comfortably prescribing to those who do not. When a critical mass of prescribers use PDMP information, the collective care each patient receives across providers theoretically can be improved and efficiencies are less likely to be compromised by any one uninformed practitioner. Moreover, prescribers may become accustomed to new practice norms, in which improved information and patient outcomes outweigh perceived burdens associated with checking PDMPs.

But are mandates an effective way to increase PDMP use and improve prescribing outcomes? Twenty states require licensed prescribers to register with the state PDMP. Use mandates go a step further and dictate the circumstances for PDMP queries. Some states require prescribers to access a patient's prescription history in the database if they suspect drug abuse; others rely on objective criteria (eTable in the Supplement). In Kentucky, Tennessee, New York, and Ohio – early adopters of comprehensive use mandates – there were substantial increases in queries and reductions in opioid prescribing following implementation. In New York, Tennessee, and Ohio, there were declines in doctor shopping. Although these results must be rigorously validated, for example, by comparing them to outcomes in states without mandates and controlling for co-interventions, they suggest the potential influence of mandates to reduce unsafe opioid prescribing.

Mandates face significant prescriber opposition across the country. Some objections relate to generic problems with PDMPs that would be exacerbated under a mandate. Prescribers have difficulty obtaining logins, systems can be "down," information is not integrated into clinical workflow, and data are often incomplete. Moreover, minimal guidance exists to assist users in interpreting query results. These drawbacks burden and create ambiguity for physicians and other prescribers.

Other objections are specific to mandating PDMP use. Robust evidence is lacking about how to best target mandates to prescriber types and contexts, which makes defining exemptions a policy challenge. Bluntly framed mandates could require physicians and other prescribers to search PDMPs when not clinically indicated or waste time that could be spent otherwise treating patients. Although mandates are not meant to deter opioid prescribing per se, resistant clinicians may simply decline to prescribe opioids, raise prescribing thresholds, refer patients elsewhere, or substitute to nonmonitored drugs - all of which could compromise appropriate symptom management.

Mandates also can entail substantial punitive consequences for prescribers. Penalties for failure to appropriately use PDMPs range from increased liability risk to loss of licensure or imprisonment – an extraordinary punishment for failing to access a website that may contain information of uncertain value (eTable in the Supplement). Mandates may influence courts to hold physicians negligent – for example, when a patient overdoses and harms herself or a third party – if PDMP data could have raised concerns about abuse and modified prescribing. To allay penalty concerns, about half of states explicitly provide that prescribers are immune from liability for checking or failing to check the PDMP. Whether these immunity grants provide meaningful protection remains to be seen.

Calls for more judicious opioid-prescribing practices and discretionary PDMP use have thus far failed to significantly curtail opioid abuse. Although increasing PDMP use seems crucial, mandates may be only one of several paths forward. Policymakers should seriously explore and evaluate more positive approaches, including pay-for-performance, malpractice discounts, or immunity from liability for prescribers who diligently use the systems.

Prescription drug monitoring program mandates are a proliferating policy tool. It will be critical to strike a balance between addressing legitimate practitioner concerns and retaining features fundamental to mandate efficacy. System imperfections, such as the lack of real-time, interstate data and lack of full integration into clinical workflow, are important drawbacks that should be addressed. However, these limitations do not render PDMPs useless, nor should they block mandates altogether. But PDMPs should enroll prescribers automatically and without difficulty.

Furthermore, mandates should be implemented only when they cover clinically appropriate circumstances and include exceptions similar to those adopted in New York (eTable in the Supplement). Requirements must be evaluated regularly and rigorously. Developing guidance based on available evidence and expert consensus about how to use PDMP data to improve the quality of pain prescribing must also be prioritized. Mandates have potential, but their viability and success will depend on how carefully they are crafted, reviewed, and refined going forward.

Harvey W. Wayson

From: Ruby Jason [ruby.jason@state.or.us]
Sent: Monday, January 05, 2015 2:02 PM
To: Gary Miner; Harvey W. Wayson; Joe Thaler; Marcus Watt; Patrick Braatz; Sarah Wickenhagen
Subject: Input from Rob Bovett regarding our discussion regarding controlled substances

As a result of our meeting on the 22nd of December meeting regarding prescription of Controlled Substances, I contact Rob Bovett regarding his work to bring forward with ever increasing issue throughout Oregon. I asked him if he was involved with the regulatory Boards and, other than his work with Pharmacy, he had not worked with a group of Boards regarding his issue. He sent me (outlined below) the initiatives he is trying to implement throughout the state. Please note that #1 and #2 were exactly what we had discussed in our meeting.

I made it clear to Rob that none of us were in a position to write specific rules for these initiatives at this point but that the success of these initiatives may be enhanced if the Boards issued joint statements regarding the depth of the issue.

I have invited Rob to attend a future meeting with our group. From this meeting we could, perhaps, come up with how we can address this issue without the difficulties of new rules which may face opposition from some of our professional associations who may not agree with us that we have an issue.

Rob can meet with us here at the OSBN offices on the following dates: Jan 22nd, 29th or 30th. If you are interested in continuing this work with us, let me know what dates would work best for you or your representative. Thanks

Ruby R. Jason, MSN, RN, NEA-BC
Executive Director
Oregon State Board of Nursing
17938 SW Upper Boones Ferry Rd.
Portland, Oregon 97224-7012
971-673-0639
Fax: 971-673-0681
Ruby.Jason@state.or.us
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-
1. Require the use of the Prescription Drug Monitoring Program (PDMP) before opiates are prescribed for chronic non-cancer pain, similar to New York law, which has already delivered some impressive results.
 2. Require the use of certain protocol for the dispensing of opiates for chronic non-cancer pain, similar to Washington law.
 3. Authorize the PDMP to send out automated notices to prescribers and pharmacists when the system detects a dangerous potential drug interaction, or potential abuse. Washington just added that to their PDMP.
 4. Provide for use of identified PDMP data by researchers comparing databases, for the purpose of establishing efficacy, on condition that any research reports only contain de-identified data. I think you may have recently spoken to Doctors Deyo and Wakeland about this issue.

5. Add local health officers to those who can access the PDMP for overdose death investigation purposes.
6. Allowing local public health access to various forms of de-identified aggregate data on the local level, like the State currently has.
7. Provide local health departments better access to the PDMP without restrictions, like the State has.
8. Allowing local public health access to more focused data, such as what is the prescribing pattern for a group of providers.
9. Linking the Emergency Department Information Exchange (EDIE) with PDMP data, like they are now doing in the State of Washington.
10. Allow the Board of Pharmacy to add additional prescription drugs (that are not scheduled controlled substances) to the PDMP.
11. Require PDMP entries to include diagnosis code(s).
12. In light of recent federal rule changes that allow take back vaults in pharmacies, require the pharmaceutical industry to pay for the cost of prescription drug take-back services and programs, similar to the Alameda County (CA) ordinance, which was just upheld by the Ninth Circuit Court of Appeals.
13. Provide a Good Samaritan safe harbor for someone that calls in an overdose, from prosecution for possession, or being held on a probation detainer or warrant stemming from the call and subsequent contact. This would make the use of Naloxone to save lives more probable.

MEMORANDUM

TO: Oregon health licensing board members and staff

FROM: Rob Bovett, Legal Counsel, Association of Oregon Counties

DATE: January 21, 2015

SUBJECT: Opiate abuse legislation

First, thank you for the opportunity to share some thoughts and legislative concepts with you on this vitally important topic. As you may have seen from my earlier email, I have been working on 13 legislative concepts. Some of those are ready for prime time, some are simply not going to fly this legislative session, and a few are in limbo. Here is my status update as to each of the 13:

1. Require the use of the Prescription Drug Monitoring Program (PDMP) before opiates are prescribed for chronic non-cancer pain, similar to New York law, which has already delivered some impressive results.

I think this will only fly if the medical community supports it, or is neutral. It is included within the attached draft legislation (LC 1387).

2. Require the use of certain protocol for the dispensing of opiates for chronic non-cancer pain, similar to Washington law.

I think this will only fly if the medical community supports it, or is neutral. It is included within the attached draft legislation (LC 1387).

3. Authorize the PDMP to send out automated notices to prescribers and pharmacists when the system detects a dangerous potential drug interaction, or potential abuse. Washington just added that to their PDMP.

I think this is ready for prime time. It is included within the attached draft legislation (LC 1387).

4. Provide for use of identified PDMP data by researchers comparing databases, for the purpose of establishing efficacy, on condition that any research reports only contain de-identified data.

I think this is ready for prime time. It is included within the attached draft legislation (LC 1387).

5. Add local health officers to those who can access the PDMP for overdose death investigation purposes.

I think this is ready for prime time. It is included within the attached draft legislation (LC 1387).

6. Allow local public health access to various forms of de-identified aggregate data on the local level, like the State currently has.

I think this is ready for prime time. It is included within the attached draft legislation (LC 1387).

7. Provide local health departments better access to the PDMP without restrictions, like the State has.

I think this is ready for prime time. It is included within the attached draft legislation (LC 1387).

~~8. Allow local public health access to more focused data, such as what is the prescribing pattern for a group of providers.~~

I think this is a dead letter.

~~9. Linking the Emergency Department Information Exchange (EDIE) with PDMP data, like they are now doing in the State of Washington.~~

I think this is a dead letter (just not practical at the moment).

~~10. Allow the Board of Pharmacy to add additional prescription drugs (that are not scheduled controlled substances) to the PDMP.~~

I think this is a dead letter. What might fly is to have the BOP send a recommended list to the legislature each session, which is fine. If the BOP tells me they want a non-CS Rx drug added, I'll do a bill for them.

~~11. Require PDMP entries to include diagnosis code(s).~~

I think this is a dead letter (just not practical).

12. In light of recent federal rule changes that allow take back vaults in pharmacies, require the pharmaceutical industry to pay for the cost of prescription drug take-back services and programs, similar to the Alameda County (CA) ordinance, which was just upheld by the Ninth Circuit Court of Appeals.

We might be able to make this one fly, but we need to find out what the pharmaceutical industry thinks first. They might want to have this done on a state level, instead of disparate county ordinances. This is not yet included in the attached draft legislation (LC 1387).

13. Provide a Good Samaritan safe harbor for someone that calls in an overdose, from prosecution for possession, or being held on a probation detainer or warrant stemming from the call and subsequent contact. This would make the use of Naloxone to save lives more probable.

I worked up some draft language with Claudia Black from Multnomah County. It has been introduced as HB 2754 in on House of Representatives (see attached). I anticipate a mirror bill will be introduced on the Senate, co-sponsored by Senator Alan Bates and Senator Jeff Kruse. I anticipate the Senate version is the one that will move.

LC 1387
2015 Regular Session
1/14/15 (MBM/ps)

DRAFT

SUMMARY

Allows additional persons to access information from prescription monitoring program.

Requires practitioners to access information from program before prescribing or dispensing prescription drug. Creates exceptions.

Directs Oregon Medical Board to adopt rules for uniform use of opioids for pain management.

Becomes operative January 1, 2016.

Declares emergency, effective on passage:

A BILL FOR AN ACT

1
2 Relating to prescription drugs; creating new provisions; amending ORS
3 431.966; and declaring an emergency.

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

5 6 PRESCRIPTION MONITORING PROGRAM

7
8 **SECTION 1.** ORS 431.966 is amended to read:

9 431.966. (1)(a) Except as provided under subsection (2) of this section,
10 prescription monitoring information submitted under ORS 431.964 to the
11 prescription monitoring program established in ORS 431.962:

12 (A) Is protected health information under ORS 192.553 to 192.581.

13 (B) Is not subject to disclosure pursuant to ORS 192.410 to 192.505.

14 (b) Except as provided under subsection [~~(2)(a)(E)~~] **(2)(a)(G)** of this sec-
15 tion, prescription monitoring information submitted under ORS 431.964 to the
16 prescription monitoring program may not be used to evaluate a practitioner's
17 professional practice.

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

1 (2)(a) To the extent that the law or regulation is applicable to the pre-
2 scription monitoring program, if a disclosure of prescription monitoring in-
3 formation, other than the sex of a patient for whom a drug was prescribed,
4 complies with the federal Health Insurance Portability and Accountability
5 Act of 1996 (P.L. 104-191) and regulations adopted under it, including 45
6 C.F.R. parts 160 and 164, federal alcohol and drug treatment confidentiality
7 laws and regulations [*adopted under those laws*], including 42 C.F.R. part 2,
8 and state health and mental health confidentiality laws, including ORS
9 179.505, 192.517 and 192.553 to 192.581, the Oregon Health Authority shall
10 disclose the information:

11 (A) To a practitioner or pharmacist, or, if a practitioner or pharmacist
12 authorizes the authority to disclose the information to a member of the
13 practitioner's or pharmacist's staff, to a member of the practitioner's or
14 pharmacist's staff. If a practitioner or pharmacist authorizes disclosing the
15 information to a member of the practitioner's or pharmacist's staff under this
16 subparagraph, the practitioner or pharmacist remains responsible for the use
17 or misuse of the information by the staff member. To receive information
18 under this subparagraph, or to authorize the receipt of information by a staff
19 member under this subparagraph, a practitioner or pharmacist must certify
20 that the requested information is for the purpose of evaluating the need for
21 or providing medical or pharmaceutical treatment [*for*] to a patient to whom
22 the practitioner or pharmacist anticipates providing, is providing or has
23 provided care.

24 (B) To a practitioner or pharmacist as part of an automated system
25 integrated into the prescription monitoring program by the authority.
26 An automated system integrated into the prescription monitoring
27 program under this subparagraph may disclose information only for
28 the purposes of notifying a practitioner or pharmacist of a potentially
29 dangerous drug interaction or of multiple practitioners prescribing
30 drugs to a patient.

31 [(B)] (C) To a practitioner in a form that catalogs all prescription drugs

1 prescribed by the practitioner according to the number assigned to the
2 practitioner by the Drug Enforcement Administration of the United States
3 Department of Justice.

4 **(D) To a district or county health officer appointed, employed or
5 under contract as described in ORS 431.418.**

6 ~~[(C)]~~ (E) To designated representatives of the authority or any vendor or
7 contractor with whom the authority has contracted to establish or maintain
8 the electronic system of the prescription monitoring program.

9 ~~[(D)]~~ (F) Pursuant to a valid court order based on probable cause and
10 issued at the request of a federal, state or local law enforcement agency en-
11 gaged in an authorized drug-related investigation involving a person to
12 whom the requested information pertains.

13 ~~[(E)]~~ (G) To a health professional regulatory board that certifies in writ-
14 ing that the requested information is necessary for an investigation related
15 to licensure, **licensure** renewal or a disciplinary action involving the appli-
16 cant, licensee or registrant to whom the requested information pertains.

17 **(H) To the State Medical Examiner or designee of the State Medical
18 Examiner, a district medical examiner appointed under ORS 146.065
19 or a deputy medical examiner appointed under ORS 146.085, for the
20 purpose of conducting a medicolegal investigation or autopsy.**

21 **(I) Upon request, and in accordance with rules adopted by the au-
22 thority, to a person to whom information is disclosed under paragraph
23 (b)(A) or (c) of this subsection for the purpose of comparing informa-
24 tion kept in different databases, provided that the person to whom the
25 information is disclosed does not publish or otherwise disclose any
26 information that identifies a patient, practitioner or drug outlet.**

27 ~~[(F)]~~ (J) To a prescription monitoring program of another state if the
28 confidentiality, security and privacy standards of the requesting state are
29 determined by the authority to be equivalent to those of the authority.

30 *[(G) To the State Medical Examiner or designee of the State Medical Ex-
31 aminer, for the purpose of conducting a medicolegal investigation or autopsy.]*

1 (b) The authority may disclose information from the prescription moni-
2 toring program that does not identify a patient, practitioner or drug outlet:

3 (A) For educational, research or public health purposes;

4 (B) To a local public health authority, as defined in ORS 431.260; or

5 (C) To officials of the authority who are conducting special epidemiologic
6 morbidity and mortality studies in accordance with ORS 413.196 and rules
7 adopted under ORS 431.110.

8 (c) **A local public health authority, as defined in ORS 431.260, may**
9 **disclose information from the prescription monitoring program that**
10 **does not identify a patient, practitioner or drug outlet for educational,**
11 **research or public health purposes.**

12 [(c)] (d) The authority shall disclose information relating to a patient
13 maintained in the electronic system operated pursuant to the prescription
14 monitoring program [*established under ORS 431.962*] to that patient at no
15 cost to the patient within 10 business days after the authority receives a
16 request from the patient for the information.

17 [(d)(A)] (e)(A) A patient may request the authority to correct any infor-
18 mation about the patient that is erroneous. The authority shall grant or deny
19 a request to correct information within 10 business days after the authority
20 receives the request.

21 (B) If the authority denies a patient's request to correct information un-
22 der this paragraph, or fails to grant a patient's request to correct informa-
23 tion under this paragraph within 10 business days after the authority
24 receives the request, the patient may appeal the denial or failure to grant
25 the request. Upon [*receipt*] **receiving notice** of an appeal under this sub-
26 paragraph, the authority shall conduct a contested case hearing as provided
27 in ORS chapter 183. Notwithstanding ORS 183.450, [*in the contested case*
28 *hearing,*] the authority has the burden **in the contested case hearing** of
29 establishing that the information included in the prescription monitoring
30 program is correct.

31 [(e)] (f) The information in the prescription monitoring program may not

1 be used for any commercial purpose.

2 [(f)] (g) In accordance with ORS 192.553 to 192.581 and federal privacy
3 regulations, any person authorized to prescribe or dispense a prescription
4 drug and who is entitled to access a patient's prescription monitoring infor-
5 mation may discuss or release the information to other health care providers
6 involved with the patient's care, *in order to provide* **for the purpose of**
7 **providing** safe and appropriate care coordination.

8 (3)(a) The authority shall maintain records of the information disclosed
9 through the prescription monitoring program including, but not limited to:

10 (A) The identity of each person who requests or receives information from
11 the program and *[the organization, if any,]* **any organization that** the person
12 represents;

13 (B) The information released to each person or organization; and

14 (C) The date and time the information was requested and the date and
15 time the information was provided.

16 (b) Records maintained as required by this subsection may be reviewed
17 by the Prescription Monitoring Program Advisory Commission.

18 (4) Information in the prescription monitoring program that identifies an
19 individual patient must be removed no later than three years from the date
20 the information is entered into the program.

21 (5) The authority shall notify the Attorney General and each affected in-
22 dividual of an improper disclosure of information from the prescription
23 monitoring program.

24 (6)(a) If the authority or a person or entity required to report or author-
25 ized to receive or release controlled substance prescription information under
26 this section violates this section or ORS 431.964 or 431.968, a person injured
27 by the violation may bring a civil action against the authority, person or
28 entity and may recover damages in the amount of \$1,000 or actual damages,
29 whichever is greater.

30 (b) Notwithstanding paragraph (a) of this subsection, the authority and
31 a person or entity required to report or authorized to receive or release

1 controlled substance prescription information under this section are immune
2 from civil liability for violations of this section or ORS 431.964 or 431.968
3 unless the authority, person or entity acts with malice, criminal intent, gross
4 negligence, recklessness or willful intent.

5 (7) *[Nothing in ORS 431.962 to 431.978 and 431.992 requires a practitioner*
6 *or pharmacist who prescribes or dispenses a prescription drug to obtain in-*
7 *formation about a patient from the prescription monitoring program.]* A prac-
8 titioner or pharmacist who prescribes or dispenses a prescription drug may
9 not be held liable for damages in any civil action on the basis that the
10 practitioner or pharmacist *[did or did not request or obtain]* requested or
11 obtained information from the prescription monitoring program.

12 **SECTION 2.** Sections 3 and 4 of this 2015 Act are added to and made
13 a part of ORS 431.962 to 431.978.

14 **SECTION 3.** (1) Except as provided in subsection (2) of this section,
15 a practitioner shall access information from the prescription moni-
16 toring program established under ORS 431.962 as described in ORS
17 431.966 (2)(a)(A) before the practitioner prescribes or dispenses a pre-
18 scription drug to a patient.

19 (2) This section does not apply to:

20 (a) A practitioner described in ORS 431.960 (4)(b).

21 (b) A veterinarian.

22 (c) A practitioner administering a prescription drug.

23 (d) A practitioner prescribing or dispensing a prescription drug at
24 a health care facility, as defined in ORS 442.015, for use on the prem-
25 ises of the health care facility.

26 (e) A practitioner prescribing a prescription drug at the emergency
27 department of a hospital, as defined in ORS 442.015, provided that the
28 practitioner prescribes no more than a five-day supply of the pre-
29 scription drug.

30 (f) A practitioner prescribing or dispensing a prescription drug to
31 a recipient of hospice services, as defined in ORS 443.850.

1 (g) A practitioner dispensing methadone for purposes related to
2 methadone maintenance.

3 (h) A practitioner for whom it is not reasonably possible to access,
4 directly or through a member of the practitioner's staff who is au-
5 thorized to access the information, the prescription monitoring pro-
6 gram in a timely manner, provided that the practitioner prescribes no
7 more than a five-day supply of the prescription drug.

8 (i) A practitioner to whom a waiver has been granted under sub-
9 section (3) of this section.

10 (j) A practitioner prescribing or dispensing a prescription drug in
11 accordance with rules adopted by the Oregon Health Authority for the
12 purpose of ensuring the timely dispensing of prescription drugs to pa-
13 tients.

14 (k) All practitioners if the prescription monitoring program is in-
15 accessible because the electronic system described in ORS 431.962 is
16 inoperable.

17 (3) The authority may grant a practitioner a waiver of the require-
18 ment to access information from the prescription monitoring program
19 under this section for good cause as determined by the authority. For
20 purposes of this subsection, good cause includes insufficient techno-
21 logical resources necessary to access the information.

22 SECTION 4. (1) In addition to any other penalty provided by law, a
23 health professional regulatory board:

24 (a) May suspend, revoke or refuse to renew a license or registration
25 of a licensee or registrant of the health professional regulatory board
26 who violates section 3 of this 2015 Act; and

27 (b) May impose on a licensee or registrant of the health professional
28 regulatory board a civil penalty not to exceed \$1,000 for each violation
29 of section 3 of this 2015 Act that is committed by the licensee or reg-
30 istrant.

31 (2) Each failure to access information from the prescription moni-

1 toring program established under ORS 431.962 is a separate violation.

2 (3) A health professional regulatory board shall impose a civil pen-
3 alty under this section in the manner provided in ORS 183.745.

4 (4) A health professional regulatory board may adopt rules neces-
5 sary to carry out the provisions of this section.

6 (5) Moneys recovered under this section must be paid into the State
7 Treasury and credited to the General Fund.

8
9 **USE OF OPIOIDS FOR PAIN MANAGEMENT**

10
11 **SECTION 5.** Sections 6 and 7 of this 2015 Act are added to and made
12 a part of ORS chapter 677.

13 **SECTION 6.** (1) As used in this section, "practitioner" has the
14 meaning given that term in ORS 689.005.

15 (2) The Oregon Medical Board shall adopt rules for the uniform use
16 of opioids for pain management. The rules must establish dosing cri-
17 teria, including:

18 (a) Except as provided in paragraphs (b), (c) and (d) of this sub-
19 section, a dosage amount that may not be exceeded unless a practi-
20 tioner first consults a specialist in pain management;

21 (b) Exigent circumstances under which the dosage amount may be
22 exceeded without first consulting a specialist in pain management;

23 (c) Circumstances under which the dosage amount may be exceeded
24 because repeated consultations with a specialist in pain management
25 are unnecessary or inappropriate; and

26 (d) Minimum training and experience necessary for a practitioner
27 to not be subject to rules adopted under this subsection.

28 (3) The board shall provide guidance to practitioners for the purpose
29 of ensuring compliance with this section. Guidance provided under this
30 subsection must include:

31 (a) Guidance on consulting specialists in pain management;

1 (b) Guidance on tracking patient progress; and

2 (c) Guidance on tracking the use of opioids.

3 (4) Rules adopted under this section do not apply to the use of
4 opioids for purposes related to:

5 (a) The provision of palliative, hospice or other end-of-life care;

6 (b) The management of acute pain caused by an injury or a surgical
7 procedure; or

8 (c) The management of chronic pain caused by cancer.

9 SECTION 7. (1) In addition to any other penalty provided by law, a
10 health professional regulatory board:

11 (a) May suspend, revoke or refuse to renew a license or registration
12 of a licensee or registrant of the health professional regulatory board
13 who violates rules adopted under section 6 of this 2015 Act; and

14 (b) May impose on a licensee or registrant of the health professional
15 regulatory board a civil penalty not to exceed \$1,000 for each violation
16 of rules adopted under section 6 of this 2015 Act that is committed by
17 the licensee or registrant.

18 (2) A health professional regulatory board shall impose a civil pen-
19 alty under this section in the manner provided in ORS 183.745.

20 (3) A health professional regulatory board may adopt rules neces-
21 sary to carry out the provisions of this section.

22 (4) Moneys recovered under this section must be paid into the State
23 Treasury and credited to the General Fund.

24
25 **TRANSITIONAL PROVISIONS**

26
27 SECTION 8. The amendments to ORS 431.966 by section 1 of this
28 2015 Act apply to information related to prescription drugs dispensed
29 before, on or after the operative date specified in section 10 of this 2015
30 Act.

31 SECTION 9. Rules adopted by a health professional regulatory board

1 relating to the use of opioids for pain management that are in effect
2 on the operative date specified in section 10 of this 2015 Act remain in
3 effect until superseded or repealed by rules adopted by the Oregon
4 Medical Board under section 6 of this 2015 Act.

5

6

OPERATIVE DATE

7

8 SECTION 10. (1) Sections 2 to 7 of this 2015 Act and the amend-
9 ments to ORS 431.966 by section 1 of this 2015 Act become operative
10 on January 1, 2016.

11 (2) The Oregon Health Authority and the Oregon Medical Board
12 may take any action before the operative date specified in subsection
13 (1) of this section that is necessary to enable the authority and board
14 to exercise, on and after the operative date specified in subsection (1)
15 of this section, all the duties, powers and functions conferred on the
16 authority and board by sections 2 to 7 of this 2015 Act and the
17 amendments to ORS 431.966 by section 1 of this 2015 Act.

18

19

UNIT CAPTIONS

20

21 SECTION 11. The unit captions used in this 2015 Act are provided
22 only for the convenience of the reader and do not become part of the
23 statutory law of this state or express any legislative intent in the
24 enactment of this 2015 Act.

25

26

EMERGENCY CLAUSE

27

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

31

House Bill 2754

Sponsored by Representative WILLIAMSON (Pre-session filed.)

SUMMARY

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

Exempts person from arrest and prosecution for certain offenses and finding of violation of terms of release or supervision if person contacts emergency medical services or law enforcement agency to obtain necessary medical assistance for other person due to drug-related overdose.

A BILL FOR AN ACT

1
2 Relating to immunity for persons who seek medical assistance.

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

4 **SECTION 1.** (1) A person who contacts emergency medical services or a law enforcement
5 agency to obtain medical assistance for another person who needs medical assistance due to
6 a drug-related overdose is immune from arrest or prosecution for an offense listed in sub-
7 section (2) of this section if the evidence of the offense was obtained because the person
8 contacted emergency medical services or a law enforcement agency as described in this
9 subsection.

10 (2) The immunity conferred under subsection (1) of this section applies to arrest and
11 prosecution for:

- 12 (a) Frequenting a place where controlled substances are used as described in ORS 167.222;
13 (b) Possession of a controlled substance as described in ORS 475.752;
14 (c) Unlawful possession of hydrocodone as described in ORS 475.814;
15 (d) Unlawful possession of methadone as described in ORS 475.824;
16 (e) Unlawful possession of oxycodone as described in ORS 475.834;
17 (f) Unlawful possession of heroin as described in ORS 475.854;
18 (g) Unlawful possession of marijuana or a marijuana product as described in ORS 475.864;
19 (h) Unlawful possession of 3,4-methylenedioxymethamphetamine as described in ORS
20 475.874;
21 (i) Unlawful possession of cocaine as described in ORS 475.884;
22 (j) Unlawful possession of methamphetamine as described in ORS 475.894;
23 (k) Unlawfully possessing a prescription drug as described in ORS 689.527 (6); and
24 (L) Unlawful possession of drug paraphernalia with intent to sell or deliver as described
25 in ORS 475.525.

26 (3) A person may not be arrested for violating or found to be in violation of the condi-
27 tions of the person's pretrial release, probation, post-prison supervision or parole if the vio-
28 lation involves the possession of a controlled substance or frequenting a place where
29 controlled substances are used and the evidence of the violation was obtained because the
30 person contacted emergency medical services or a law enforcement agency to obtain medical
31 assistance for another person who needed medical assistance due to a drug-related overdose.

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

1 (4) A person may not be arrested on an outstanding warrant for any of the offenses listed
2 in subsection (2) of this section if the location of the person was obtained because the person
3 contacted emergency medical services or a law enforcement agency to obtain medical as-
4 sistance for another person who needed medical assistance due to a drug-related overdose.

5 (5) The immunity from arrest and prosecution described in this section shall not be
6 grounds for the suppression of evidence relating to a criminal offense other than the offenses
7 listed in subsection (2) of this section.

8 (6) As used in this section:

9 (a) "Controlled substance" has the meaning given that term in ORS 475.005.

10 (b) "Drug-related overdose" means an acute condition including mania, hysteria, extreme
11 physical illness, coma or death resulting from the consumption or use of a controlled sub-
12 stance, or another substance with which a controlled substance was combined, that a person
13 would reasonably believe to be a condition that requires medical attention.

14 SECTION 2. Section 1 of this 2015 Act applies to conduct occurring on or after the ef-
15 fective date of this 2015 Act.

16



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

Year 5, Period 1 Report: July 1, 2014 – December 31, 2014

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

Executive Summary

Health Professionals' Services Program Satisfaction Survey: Year Five, Period 1 - Report

Overview: This Health Professionals' Services Program report reviews the survey results for the first-period of the fifth year of the program, covering July 1, 2014 through December 31, 2014. Surveys were sent to the following groups of stakeholders at the beginning of January 2014: Licensees, Employers (Workplace Monitors), Treatment Providers, Health Associations, and the Boards. Each of these groups of stakeholders will be surveyed again in July 2015. An overview of the combined number of surveys sent, combined number of responses received and the combined response rate for both January 2015 is displayed below and broken down by stakeholder group:

Table 1: Response Rate - Year 5, 1 st Period	Licensees	Employers (Workplace Monitors)	Treatment Providers	Health Associations	Boards
# Sent	237	176	180	9	5
# of Responses	65	36	24	1	7
Response Rate	27.4%	20.5%	13.3%	11.1%	71.4%

Highlights

One-fifth of all current workplace monitors responded to the survey and 89% of those noted that they were either "very satisfied" or "satisfied" with the support they receive when supervising licensees. Just over 80% of respondents indicated that they rate RBH's ability to monitor the licensee to ensure safety in the workplace as "excellent" or "above average." Finally, more than 80% rate their overall experience working with RBH HPSP as "excellent" or "above average."

Licensees provided strong ratings of the program again this survey. The pool that responded to the survey, representing just over one-quarter of the enrolled licensees, was representative of the licensee population in terms of board make-up. Strong ratings were provided for agreement monitors, communication promptness, clarity, and professionalism of staff. For each of these items, between 77% and 85% of respondents rated them positively. Each of the program components queried was most frequently rated as "helpful." Fifty-four percent (54%) of respondents rated the program as "excellent" or "above average." Comments provided, even though made by just less than half of the respondents, were more positive than in any recent survey.

More treatment providers responded to the survey this period than previously, although the response rate is still low at 13.3%. The majority of respondents "agreed" that their concerns were responded to promptly, that information was communicated clearly and professionally and that they had all the information needed when seeing the client. "Excellent" was the most common rating of the overall experience working with RBH, representing a continued improvement from the last few years. However comments were primarily negative in harsh contrast to these data points. The RBH Policy Advisory Committee (PAC) will specifically review these comments and implement appropriate action plans.

One professional association representative responded to the survey. This representative of the Oregon Nurses Association indicated the program is not valuable to members and that feedback from members about HPSP is poor. RBH will continue efforts this year to reach out to all four professional associations and to partner with them.

All four Boards provided responses to the survey this period. "Excellent" was the most common rating given to the overall program. This was also the case for staff knowledge of a case, response timeframes and ability to respond to program administration concerns. The efforts from the Boards and RBH to further strengthen the partnership was evident in the responses.

All responses will be reviewed by the PAC and an action plan will be put into place to address in order to provide for continued improvement. Concerns about communication and consistency will be addressed as the first priorities.

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

Purpose

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

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

Feedback includes information about RBH customer service, Agreement Monitors, service components, and overall services.

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

Data Results

Response Rate

Table 1: Response Rate	This Period	Year 4	Year 3	Year 2	Year 1
# Sent	237	509	915	1330	1481
# of Responses	65	197	246	367	342
Response Rate	27.4%	38.7%	26.9%	27.6%	23%

The HPSP Licensee Satisfaction Survey was issued to 100% of the Licensees enrolled in the HPSP Program at the close of December 2014. The survey was emailed to 218 licensees and mailed to 19. A total of 65 responses were received; representing a response rate of 27.4%. Although this is not as high as last year (year four), it is consistent with the rates seen in years two and three.

Respondents

Question 1: 44.6% of respondents this period were representatives of the Board of Nursing. The Medical Board follows with 38.5%, then the Board of Dentistry and the Board of Pharmacy with 7.7% each. One survey respondent (1.5%) did not indicate with which board they are associated.

Data Table 2:

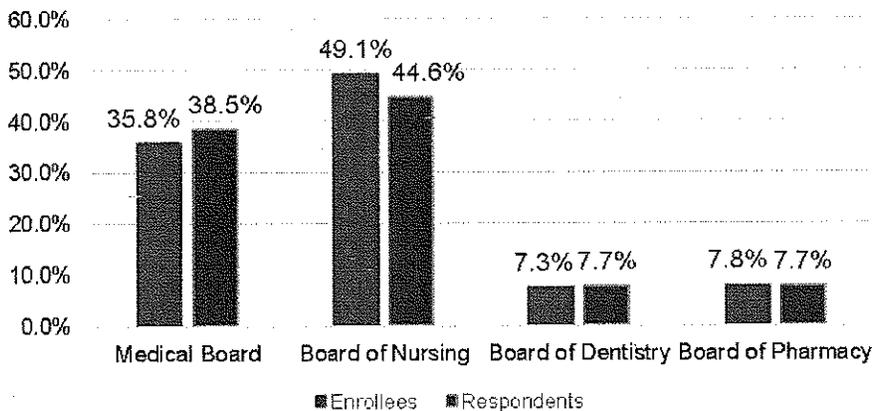
Table 2: Respondents by Board	This Period (n=65)		Year 4 (n=197)		Year 3 (n=246)	
	#	%	#	%	#	%
Medical Board	25	38.5%	81	41.1%	104	42.8%
Board of Nursing	29	44.6%	87	44.2%	115	47.3%
Board of Dentistry	5	7.7%	17	8.6%	15	6.2%
Board of Pharmacy	5	7.7%	9	4.6%	9	3.7%
No Response	1	1.5%	3	1.5%	3	1.2%

The responses are representative of the enrolled licensee population with a very slight skew (less than 5%) towards the Medical Board and away from the Board of Nursing.

Data Table 3 and Figure 1:

Table 3: Comparison of Enrollees to Respondents	Percent of Enrollees (12/31/14)	Percent of Respondents (This Period)
Medical Board	35.8%	38.5%
Board of Nursing	49.1%	44.6%
Board of Dentistry	7.3%	7.7%
Board of Pharmacy	7.8%	7.7%

Figure 1: Percent of Enrollees vs. Percent of Respondents



Customer Service

Question 2: This question asks respondents to “Think about [their] most recent call to RBH.....” and evaluate two statements, one regarding responsiveness and the other regarding clarity and professionalism of the communication. The mode response to both questions was “strongly agree.” This is consistent with the last two years. The percentage of “strongly agree” responses has increased by a few percentage points.

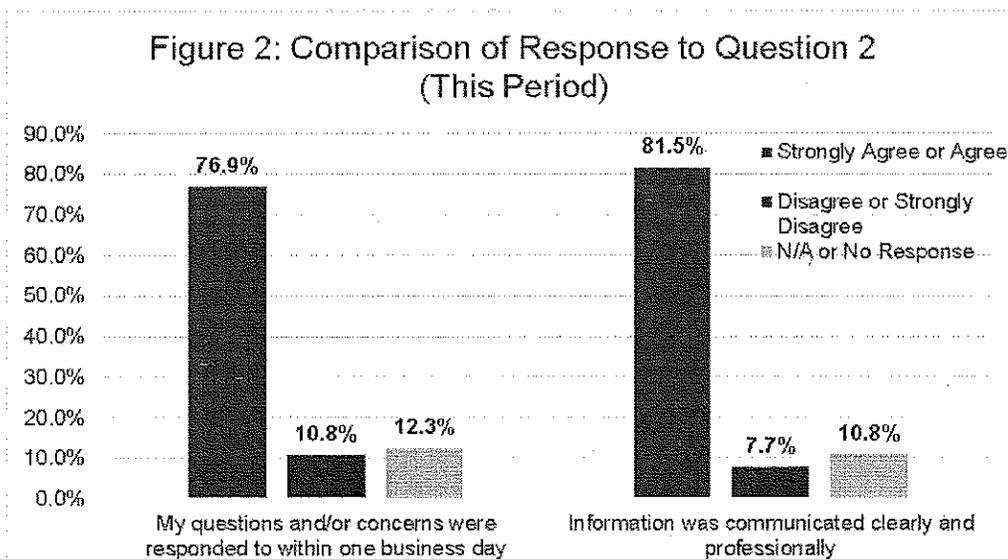
Data Tables 4a and b: The mode (most frequent) response is highlighted in red. Not all responses have a mode.

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

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

For the question about timeliness of responses, we find that 77% of respondents “strongly agree” or “agree” compared to only 11% who “disagree” or “strongly disagree.” For the question about clarity/professionalism of responses we find that 81% “strongly agree” or “agree” while only 8% “disagree” or “strongly disagree.”

Figure 2



Agreement Monitors

Question 3: Respondents are asked to react to the following: "Regarding our Agreement Monitors, to what extent do you agree that..." The first item indicates that the Agreement Monitor is knowledgeable about the respondent's case and the second indicates that the respondent's needs and concerns are understood. Again we see that the mode response to both items is "Strongly Agree" with an increase of a few percentage points over last year's responses.

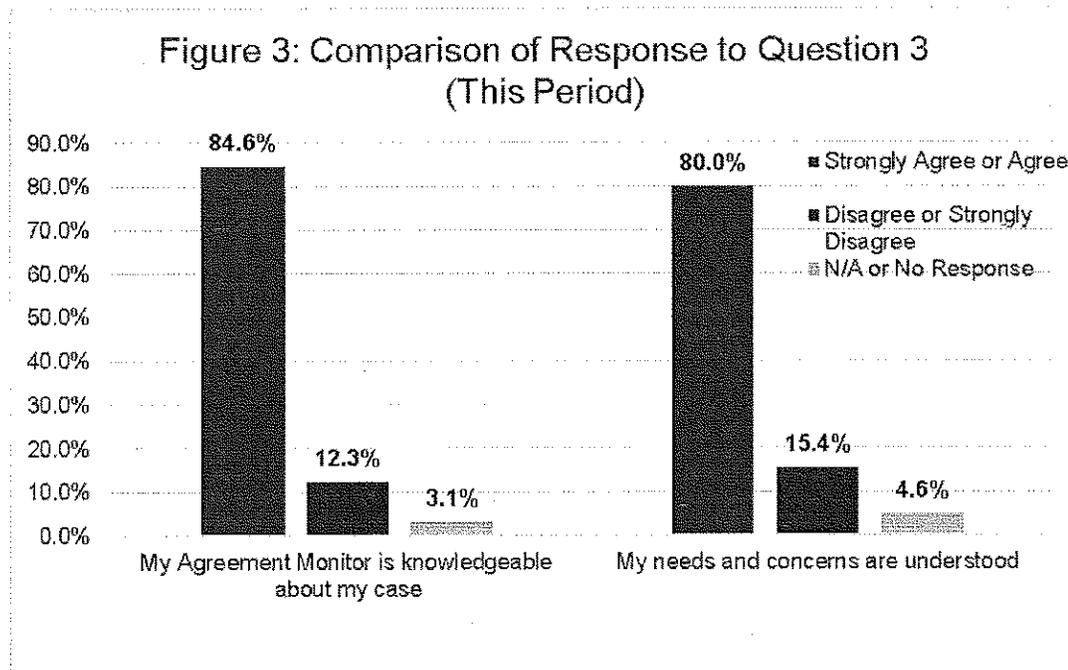
Data Table 5a and b: The mode (most frequent) response is highlighted in red. Not all responses have a mode.

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

Table 5b: Year 4 (n=197)	Strongly Agree		Agree		Disagree		Strongly Disagree		N/A		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
My Agreement Monitor is knowledgeable about my case	84	42.6%	88	44.7%	13	6.6%	9	4.6%	1	0.5%	2	1.0%
My needs and concerns are understood	75	38.1%	69	35.0%	25	12.7%	17	8.6%	2	1.0%	9	4.6%

The positive responses to both items far outweigh the negative responses as seen in previous years. 84.6% of respondents "strongly agree" or "agree" that their agreement monitor is knowledgeable about [his/her] case and 80% respondents "strongly agree" or "agree" that [his/her] needs and concerns are understood.

Figure 3:



Service Components

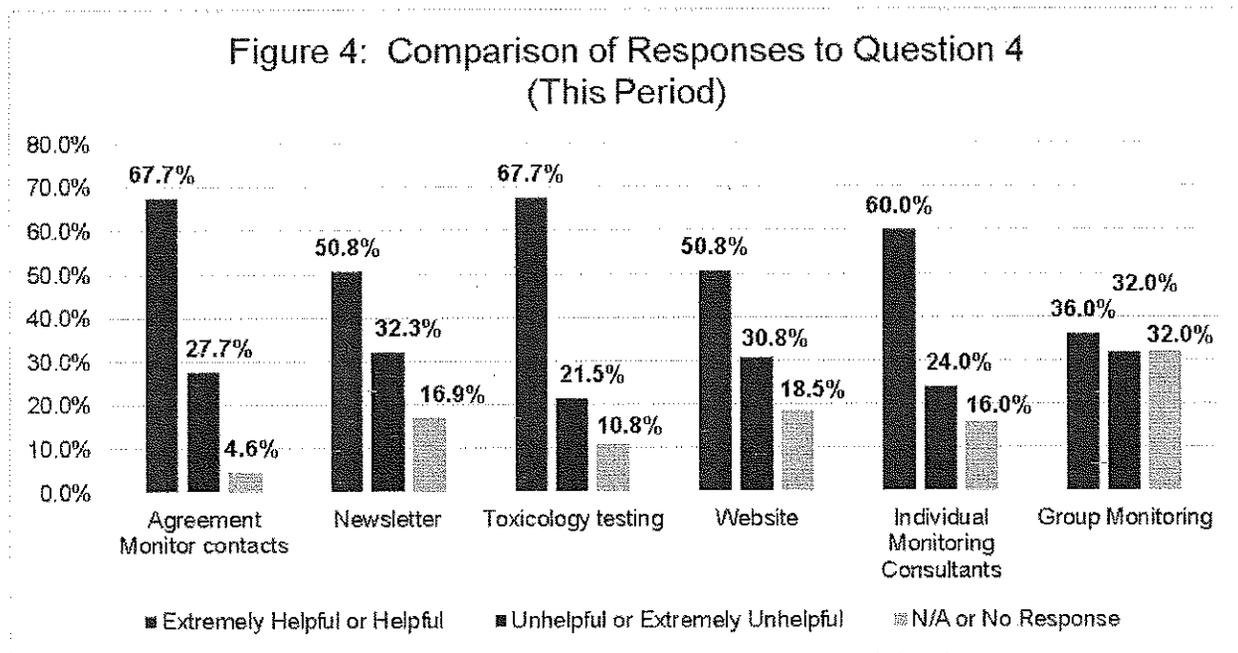
Question 4: This item asked respondents to "Please rate the following services as they contribute to your successful completion of the program." Agreement Monitor contacts, newsletters, toxicology testing and the website are all listed for rating; Individual Monitoring Consultants and Group Monitoring are also included for Medical Board (OMB) participants only. As we have seen for the last two years, the majority of respondents both for the period and the year rated each service element as "helpful." Further, as displayed in Figure 4 (next page), the positive responses again outweigh the negative responses on each item. With the exception of "Group Monitoring," more than 50% of respondents found each service item to be either "helpful" or "extremely helpful." In fact, respondents identified Agreement Monitor contacts and toxicology testing as most helpful, both at 67.7%.

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

Table 6a: This Period (n=65) (*OMB only- n=25)	Extremely Helpful		Helpful		Unhelpful		Extremely Unhelpful		N/A		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
Agreement Monitor contacts	16	24.6%	28	43.1%	16	24.6%	2	3.1%	1	1.5%	2	3.1%
Newsletter	5	7.7%	28	43.1%	19	29.2%	2	3.1%	8	12.3%	3	4.6%
Toxicology testing	16	24.6%	28	43.1%	8	12.3%	6	9.2%	5	7.7%	2	3.1%
Website	4	6.2%	29	44.6%	17	26.2%	3	4.6%	8	12.3%	4	6.2%
Individual Monitoring Consultants*	4	16.0%	11	44.0%	2	8.0%	4	16.0%	3	12.0%	1	4.0%
Group Monitoring*	4	16.0%	5	20.0%	4	16.0%	4	16.0%	7	10.8%	1	1.5%

Table 6b: Year 4 (n=197) (*OMB only- n=81)	Extremely Helpful		Helpful		Unhelpful		Extremely Unhelpful		N/A		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
Agreement Monitor contacts	49	24.9%	83	42.1%	44	22.3%	13	6.6%	6	3.0%	2	1.0%
Newsletter	8	4.1%	102	51.8%	54	27.4%	14	7.1%	14	7.1%	5	2.5%
Toxicology testing	36	18.3%	91	46.2%	41	20.8%	18	9.1%	6	3.0%	5	2.5%
Website	9	4.6%	92	46.7%	52	26.4%	12	6.1%	26	13.2%	6	3.0%
Individual Monitoring Consultants*	16	19.8%	26	32.1%	10	12.3%	8	9.9%	19	23.5%	2	2.5%
Group Monitoring*	11	13.6%	26	32.1%	7	8.6%	12	14.8%	22	27.2%	3	3.7%

Figure 4:



Overall Rating of Services

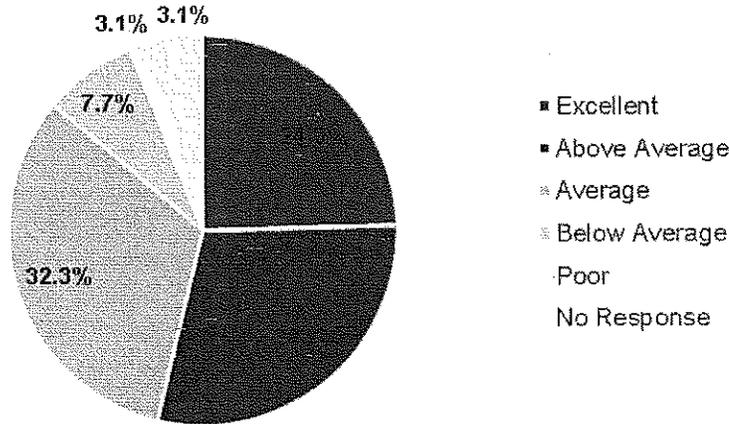
Question 5: Respondents were asked to rate the overall services. The mode response was "average" at 32%. This is consistent with Years four and two, although in year three the mode was "above average." The mode does not fully communicate the data trends: Combining the "excellent" and "above average" ratings, the total is almost 54% this period, similar to the approximately 50% the last two years and an improvement from 42% in year two. Further there has been a significant increase in the percentage of "excellent" ratings over time, peaking at 24.6% this period. Finally, there were only 10% "below average" or "poor" responses this period, the lowest yet.

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

Table 7: Overall Rating	This Period (n=65)		Year 4 (n=197)		Year 3 (n=246)		Year 2 (n=367)	
	#	%	#	%	#	%	#	%
Excellent	16	24.6%	47	23.9%	42	17.1%	52	14.2%
Above Average	19	29.2%	53	26.9%	81	32.9%	102	27.8%
Average	21	32.3%	60	30.5%	59	24.0%	125	34.1%
Below Average	5	7.7%	17	8.6%	30	12.2%	44	12.0%
Poor	2	3.1%	10	5.1%	24	9.8%	40	10.9%
No Response	2	3.1%	10	5.1%	10	4.1%	4	1.1%

Figure 5:

Figure 5: Overall, how do you rate our services to you (Question 5) - This Period



Additional Comments

At the conclusion of the survey, respondents are asked for any additional comments. Twenty-four (24) comments were received, reviewed, and categorized this period. Comments were received from 42.9% of respondents.

Comments were first categorized with an overall type: positive, negative, neutral, or mixed. This period, 25.0% were positive, 45.8% were negative, 12.5% were a mixture of positive and negative and 16.7% were neutral. (See Figure 6.) Last period, 70% of the comments were negative in tone so this is a notable improvement. Comments were also categorized by area (see Data Table 8). Each issue within a comment was categorized to maximize the ability to capture all feedback. Program Structure was the area that licensees provided the most comments about. Communication issues were the next most common area mentioned. Agreement monitors and toxicology were commented on more frequently in past years.

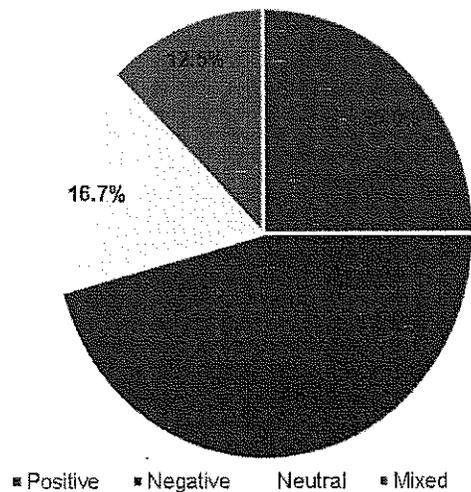
Table 8:

Categories of Comments Received		#	%
Communication	Negative	5	16.1%
	Positive	1	3.2%
Financial Comp	Negative	3	9.7%
General	Negative	1	3.2%
	Positive	3	9.7%
Program Structure	Negative	7	22.6%
	Neutral*	3	9.7%
	Positive	1	3.2%
Staff – Agreement Monitor	Negative	1	3.2%
	Positive	3	9.7%
Staff - General	Negative	1	3.2%
Toxicology / Lab Locations	Negative	1	3.2%
	Positive	1	3.2%

* Recommendation

Figure 6:

Figure 6: Comment Type



Actual Comments Received – January 2015

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

1. very responsive :)
2. unable to get ahold of people. Multiple messages left
3. The new hours of my text site are extremely inconvenient (8-5). I am very stressed on test days to make it to lab by its closing time of 5:00 pm when I am off work at 5:30. I have to pray I can get off early which is rare because my work is not willing. This means I have to drive after work to [Name] Lab which is very far. Any way you could give the [name of location] clients a lab that is open later???
4. The frequency of check ins and monitoring consultant visits should decline with time in the program.
5. This survey is absurd. Participation in the events you are asking me to rate is required as part of the program. It is circular to ask if meeting the requirements is helping me successfully meet the requirements. If the question were "are these programs helpful in developing resilience improving mental and emotional health or preventing relapse?" the honest answer is no. Per the recommendations of the board's own independent evaluator, it was not recommended that I be required to participate in anything other than 6 months of independent monthly counselling and 24 months of monitoring. How it came to be that I am signed required to participate in all of these programs remains a mystery.
6. I have been in the Nurse monitoring program for almost 5 years now. There have been so many times where things are not clearly conveyed by my monitor or not conveyed at all. The drug testing is super expensive (almost \$70 each time) and some months I get tested up to 4 times.
7. Every time I call my agreement monitor I get voice mail.
8. I am in good recovery thanks to many people and groups including RBH. THANK YOU.
9. Rediculously expensive...and extensively too long of a time frame...how is that supposed to help my recovery?
10. Needs to acknowledge and integrate professional counselors therapy with the monitoring program.
11. Unfortunately, there were a couple "mishaps" when I first enrolled. Staff neglected to take off the interim consent order on my license when they said they would - I had to follow-up and call multiple times in order to assure it was taken care of. Also, because someone "accidentally" pushed the wrong "button," I was informed through the IVR system that I was "non-compliant" (which was not true) - per the IVR recording, I was to "call RBH as soon as possible." This made my heart drop, as well as cause a semi-anxiety attack, only to find that it was a "mistake." Lastly, I was given a list of "updated and approved" sites to U/A at. When I went to one of the approved sites per RBH (after waiting 20 minutes) - I was then informed that "they no longer work with RBH." This was frustrating and a waste of time. Besides these occurrences, I believe RBH is helpful. However, these occurrences (though minuscule) could have been avoided and caused quite a bit of anxiety on my part. I do not mean to victimize myself, but if this can be avoided in the future for other-RBH professionals, it would be extremely helpful.
12. talking with my contact, it is checking off my requirements for the week of what I need to do to stay in compliance and that is it. My counselors at [location] have tried to contact them and never get a response. The only positive part of this program for me is the testing. it keeps me accountable. which I definitely need in my early sobriety. Any other aspect to this program is useless. There is no support, no help in trying to find new employments. They are non medical people who do not have a clue what we do or did in our jobs.
13. I'm glad now we can meet our monitor face to face.
14. [Name of Agreement Monitor] has been a breath of fresh air in the addiction treatment community. She is compassionate, knowledgeable
15. I find the program helpful, reasonable, and workable.
16. There is a complete lack of consistency with the policies in this program.
17. we should have support groups for Nurses. Perhaps once a month meetings.
18. [Name of Agreement Monitor] is wonderful!
19. Fewer testing would be great, cost is high
20. [Name of Agreement Monitor] is a superb communicator!!! The 1size fits all care plan regardless of specific chemical issue isnt able to customize to individual situations and needs
21. You are basically a rather punitive compliance operation. You do your job but you don't really give a crap about us as individuals and only my counselor actually helps me with recovery. Did you ever figure out what "non-therapeutic counseling" is? Hint: It is a dumb statement.
22. I faithfully send a e-mail or call each Friday and leave a voice message if no answer. I have had two different nurse monitors since I have been in the program for a little over two years now. I have only spoken with each of them twice. I believe according to the contract, we are to speak at least once a month in person. Maybe this would be a good time to remind them what is expected of them.

23. My testing site is open until midnight - I would like it if I was able to check (either by phone or website) my testing status until midnight, and not get locked out in the afternoon.
24. Would be nice if the program would consider aa meetings and sponsoring, sponsorship in lieu of those required to travel long distances to group meetings that are mandatory. Sponsorship through such meetings may be helpful to those receptive to it. Health care group meetings should be available in [location]. I think my counsellor would serve well and he may be receptive to weekly meetings in [location]. He came highly recommended through [Name of Program]. I have brought it up to him before. Thanks. [Name] in [location]

Summary Analysis

The licensee survey response rate was 27.4% and the pool of respondents was representative of the licensee population with only a slight skew (less than 5%) towards the Medical Board and away from the Board of Nursing.

When thinking about their most recent call to RBH, 77% of respondents this year indicate that they "agree" or "strongly agree" that their questions/concerns were responded to promptly. Similarly, 81% indicate that they "agree" or "strongly agree" that information was communicated clearly and professionally. The mode response to both of these items was "strongly agree."

Agreement Monitors continue to receive strong ratings this year: 85% of respondents "strongly agree" or "agree" that their agreement monitor is knowledgeable about [his/her] case and 80% respondents "strongly agree" or "agree" that [his/her] needs and concerns are understood. Again, the mode response for both items was "strongly agree."

When rating how various components contribute towards the successful completion of the program, Agreement Monitor contacts, Newsletters, Toxicology testing, the Website, Individual Monitoring, and Group Monitoring were all most frequently rated as "Helpful" both for the period and the year. In fact, with the exception of "Group Monitoring," more than 50% of respondents found each service item to be either "helpful" or "extremely helpful." In fact, respondents identified Agreement Monitor contacts and toxicology testing as most helpful, both with 67.7% of respondents endorsing them as "helpful" or "extremely helpful."

Overall services were rated favorably, with 54% of respondents rating the program "excellent" or "above average" and only 10% rating it "below average" or "poor."

Comments were received from 42.9% of respondents this period. Of these comments, 25.0% were positive, 45.8% were negative, 12.5% were a mixture of positive and negative and 16.7% were neutral. The comments included several specific recommendations for improvement which the RBH PAC will carefully review.

Reliant Behavioral Health

Health Professionals' Services Program (HPSP)

Satisfaction of EMPLOYERS / WORKPLACE MONITORS

Purpose

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

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

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

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

Data Results

Response Rate

Table 1: Response Rate	This Period	Year 4	Year 3
# Sent	176	349	389
# Responses	36	89	73
Response Rate	20.5%	25.5%	18.8%

The HPSP Employers Satisfaction Survey was distributed to Workplace Monitors through email and mail. Out of the total 176 surveys distributed, 36 responses were received for a response rate of 20.5%. Although this is a decrease from last year's rate of 25.5%, it still represents an improvement from the rates seen the first three years of the program.

Type of Service Provided by Employer

Question 1: Respondents are first asked the type of services provided by their organization. The most frequent response for the period was "medical" at 50% followed by "nursing" at 33%. Although the breakdown of the licensee population is heavily weighted towards nurses, it can be assumed that a number of these nurses work in "medical" offices. Thus, the response to this question does not necessarily mean that the data is inconsistent with and unrepresentative of the license population. That said, there are not any responses in the pharmacy service industry so the pharmacist employers are not represented in this survey data.

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

Table 2: Type of Services Provided	This Period (n=36)		Year 4 (n=89)		Year 3 (n=73)	
	#	%	#	%	#	%
Medical	18	50.0%	35	39.3%	33	45.2%
Nursing	12	33.3%	41	46.1%	36	49.3%
Pharmacy			2	2.2%	1	1.4%
Dental	3	8.3%	5	5.6%	2	2.7%
Other	1	2.8%	4	4.5%	1	1.4%
No Response	2	5.6%	2	2.2%		

Services

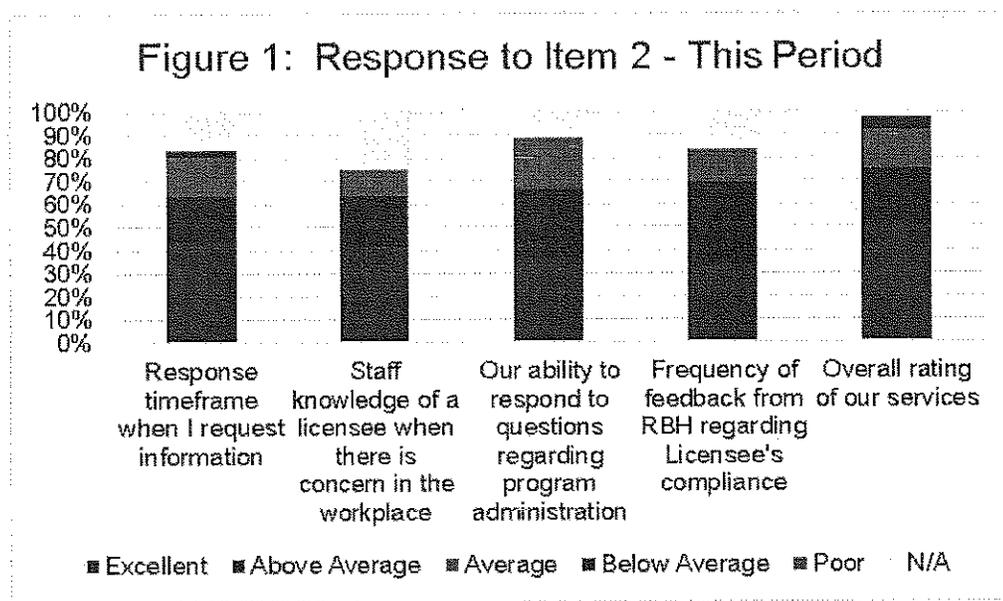
Question 2: Respondents are then asked to rate HPSP's services, including timeliness; knowledge of licensee when there is a concern in the workplace; ability to respond to questions regarding program administration; and frequency of feedback from RBH. Finally, an overall rating is requested. The mode response was "excellent" for all items except for "frequency of feedback" for which the mode was "above average." The mode response in year four was "excellent" for all items. Notably, the apparent decline in the mode for "frequency of feedback" actually represents an improvement: there was a slight increase in the percentage of "excellent" responses but a dramatic increase in the percentage of "above average" responses. This was counterbalanced by a decrease in "average" responses. Overall this period, a minimum of 63% of responses to each item was either "excellent" or "above average." Less than 8% of responses to any item was "below average" or "poor."

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

Table 3a This Period (n=36)	Excellent		Above Average		Average		Below Average		Poor		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
Response timeframe when I request information	16	44.4%	7	19.4%	6	16.7%	1	2.8%			6	16.7%
Staff knowledge of a licensee when there is concern in the workplace	15	41.7%	8	22.2%	4	11.1%					9	25.0%
Our ability to respond to questions regarding program administration	13	36.1%	11	30.6%	8	22.2%					4	11.1%
Frequency of feedback from RBH regarding Licensee's compliance	12	33.3%	13	36.1%	2	5.6%			3	8.3%	6	16.7%
Overall rating of our services	18	50.0%	9	25.0%	6	16.7%	2	5.6%			1	2.8%

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

Figure 1:



Supervision Support

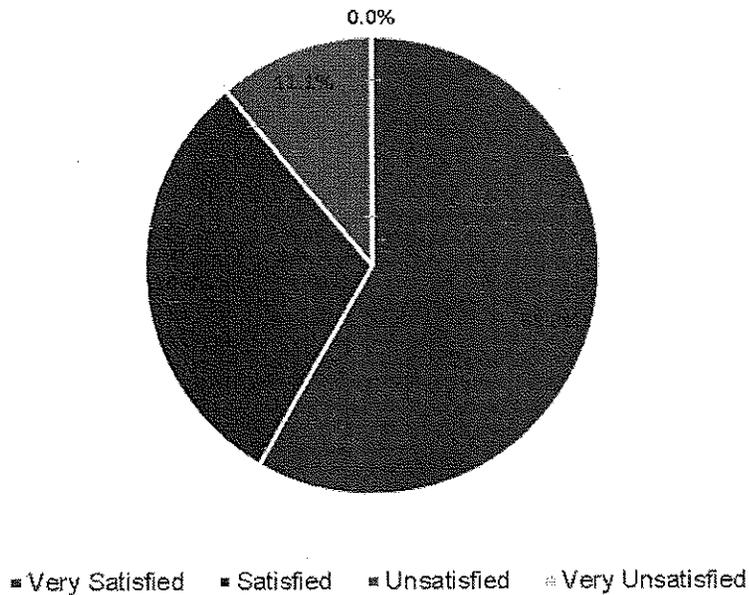
Question 3: The next item reads: "RBH supports your supervision of licensees. How satisfied are you with our support?" As we have seen previously, the majority of respondents are "very satisfied." The percentage providing this response has grown each year. There were a few more "unsatisfied" responses this period compared to the last two years however. Still, approximately 89% of respondents were "satisfied" or "very satisfied."

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

Table 4: Supervision Support	This Period (n=36)		Year 4 (n=89)		Year 3 (n=73)	
	#	%	#	%	#	%
Very Satisfied	21	58.3%	50	56.2%	36	49.3%
Satisfied	11	30.6%	35	39.3%	32	43.8%
Unsatisfied	4	11.1%	3	3.4%	5	6.8%
Very Unsatisfied						
No Response			1	1.1%		

Figure 2:

Figure 2: Satisfaction with Support (Item 3) - This Period



Workplace Safety

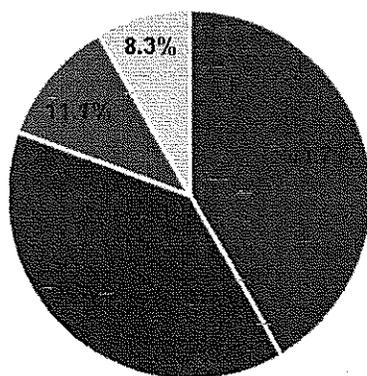
Question 4: RBH's ability to monitor the licensee to ensure safety in the workplace is queried in the next item. Again this period we find that the responses were positive with 41.77% rating this item "excellent," and 38.9% rating it "above average." Less than 20% of respondents rated this item "average" or "below average."

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

Table 5: Workplace Safety	This Period (n=36)		Year 4 (n=89)		Year 3 (n=73)	
	#	%	#	%	#	%
Excellent	15	41.7%	35	39.3%	31	42.5%
Above Average	14	38.9%	33	37.1%	18	24.7%
Average	4	11.1%	19	21.3%	21	28.8%
Below Average	3	8.3%			2	2.7%
Poor						
No Response			2	2.2%	1	1.3%

Figure 3:

Figure 3: RBH's Ability to Monitor the Licensee to Ensure Safety - This Period



■ Excellent ■ Above Average ■ Average ■ Below Average

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

Actual Comments – This Period:

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

1. I have had to refax the monitor paper multiple times
2. I appreciate the ability to send the monthly reports electronically via email (not having to print and fax)
3. I have received any communication since the clinician was brought on.
4. Question the test used to measure alcohol use; it seems to have been inaccurate, and the subject lost a week of work waiting to meet with the evaluator.

- It is difficult to remember to send in the monthly reports without reminders. I need an email for each RN I am supervising about a week before the report is due-with their name-included. It isn't helpful to get a reminder that something is overdue without the name of the nurse included.

Overall Experience

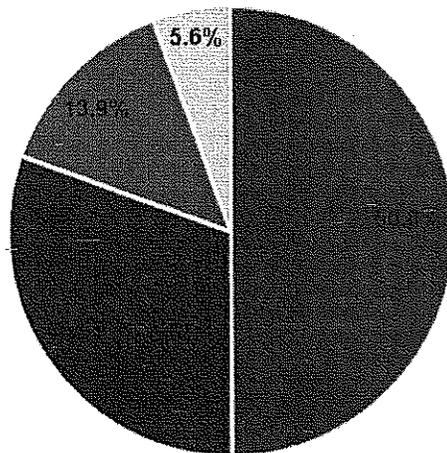
Question 5: Respondents are asked to rate their overall experience working with RBH. More than 80% of responses were either "above average" or "excellent." The mode responses was "excellent" (50%). There continue to be no "poor" responses.

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

Table 6: Overall Experience	This Period (n=36)		Year 4 (n=89)		Year 3 (n=73)	
	#	%	#	%	#	%
Excellent	18	50.0%	37	41.6%	31	42.5%
Above Average	11	30.6%	30	33.7%	20	27.4%
Average	5	13.9%	18	20.2%	15	20.5%
Below Average	2	5.6%	2	2.2%	4	5.5%
Poor						
N/A or No Response			2	2.2%	3	4.1%

Figure 4:

Figure 4: Overall Experience - This Period



■ Excellent ■ Above Average ■ Average ■ Below Average

Additional Comments

Actual Comments – This Period

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

1. Everything has run like clock work. Thanks for providing the opportunity for this wonderful RN to return to work in our program.
2. I find it difficult to rate my experience as above or below average, as this is the only time I have been involved in such monitoring of a colleague. I can say that the service has been very supportive of our needs in a delicate situation.
3. RBH sends multiple requests for reports already sent to them, however makes no direct communication as to how the clients are doing or what the clients ongoing needs may be. There seems to be a lack of organization at their office which then requires repeated responses from me. I don't appreciate the waste of time. The electronic version of the report form is a better form but cannot be saved or printed so is essentially unusable. This is too bad because it is a more comprehensive assessment of how the client is doing in their position.
4. I have had no contact with RBH other than completing the monthly monitoring forms.
5. Previous experiences were better
6. you ask for monthly feedback. It would be nice to get occ. feedback from you.
7. Would appreciate an online survey for reporting monthly.

Summary Analysis

The HPSP Employers' / Workplace Monitor's Satisfaction Survey had a response rate of 20.5%. Primarily, respondents indicated that their organizations provide either medical services (52.9%) or nursing services (35.3%). None of the respondents indicated that they provided pharmaceutical services.

Strong ratings were provided for HPSP's customer service, particularly in the case of timeliness of responses, knowledge of licensees when there is a concern in the workplace, ability to respond to questions regarding program administration and frequency of feedback regarding licensee's compliance. With only one exception the mode response to these items was "excellent." The exception was for "frequency of feedback" which had a mode rating of "above average." Although the mode for this item was "excellent" last year, this year's ratings still represented an overall improvement due to a substantial increase in the number of people rating the program "above average" instead of "average." In fact, less than 8% of responses to any item was "below average" or "poor."

Eighty-nine percent (89%) of respondents indicated that they were either "very satisfied" or "satisfied" with the support they receive when supervising licensees. Just over 80% of respondents indicated that they rate RBH's ability to monitor the licensee to ensure safety in the workplace as "excellent" or "above average." Finally, more than 80% rate their overall experience working with RBH HPSP as "excellent" or "above average."

A total of 12 comments were provided. These comments varied greatly and will be reviewed in detail by the PAC. One area that RBH can focus on is continuing to improve two-way communication with the Workplace Monitors.

Reliant Behavioral Health

Health Professionals' Services Program (HPSP)

Satisfaction of PROFESSIONAL ASSOCIATIONS

Purpose

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

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

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

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

Data Results

Response Rate

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

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

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

A total of nine surveys were emailed. One response was received for a response rate of 11.1%.

Results are provided for informational purposes only due to the small response rate.

Membership of Respondent

The first question asks respondents of which professional association they are members. The respondent this period was from the Oregon Nursing Association.

Table 2: Role of Respondent	This Period (n=1)		Year 4 (n=2)	
	#	%	#	%
Oregon Nursing Association	1	100%	1	50%
Oregon Medical Association			1	50%
Oregon Dental Association				
Oregon Pharmacy Association				

Customer Service and Communication

Question 2: Survey respondents are asked to rate three different statements relating to customer service, particularly timeliness and knowledge level.

Data Table 3 and 3a:

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

Table 3a: Year 4 (n=2)	Excellent		Above Average		Average		Below Average		Poor		N/A	
	#	%	#	%	#	%	#	%	#	%	#	%
The timeliness of our response to your inquiries					1	50%					1	50%
The knowledge level of our staff					1	50%					1	50%
Overall rating of our services					1	50%					1	50%

Value to Members

Question 3: Respondents are then asked "How valuable is the Health Professionals' Services Program to your membership?" The one respondent replied "unvaluable."

Data Table 4:

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

Feedback from Membership

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

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

Table 5: Value to Membership	This Period		Year 4	
	#	%	#	%
Excellent				
Above Average				
Average				
Below Average			2	100%
Poor	1	100%		
N/A				

Additional Comments

Actual Comments – January 2015:

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

1. One of our members has had little success in interacting with the staff from RBH. Additionally, despite her voluntary admission for a substance use disorder, she has been subjected to many urine tests. From her description, and her particular situation, it seems excessive. In another case, the frequency of urine testing and the type of testing seems to be inconsistent with the situation.

Summary Analysis

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

The response was from the Oregon Nurses Association. The value of the HPSP services to membership was rated "unvaluable." The feedback received from membership was rated "poor." The comment received was negative, citing frequency of urine tests and difficulties interacting with staff by a member.

Reliant Behavioral Health

Health Professionals' Services Program (HPSP)

Satisfaction of TREATMENT PROVIDERS

Purpose

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

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

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

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

Data Results

Response Rate

Table 1: Response Rate	This Period	Year 4	Year 3	Year 2
# Sent	180	387	294	62
# Responses	24	28	27	5
Response Rate	13.3%	7.2%	9.2%	8.1%

Satisfaction Survey was distributed to those individuals and programs that provide various treatment services to Licensees enrolled in HPSP. A total of 180 surveys were sent by mail or email this period and 24 responses were received. The response rate this period was 13.3%, an improvement over prior years.

Role of Respondent

The first question asks the respondents the capacity in which they have provided services to HPSP licensees. They are able to provide more than one response. The 24 respondents provide a total of 33 responses. As a result, percentages total more than 100%. Fifty percent (50% (12)) of respondents indicated that one of their roles is mental health therapist. This was closely followed by the role of Monitor (e.g. PMC, GMC or Quarterly Monitor) with 11 (33.3%) of the responses. Last year the majority of respondents indicated that they were Monitors at 39.4%.

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

Table 2: Role of Respondent	This Period (n=24)		Last Year (n=28)	
	#	%	#	%
Chemical Dependency Counselor	7	29.2%	4	14.3%
Evaluator	1	4.2%	2	7.1%
Mental Health Therapist	12	50.0%	6	21.4%
Monitor (PMC / GMC / Quarterly Monitor)	11	45.8%	13	46.4%
Pain Management			1	3.6%
Psychiatrist	1	4.2%	2	7.1%
Treating physician	1	4.2%	1	3.6%
Other			2	7.1%
Unspecified			2	7.1%

Customer Service and Communication

Question 2: Survey respondents are asked to rate three different statements relating to customer service, particularly communication between HPSP and the provider. The majority of respondents "Agreed" that their concerns were responded to promptly, that information was communicated clearly and professionally and that they had all the information needed when seeing the client. An additional 25-30% of respondents "strongly agreed" with each of the three statements. This is consistent with responses last year and continues to represent an improvement from year three.

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

Table 3a: This Period (n=24)	Strongly Agree		Agree		Disagree		Strongly Disagree		N/A		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
My questions and/or concerns were responded to promptly	6	25.0%	12	50.0%	2	8.3%	1	4.2%	3	12.5%		
Information was communicated clearly and professionally	6	25.0%	13	54.2%	2	8.3%	1	4.2%	2	8.3%		
I had all the information I needed when I saw the licensee	7	29.2%	12	50.0%	3	12.5%	2	8.3%				

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

Overall Experience

Question 3: Respondents are next asked "Overall, how would you rate your experience working with RBH staff of the HPSP program?" The mode response was "excellent" for this period, compared to "above average" last year (year 4) and "average" in year 3.

Data Table 4: The mode (most frequent) response is highlighted in red.

Table 4: Overall Rating	This Period (n=24)		Year 4 (n=28)		Year 3 (n=27)	
	#	%	#	%	#	%
Excellent	8	33.3%	7	25.0%	5	19.2%
Above Average	5	20.8%	10	35.7%	4	15.4%
Average	7	29.2%	8	28.6%	12	46.2%
Below Average	3	12.5%	3	10.7%	4	15.4%
Poor					1	3.8%
N/A or No Response	1	4.2%			1	3.8%

Additional Comments

Actual Comments – This Period:

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

- I have not had any contact with HPSP staff. All communication comes from the licensee. The licensee is also sometimes unaware of expectations of HPSP.
- I did not have information about this program.
- The communication and working with agreement monitors and other admin staff has been excellent. However, communication with program manager [name] has been poor. My hope is this would improve.
- The medical board's and HPSP's stand of monitoring and not supporting physicians has greatly limited physicians asking for help who might need assistance with addiction issues.
- There doesn't seem to be an investment in the care of each participant. There should be an initial planning meeting with all parties involved paid for by HPSP, otherwise everyone is less effective, working in a vacuum with this type of care.
- Your reimbursement rate is horribly low and makes me wonder if I can afford to see your members.
- The fact that health professionals have no support or advocacy in this present program but are simply monitored has greatly limited the numbers of professionals which have traditionally been served in this area

8. I appreciate the service you offer for licensee's.
9. Everyone on the RBH staff was polite and professional even though they understood that I disagreed with the basic tenants of the program which was ultimately why I discontinued working for the program.
10. I have worked with the program for several years and am in a fairly urban setting. Although I have inquired about additional referrals and have offered to do groups as well, no referrals have been forthcoming. In addition, I have not been kept abreast of issues with some of the licensees I have worked with and their issues.

Summary Analysis

The response rate to the HPSP Treatment Provider Satisfaction Survey was 13.3%, representing a significant improvement. Respondents varied in their relationship to the licensee. Fifty percent (50%) indicated that in one of their roles they serve as a Mental Health Therapist and 45% described one of their roles as a monitor (e.g GMC,PMC).

The majority of respondents "agreed" that their concerns were responded to promptly, that information was communicated clearly and professionally and that they had all the information needed when seeing the client. "Excellent" was the most common response to the overall experience working with RBH, representing a continued improvement from the last few years.

Ten comments were received and were primarily negative. This is in contrast to the positive data responses already described. The PAC will review each comment individually and develop an appropriate action plan. Clearly, RBH should continue to work to strengthen the relationship with the various Treatment Providers based on the feedback provided and the response rate. A collaborative relationship will be beneficial to the support of the licensees in their recovery and will improve monitoring.

Reliant Behavioral Health

Health Professionals' Services Program (HPSP)

Satisfaction of BOARDS

Purpose

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

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

Feedback includes information about the overall program and staff, timeliness of responses to inquiries, knowledge level of staff, RBH's ability to enroll referred licensees, and RBH's ability to administer the program.

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

Data Results

Response Rate

Table 1: Response Rate	This Period	Year 4	Year 3
# Sent	7	13	17
# Returned	5	8	8
Response Rate	71.4%	61.5%	47.1%

The HPSP Boards Satisfaction Survey was emailed to representatives at 100% of the participating Boards. The response rate was 71.4%, representing five responses to seven surveys sent. This is an improvement from last year's response rate of 61.5% and the prior year's rate of was 47.1%.

Respondents

Question 1: This period surveys were sent to three representatives from the Medical Board, two from the Board of Pharmacy and one each from the other two boards. Respondents this period represented all four boards: the Medical Board (2), the Board of Dentistry (1) the Board of Pharmacy and the Board of Nursing (1).

Table 2: Respondents by Board	This Period (n=5)		Year 4 (n=8)		Year 3 (n=8)	
	#	%	#	%	#	%
Medical Board	2	40.0%	4	50.0%	5	62.5%
Board of Nursing	1	20.0%	1	12.5%	1	12.5%
Board of Dentistry	1	20.0%	2	25.0%		
Board of Pharmacy	1	20.0%	1	12.5%	2	25%

Services

Question 2: Respondents were asked to rate four different service components based on their experience. The mode response for each item was "Excellent," with at least 60% of responses. There were also 20-40% "Above Average" responses for each item. There was one "Below Average" response for the first item, "staff knowledge...." Despite this response, the overall data represents a major improvement from last year's data. (See Tables 3a and 3b.)

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

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

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

What Should We Improve?

Actual Comments – January 2015:

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

1. Performance among the monitors is extremely variable. Oftentimes it appears that they do not read evaluation reports, licensees are concerned that there is little contact or response. Usually centers around the same monitors.

Additional Comments

Actual Comments – January 2015:

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

1. I believe we have hit that phase in the program where the bugs and been worked out and we are moving along well. The trick is to not become complacent. Quality of evaluations, monthly reports and treatment programs change with time so diligence on quality should be an on going process.
2. I think we have an excellent working relationship.
3. Overall I believe that some of the issues with the nursing board are due to the relationship with the program which is clearly different from all the other boards. The BON also needs to work towards how the relationship can be improved.

Summary Analysis

The response rate this period was 71.4% with responses from all four Boards.

The following four statements were rated:

1. Staff knowledge of the case when I need to discuss a board referred licensee
2. Response timeframe when I request information
3. Our ability to respond to Board concerns regarding program administration
4. Overall, how do you rate our services

These items all had a mode response of "Excellent" and showed great improvement from the prior year. There was one "Below Average" response for the first item which is related to staff. There was also a comment made expressing concern about consistency among agreement monitors. Other comments noted an excellent working relationship between RBH and the board and that things are "moving along well." The relationship with the BON was discussed in the last comment.

UNFINISHED
BUSINESS
&
RULES

Nothing to report under this tab

CORRESPONDENCE

Nothing to report under this tab

OTHER ISSUES

PORTLAND, OR 97201
(971) 673-3200

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

Name of Institution/Program:	South Puget Sound Community College Dental Assisting Tech.		
Name of Program Director:	Dr. Dana Larson		
Address:	2011 Mottman Rd SW		
City:	State:	Zip code:	Telephone:
Olympia	WA	98512	360-596-5295

Date Institution/Program adopted/revised current Curriculum:	February 19, 2013
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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: 2-2-2015

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Date:	_____
<input type="radio"/>	Application
<input type="radio"/>	Paid Receipt
Initials:	_____

EXPANDED FUNCTION DENTAL AUXILIARY (EFDA) 2015-2016

Application Dates: January 2, 2015 to July 1, 2015

Last name, First name, M.I.:	Student ID#:
Email address:	Social Security#:
Day telephone:	Date of Birth:
Previous Last Names:	
Are you currently Certified (CDA) with the Dental Assisting National Boards? <input type="checkbox"/> YES <input type="checkbox"/> NO **if yes, please attach a copy of your current Certificate	
Education and Training (check one): <input type="checkbox"/> Graduate from a Commission on Dental Accreditation (CODA) Dental Assisting Program **attach a copy of Certificate of Completion or proof of completion with name of school and year graduated <input type="checkbox"/> Graduate from a non-accredited Commission on Dental Accreditation, Dental Assisting Program ** attach a copy of Certificate of Completion or proof of completion with name of school and year graduated <input type="checkbox"/> Education/trained on the job in the profession of Dental Assisting. **list dental practice in which training took place and include dentist's name and contact information: a. _____ b. _____	
Employment Information: List employer(s) where you have assisted in restorative procedures for three of the last five years:	
Dentist: _____	Dates: _____ Phone Number: _____
Dentist: _____	Dates: _____ Phone Number: _____
Dentist: _____	Dates: _____ Phone Number: _____
Before submitting this form, students are required to:	
<input type="checkbox"/> Complete the online South Puget Sound Community College Application. https://www.public.ctc.edu/ApplicantWebClient/Applicant/ApplyWelcome.aspx	
<input type="checkbox"/> Pay the \$25 application fee (code AD) and submit the receipt with application. If mailing the form, submit the fee for processing. This fee is non-refundable.	
<input type="checkbox"/> Include all required supporting documentation with application AND sign and date Page 4:	
<input type="checkbox"/> Copy of Current RDA credential	
<input type="checkbox"/> Proof of Hepatitis B inoculation or immunity	
<input type="checkbox"/> Sponsoring Dentist Statement of Commitment Form	
<input type="checkbox"/> Current CPR Card	

ADMISSIONS CRITERIA:

- Three years of chairside dental assisting experience in the last 5 years
- Current RDA credential
- Proof of Hepatitis B inoculation or immunity
- Employment with a 'sponsoring dentist' who provides mentoring, instructional support and the clinical aspect of the last quarter in the program
- Passing scores on SPSCC pre-entrance exams: Chairside (written multiple choice – questions covering basic chairside assisting information) and practical coronal polish, sealants, and radiographs on simulators. Pre-entrance exams evaluate an applicant's knowledge of basic chairside assisting, their ability to place sealants, perform coronal polishes, and capture a diagnostic, full-mouth set of intra-oral radiographs.
- Current CPR card
- If applicant is NOT a graduate of a CODA dental assisting program, he or she MUST be a current CDA (Certified Dental Assistant). A copy of the Certificate or test results must be attached to the application. A Dental Assisting Course will be provided through the EFDA Program to satisfy Washington State's credentialing requirements for assistants who did not complete a program accredited by CODA but are certified.

APPLICATION PROCESS:

- Complete South Puget Sound Community College EFDA application and submit it with a \$25.00 non-refundable fee.
- Provide all documentation required on the EFDA application.
- Incomplete applications will not be processed or returned.
- Deadline for completed applications to be received by SPSCC: **July 1 of the application year, however, late applications may be considered by Program Director if openings are available.** Enrollment is limited to 15. The Program Director and SPSCC will keep application and submitted materials to be applied to the fall enrollment. Students with strong testing scores will not have to retest to be considered.
- Priority consideration for the pre-entrance exam will be given to the first 18 applicants with complete applications. Applicants will be notified no later than the end of the first week in July if they have or have not been selected to take the pre-entrance exam. The applicant's assigned exam date will be given at this time. Exams are given during the last three weeks of July and take up to three hours to complete. Exam packets will be sent to explain the process, and students will be notified of acceptance, or alternate status, the day after all testing is completed.
- Students register for courses by permission only from Dana Larson, Program Director.

IF ACCEPTED INTO THE EFDA PROGRAM STUDENTS WILL RECEIVE A PACKET OF INFORMATION REGARDING NEXT STEPS.

The packet will include:

- Related terminology and definitions (provided)
- Reading assignment in textbook (student will need to purchase) and related materials for first class lecture
- Detailed list of needed supplies and materials
- Contract between the sponsoring dentist and SPSCC that will need to be signed (unless the sponsoring dentist has already signed a contract with the college within the last three years).

EFDA PROGRAM ADDITIONAL INFORMATION

- The Expanded Function Dental Auxiliary (EFDA) is a licensed health care professional who is an integral member of the dental health team and can deliver services in a variety of settings from private dental practices to schools and community dental clinics.
- Besides the tasks presently allowed by law for the Registered Dental Assistant, the EFDA can place and finish amalgams and composite restorations as well as take final impressions.
- The EFDA can provide care under general supervision (dentist not present in office at the time) to include: coronal polish, sealants, fluoride treatment and exposing / processing dental radiographs.
- Licensure is granted by Washington State Department of Health. To become a licensed EFDA the applicant must successfully complete EFDA courses approved by the Dental Quality Assurance Commission, pass the Washington State Restorative Exam (WARE) written exam and the Western Regional Examining Board (WREB) practical exam. EFDA courses at South Puget Sound Community College are designed for the working Registered Dental Assistant. The courses are rigorous and are intended for committed and dedicated RDAs.
- All three quarters classes will be on Tuesdays from 5:30 to 8:30PM.

EXPANDED FUNCTION DENTAL AUXILIARY (EFDA) COURSES:

- The EFDA courses consist of three credit bearing classes. All three courses (Dent 200, 201 & 202) must be taken in succession.
- Only students with a grade of 'B' or better in each quarter class will be able to register for subsequent courses. Course content includes didactic, laboratory, and clinical components.
- Students must pass all three courses to successfully complete the EFDA program at South Puget Sound Community College and, thus, qualify to take the WARE (Washington Restorative Exam) and WREB (Western Regional Examining Board).

COURSES	CREDITS	LECTURE HRS	LAB HRS	CLINIC HRS in office	TOTAL HRS
Dent 200 – Fall Quarter	2	11	22	0	33
Dent 201 Winter Quarter	3	11	22	33	66
Dent 202 – Spring Quarter	4	11	22	66	99
Total EFDA Curriculum Credits/Hours	9	33	66	99	198

EFDA PROGRAM ADDITIONAL INFORMATION

PROGRAM COSTS (DOLLAR AMOUNTS ARE APPROXIMATE AND SUBJECT TO CHANGE):		
Application Fee	\$ 25.00	
Tuition	\$ 1,114.00	Subject to change by legislature Varies depending upon what the sponsoring dentist provides the student.
Lab Kit	\$ 1,000.00	
Acidental Typodont & Teeth	\$ 700.00	
White full Length Lab Coat	\$ 35.00	Subject to change due to manufacturer pricing and need for more teeth.
Personal Protection Equipment	\$ 50.00	
Textbook (2)	\$ 250.00	
Loups eye wear and light	\$ 1,000.00	Dependent upon manufacturer and the student's preference.
Malpractice Insurance	\$ 16.25	Yearly Fee
TOTAL:	\$ 4,190	

The costs listed below are not program costs at South Puget Sound Community College, but costs to become licensed by the State of Washington. They are listed for information only.	
EFDA State Licensure	175.00
WARE: Washington Restorative Exam, Written	275.00
WREB: Western Regional Examining Board, Restorative Exam	515.00
TOTAL	\$965.00

- Submit application to the Student Services One Stop in building 22 or mail to:

South Puget Sound Community College - Attention: Jean Walls - 2011 Mottman Road SW - Olympia, WA 98512

- Please contact Jean Walls at jwalls@spscc.edu or Heidi Dearborn at hdearborn@spscc.edu with any questions about the admissions process.
- Please contact Dr. Dana Larson, Director, at dlarson@spscc.edu or Cozette Polzin, Instructor, at cpolzin@spscc.edu with any questions about the curriculum.
- It is the student's responsibility to make sure all required documents are received.

EFDA students must follow all WISHA/OSHA protocol for infection control, hazardous materials / waste, and patient / operator safety. Access to a computer, internet, and email is mandatory.

Your signature certifies and confirms you have read, understood, and agree to comply with the requirements for the EFDA Program.

Applicant signature _____ Date _____

SPONSORING DENTIST: STATEMENT OF COMMITMENT

PLEASE PRINT

EFDA APPLICANT'S NAME: _____ DATE: _____

SPONSORING DENTIST'S NAME: _____

ADDRESS: _____ CITY: _____ ZIP CODE: _____

PHONE NUMBER: _____ EMAIL ADDRESS: _____

Thank you for considering being a sponsoring dentist for the applicant listed above. The Expanded Functions Dental Auxiliary Program at South Puget Sound Community College is a partnership between the dental community, student and the college. All play vital roles in the student's success. The sponsoring dentist contributes by:

- ✓ Providing the employee / EFDA student with the preceptorship site second and third quarters for taking final impressions and placing and finishing 64 required restorations in patients who have been screened and chosen by the dentist.
- ✓ Complete written evaluations (provided) for each composite and amalgam placed
- ✓ If you do not use amalgam as a restorative material, help the student secure needed sites where student can place/carve required amalgam restorations.
- ✓ Guiding and mentoring the EFDA student as he/she practices placing amalgam and composite restorations in assigned typodont teeth.
- ✓ First quarter, helping to evaluate the student's restorations in typodonts using the evaluations provided by the college.
- ✓ If possible, providing (temporarily) needed restorative instruments, dental materials and a high speed handpiece for the student from your office. Students can also purchase these instruments and materials through an arrangement with Smart Practice. It is not expected that the sponsoring dentist provide the items; but if provided, it is very much appreciated.
- ✓ Sponsoring dentists need to provide contact information to receive pertinent information including review of the preceptorship and other responsibilities.
- ✓ Signing a contract agreement with SPSCC. This agreement is for the dentist's protection as well as the college and is a very basic contract. FYI: Students will be required to purchase malpractice insurance from the college before starting the preceptorship in your office.
- ✓ Contacting the professor regarding any concerns or questions as needed.

This form must be signed by the sponsoring dentist, attached to the student's application and turned into the college before the student can be considered for testing and registration.

i have read the *Sponsoring Dentist: Statement of Commitment* and agree to help the EFDA student /employee accomplish the goals of the program at South Puget Sound Community College.

Sponsoring Dentist's signature: _____ Date: _____

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**SOUTH PUGET SOUND
COMMUNITY COLLEGE**

TITLE: Expanded Functions Dental Auxiliary I **DEPT:** DENT **No.** 200 **CREDITS** 2

COURSE OUTLINE

COURSE DESCRIPTION: Combined lecture/lab course. In the lab setting, place, carve, and finish amalgam and composite restorations as well as take final impressions and construct temporary crowns. This includes: dental materials, assessment, indications and contraindications, armamentarium, Black's cavity classifications, occlusal relations, and ergonomics.

Prerequisite: Student is admitted upon approval by Program Director. Must have completed an accredited Dental Assisting Program, or be a currently Certified Dental Assistant. Applicants need to have a Washington State Registered Dental Assistant credential. Must have at least three years of recent full-time equivalent working experience as a Dental Assistant. Must be able to satisfactorily perform a coronal polish, sealant placement, full mouth set of radiographs, and pass a written exam.

I. INSTRUCTIONAL RESOURCES:

- A. Fundamentals of Operative Dentistry a Contemporary Approach. Third Edition, Quintessence Books, Author: Summitt, Robbins, Hilton, Schuntz, or similar text.
- B. The Dental Assistant. Seventh Edition, Delmare Books, Author: Anderson and Pendleton.

II. STUDENT LEARNING OUTCOMES:

Upon completion of the course, the student will be able to:

- A. Describe each permanent tooth according to anatomical features, function, and morphology as it pertains to restorative materials.
- B. Describe each deciduous tooth according to anatomical features, function, and morphology as it pertains to restorative materials.
- C. List the oral anatomy.
- D. List the universal charting system.
- E. Review risk management and charting.
- F. Identify Black's Classification of cavity preparation.
- G. Describe the importance of ergonomics as the operator during the placing and finishing of restorations.
- H. Identify the armamentarium used to place, carve, and finish amalgam restorations.
- I. Identify the armamentarium used to place and finish composite restorations.
- J. Explain the function and correct placement of the wedge, Tofflemire retainer/matrix and the Composi tight.
- K. Describe how tissues surrounding the tooth may be impacted during the placement of matrix/wedge and causes of improperly contoured restoration.
- L. List and describe the surfaces within a cavity preparation.
- M. Describe various systems for bonding, bases, and liners.
- N. Describe the correct use of PPE's.
- O. Explain the physical properties, manipulation techniques, and safety protocol of amalgam.
- P. Explain the advantages, indications, and contraindications for placing, condensing, and carving amalgam and composite restorations.
- Q. Describe the principals and procedural steps for placing, condensing, carving amalgam restorations.
- R. Describe correct occlusal relations and the process for checking/adjusting the occlusion of an amalgam and composite restoration.
- S. Describe the desirable restorative outcomes of correctly placed amalgam.
- T. Demonstrate correctly placing and carving amalgam restorations in typodont teeth.
- U. Differentiate between composite materials, appropriate uses, advantages/disadvantages, and indications/contraindications to include: glass ionomer; resin-filled glass ionomer; resin composite; flowable resin composite.

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- V. Explain the physical properties of composites to include shrinkage, thermal expansion, and wear resistance.
 - W. Describe the factors that affect shade selection of composite restorative materials.
 - X. Explain the importance of moisture control and preventing contamination of the cavity preparation before placement of restorative materials.
 - Y. Describe the principles and procedural steps in placing and finishing composite restorations to include desirable restorative outcomes.
 - Z. Describe appropriate postoperative instructions after the placement of amalgam and composite restorations.
 - AA. Demonstrate the correct placing and carving of composite restorations in typodont teeth.
 - BB. List the different kinds of impression materials and their uses.
 - CC. List anatomical structures that should be included in final impressions.
 - DD. Describe the different systems for gingival deflection and retraction including homeostasis.
 - EE. Demonstrate the steps for placing and removing gingival retraction cord.
 - FF. Describe the purpose of the taking of an occlusal relations impression (bite registration).
 - GG. List the guidelines to follow when selecting the proper tray size for the mandibular and maxillary arch and check-bite trays.
 - HH. Indicate guidelines to follow when working with a patient who has a tendency to gag.
 - II. Indicate instructions given to patients while taking maxillary and mandibular impressions.
 - JJ. Demonstrate operator and patient positioning while taking mandibular and maxillary impressions.
 - KK. Describe and demonstrate manipulation of impression materials for final impressions.
 - LL. Discuss the common anomalies to examine before taking impressions.
 - MM. Describe the criteria for preparing and properly seating a loaded impression tray.
 - NN. Properly load and, after removing the gingival packing cord, seat, align, and stabilize the loaded tray to create accurate impressions.
 - OO. Demonstrate the correct way to remove an impression tray after the material has set up.
 - PP. Evaluate the final impression for accuracy according to established criteria.
 - QQ. Discuss probable results when seating the impression tray too far anterior or posterior.
 - RR. Demonstrate the correct handling of final impression after removal from the oral cavity.
 - SS. Demonstrate the process of preparing the final impression for transport to prevent cross-contamination.
 - TT. Demonstrate the technique for taking bite registrations.
 - UU. Explain the importance of work and setting times in situations where two impression materials are used simultaneously.
 - VV. Indicate how the setting time of impression material can be altered.
 - WW. Review the components necessary for completion of a laboratory prescription.
 - XX. Describe the steps in computer-assisted design and computer-assisted manufacturing.
- III. COLLEGE-WIDE ABILITIES:**
- A. Think logically and critically.
 - B. Understand ethical responsibilities and consequences.
- IV. COURSE CONTENT:**
- A. Full permanent and deciduous dentition Features, function, identifying factors:
 - a. Anterior teeth.
 - b. Posterior teeth.
 - c. Morphology as it pertains to placing restorative materials.
 - B. Black's Classification of cavity preparation:
 - a. Teeth and surfaces in each classification
 - i. Class I – Pit and fissure.
 - ii. Class II – Posterior interproximal.

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- iii. Class III – Anterior interproximal.
 - iv. Class IV – Anterior interproximal involving incisal angle.
 - v. Class V – Gingival margin anterior/posterior.
 - vi. Class VI – Incisal edge or occlusal cusp tips.
- C. Anatomy of cavity preparation:
- a. Axial wall.
 - b. Distal wall.
 - c. Facial wall.
 - d. Gingival floor.
 - e. Lingual wall.
 - f. Mesial wall.
 - g. Pulpal floor.
 - h. Margins of prep.
 - i. Cavosurface margin.
- D. Risk management and charting.
- E. Correct use of PPE's during procedures.
- F. Intra oral anatomy.
- G. Ergonomics:
- a. Patient position in relationship to operator and arch/tooth being worked on.
 - b. Operator position in relationship to the patient and arch/tooth being worked on.
 - c. Correct seating in operator's chair.
 - d. Relationship to procedural tray and materials.
 - e. Dental light positions for maxillary and mandibular arches.
 - f. Use of fulcrums.
- H. Armamentarium used to place and finish amalgam/composite restorations
- a. Equipment.
 - b. Instruments.
 - c. Materials.
 - d. Tray set up.
- I. Maintain operator's field:
- a. Moisture control before and during placement of restorative materials.
 - b. Retraction.
 - c. Use of dental dam.
 - d. Dental light position.
- I. Matrix and wedge:
- a. Tofflemire retainer system/Composi tight/other.
 - b. Placement/evaluation.
 - c. Criteria for effectiveness:
 - i. Contour of tooth.
 - ii. Proximal contacts.
 - iii. Incorrect placement's impact on gingival tissues.
- J. Prepare/place/evaluate dental materials:
- a. Bases.
 - b. Liners.
 - c. Bonding materials.
- K. Place, condense, and carve amalgam and composite restorations.
- L. Amalgam safety protocol:
- a. MSDS.
 - b. Excess amalgam disposal.
 - c. Handling of amalgam during mixing, placing and carving.

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- M. Physical properties of composite and amalgam to include: composition, shrinkage, thermal expansion and wear resistance.
- N. Composite shade selection.
- O. Use of curing light:
 - a. Eye protection.
 - b. Recommended seconds.
 - c. Monitoring effectiveness of light.
 - d. Auto cure/light cure.
- P. Place and finish composite restorations:
 - a. Standard placement.
 - b. Incremental system.
- Q. Evaluation of composite and amalgam restorations
 - a. Well adapted.
 - b. Functionally correct.
 - c. Esthetically pleasing.
 - d. Harmonious anatomy.
- R. Check occlusion relation of composite/amalgam restoration:
 - a. Procedure.
 - b. Instruments.
 - c. Adjusting restoration.
- S. Post operative instructions.
- T. Impression materials: Polyether, polysulfide, polyvinyl siloxane, hydrocolloids.
- U. Two-paste impression system:
 - a. Mixing/working time.
 - b. Setting times.
 - c. manipulation of material.
 - d. Loading of syringe/tray.
- V. Taking of final impressions:
 - a. Most common materials and trays used today.
 - b. Purpose of final impressions/
 - c. Moisture control/
 - d. Anatomical structures that should be present in final impression/
 - e. Characteristics of satisfactory final impression.
 - f. Common anomalies to examine before taking impressions.
- W. Gingival retraction in preparation for final impressions:
 - a. Different type of materials.
 - b. Instrumentation.
 - c. Homeostasis.
 - d. Placement/removal.
- X. Selection of proper tray size:
 - a. Maxillary.
 - b. Mandibular.
 - c. Modifying tray.
 - d. Custom trays.
 - e. Check bite tray.
- Y. Bite registration:
 - a. Purpose.
 - b. When taken.
 - c. Materials used.
 - d. Mixing.

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- e. Placing material and using visual markers for accurate seat and bite.
 - f. Importance of correct bite.
 - g. Gauging correct bite.
 - Z. Manipulation of impression materials:
 - a. Dispensing.
 - b. Loading tray.
 - c. Working time.
 - AA. Seating loaded tray:
 - a. Operator position.
 - b. Patient position.
 - c. Instructions to patient.
 - d. Maxillary/mandibular.
 - e. Triple tray.
 - f. Setting times.
 - g. Altering setting times.
 - BB. Managing patient with gag reflex.
 - CC. Managing patient during placement and removal of impression.
 - DD. Evaluate final impression for accuracy:
 - a. Correct seat of tray.
 - b. Clear and visible marginal prep line.
 - c. No distortion of impression or images.
 - d. Results of tray seated too far anterior or posterior.
 - EE. Handling of final impression after removing from oral cavity:
 - a. Asepsis.
 - b. Protect integrity of impression.
 - c. Labeling of impression to include completion of laboratory prescription.
 - FF. Prepare final impression for transport to lab:
 - a. Treatment of contaminated final impression before sending to lab.
 - b. Components necessary for completion of a laboratory prescription.
 - GG. Computer-assisted designed/manufactured porcelain crowns.
- V. EVALUATION:**
- A. Evaluation will be based upon exams, competencies, written assignments, and participation as determined by the instructor.
 - B. The grading system will be in accordance with the South Puget Sound Community College Handbook.

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**SOUTH PUGET SOUND
COMMUNITY COLLEGE**

TITLE: Expanded Functions Dental Auxiliary II **DEPT:** DENT **No.** 201 **CREDITS** 3

COURSE OUTLINE

COURSE DESCRIPTION: This is a combination lecture, lab, and clinical application. Content includes: placement of restorative materials in patient simulators, mock WREB exams, preparation for the Washington Auxiliary Restorative Exam (WREB), Washington State Dental Practice Act, ethics, cultural diversity, endodontically restored teeth, oral health instructions to patients, related pharmacology, dental emergencies, and health history alters. In a clinical setting, students will perform on patients: coronal polish, sealants. fluoride application, and construction of temporary restorations.

Prerequisite: Must have passed previous quarter Dent 200.

I. INSTRUCTIONAL RESOURCES:

- A. Fundamentals of Operative Dentistry a Contemporary Approach. Third Edition, Quintessence Books, Author: Summitt, Robbins, Hilton, Schuntz, or similar text.
- B. The Dental Assistant, Seventh Edition, Delmare Books, Authors: Anderson & Pendleton
- C. Lab supplies as listed in separate handout. These can be purchased or supplied by the sponsoring dentist.

II. STUDENT LEARNING OUTCOMES:

Upon completion of the course, the student will be able to:

- A. Describe ethics and the Washington State Dental Practice Act as it pertains to: WAC; regulation of health care workers; Registered Dental Assistants; Expanded Functions Dental Auxiliary; expanded functions dental assistant; Dental Quality Assurance Commission; Uniform Disciplinary Act (UDA).
- B. Describe the dental emergencies that may occur in a dental office and how to respond.
- C. Describe relevant factors regarding the common use of drugs in dentistry and medicine, dosage and effects.
- D. Review patient's health history and note alerts, indications, and contraindications for treatment.
- E. Understand the role of cultural diversity in communicating to patients, peers, and employers.
- F. Prepare the armamentarium for amalgam and composite procedures.
- G. Follow amalgam safety protocol.
- H. Demonstrate the correct isolation and maintenance of the operator's field.
- I. Utilize ergonomics while placing and carving restorations to include: correct seating (operator and patient); placement of dental light; placement of equipment and materials; procedure set up.
- J. Correct use of PPE's.
- K. Demonstrate the use of the HVE and 3-way syringe when working without an assistant.
- L. Demonstrate efficient and effective placement of matrix and wedge for amalgam and composite restorations using Tofflemire and Compositi-tight systems.
- M. Prepare and place bases/liners/bonding materials as directed for restorative procedures.
- N. Demonstrate the correct use of the light cure unit to include operator and patient safety.
- O. Demonstrate proper trituration of amalgam and evaluate correctness of material before placing.
- P. Using criteria from Dent 200, place, condense, and carve amalgam restorations on typodonts.
- Q. Using criteria from Dent 200, place and finish composite restorations on typodonts.
- R. Evaluate amalgam and composite restorative outcomes to the established criteria including: well adapted; functionally correct; esthetically pleasing; harmonious anatomy.
- S. Check and adjust occlusal relations on completed restorations.
- T. Prepare for the Western Regional Examining Board (WREB) practicum exam.
- U. Prepare for the Washington Auxiliary Restorative Exam (WARE) written exam.
- V. Perform functions appropriate for different scenarios while maintaining proficiencies.

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- W. Review and perform oral health instructions, coronal polish, fluoride treatment, and sealant on clinical patient.
- X. Fabricate temporary restorations to include: acrylic; metal crown form; IRM.
- Y. Using criteria from Dent 200, take final impressions on typodonts.
- Z. Explain how endodontically treated teeth are to be restored using composite and amalgam materials.

III. COLLEGE-WIDE ABILITIES:

- A. Think logically and critically.

IV. COURSE CONTENT:

- A. Washington State Dental Practice Act:
 - a. Dental Quality Assurance Commission.
 - b. Uniform Disciplinary Act.
 - c. Expanded Functions Dental Auxiliary.
 - d. Registered Dental Assistant.
 - e. WAC/RCW.
- B. Ethics.
- C. Endodontically restored teeth.
- D. Review for the Washington Auxiliary Restorative Exam (WARE) midterm and final exam.
- E. Lab practice:
 - a. Amalgam restorations.
 - b. Composite restorations.
- F. Mock WREBS in lab setting.
- G. Oral health instruction to patients.
- H. Coronal polish/fluoride/sealants review:
 - a. Indications/contraindications.
 - b. Various materials used.
- I. Health history alerts.
- J. Dental emergencies.
- K. Related pharmacology.
- L. Cultural diversity.
- M. DA review.
- N. Proficiencies/scenarios assigned.
- O. Clinical application:
 - a. Temporary crowns and restorations.
 - b. Coronal polish, fluoride, and sealants.
 - c. Taking of final impressions.
- P. Continued requirements/proficiencies on typodonts:
 - a. Amalgam restorations.
 - b. Composite restorations.

V. EVALUATION:

- A. Evaluation will be based upon exams, competencies, written assignments and participation as determined by the instructor.
- B. The grading system will be in accordance with the South Puget Sound Community College Handbook.

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TITLE: Expanded Functions Dental Auxiliary III **DEPT:** DENT **No.** 202 **CREDITS** 4

COURSE OUTLINE

COURSE DESCRIPTION: This is a combination of lecture, lab and clinical application. It includes: mock WREB practice and final exam; preparation for mock WREB mid-term and final exam; lab review and continued practice with restorations; clinical application and evaluation of amalgam and composite restorations by the sponsoring dentist.

Prerequisite: Successful completion of DENT 201 with a "B" or better.

I. INSTRUCTIONAL RESOURCES:

- A. Fundamentals of Operative Dentistry a Contemporary Approach. Third Edition, Quintessence Books, Author: Summitt, Robbins, Hilton, Schuntz, or similar text.
- B. The Dental Assistant, Seventh Edition, Delmare Books, Authors: Anderson & Pendleton.

II. STUDENT LEARNING OUTCOMES:

Upon completion of the course, the student will be able to:

- A. Prepare appropriate armamentarium for amalgam and composite restorations.
- B. Follow amalgam safety protocol.
- C. Ensure moisture control and non-contamination of the cavity preparation during the procedure.
- D. Demonstrate proper placement of matrix and wedge.
- E. Prepare, place, and finish assigned amalgam/composite restoration to include bases, liners, bonding materials.
- F. Evaluate each restoration according to the established criteria which includes: Well-adapted, functionally correct, esthetically pleasing (composite), harmonious anatomy, and correct proximal contacts.
- G. Check bite and make occlusal adjustments as needed.
- H. Provide post-operative instructions to clinical patients.
- I. Prepare for State WARE exam:
 - a. review.
 - b. mock WARE mid-term exam.
 - c. mock WARE final exam.
- J. Take graded assigned mock WREB exams, using typodonts, in preparation for the State WREB exam requirement.

III. COLLEGE-WIDE ABILITIES:

- A. Think logically and critically.

IV. COURSE CONTENT:

- A. Concerns / guidelines when working on patients.
- B. Licensed EFDA guest panel.
- C. Prepare for Washington State Restorative Exam (WARE).
- D. Mock WARE mid-term and final.
- E. Prepare for Western Regional Examining Board (WREB) exam.
- F. Mock WREB final exam.
- G. Lab application: review/continued practice:
 - a. Amalgam restorations on simulators.
 - b. Composite restorations on simulators.
- H. Clinical application on patients:
 - a. Amalgam restorations.

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- b. Composite restorations.
- c. Final impressions.
- d. Postoperative instructions.

V. EVALUATION:

- A. Evaluation will be based upon exams, competencies, written assignments and participation as determined by the instructor.
- B. The grading system will be in accordance with the South Puget Sound Community College Handbook.

**NEWSLETTERS
&
ARTICLES OF
INTEREST**

Nothing to report under this tab

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 HYGIENE

H6901	DEVON M PALMORE, R.D.H.	12/17/2014
H6902	SAMANTHA JO SHIPMAN, R.D.H.	12/26/2014
H6903	PHI JOHNNY TRAN, R.D.H.	12/26/2014
H6904	STEPHANIE NICOLE MARTINEZ, R.D.H.	12/30/2014
H6905	KIMBERLY SUE UPDEGRAFT, R.D.H.	1/9/2015
H6906	KAELA MARIE MORSS, R.D.H.	1/9/2015
H6907	MOLLIE ELIZABETH BRYANT, R.D.H.	1/22/2015
H6908	ALLISON J ARIAS, R.D.H.	1/28/2015
H6909	SMURF DARROW, R.D.H.	1/28/2015

DENTISTS

D10171	MACIEJ W DOLATA, D.D.S.	12/17/2014
D10172	EMILY CHRISTINE JONES, D.M.D.	12/17/2014
D10173	ARON D KIVEL, D.D.S.	12/17/2014
D10174	EUNSUN LEW, D.D.S.	12/17/2014
D10175	THAD LANGFORD, D.D.S.	12/17/2014
D10176	MIN SOO HAN, D.D.S.	12/17/2014
D10177	TYLER L CLARK, D.D.S.	1/9/2015
D10178	VANESSA N BROWNE, D.D.S.	1/9/2015
D10179	JOSHUA F TEH, D.D.S.	1/9/2015
D10180	WILSON D LEE, D.D.S.	1/20/2015
D10181	JOSHUA MICHAEL VAN DER BUNT, D.M.D.	1/22/2015
D10182	LESLEE SINGLETON HUGGINS, D.D.S.	1/22/2015
D10183	SUMEDHA SHARMA, D.M.D.	1/22/2015
D10184	ANNA THAO NGUYEN, D.M.D.	1/22/2015
D10185	CHRISTOPHER THOMAS BRADY, D.M.D.	1/22/2015
D10186	EMINE ZENGİN-DEMİR, D.M.D.	1/22/2015
D10187	JOSEPH VINCENT CALIFANO, D.D.S.	1/22/2015
D10188	MATTHEW C ALDRIDGE, D.M.D.	2/4/2015

ORAL AND MAXILLOFACIAL SPECIALTY

D10189	Michael P. Malmquist, D.M.D.	2/4/2015
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**LICENSE, PERMIT
&
CERTIFICATION**

Nothing to report under this tab