

PUBLIC PACKET

**OREGON BOARD  
OF  
DENTISTRY**

**BOARD MEETING  
APRIL 19, 2013**

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# APPROVAL OF MINUTES

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**OREGON BOARD OF DENTISTRY  
MINUTES  
February 15, 2013**

MEMBERS PRESENT: Patricia Parker, D.M.D., President  
Jonna E. Hongo, D.M.D., Vice-President  
Brandon Schwindt, D.M.D., (portion of meeting)  
Alton Harvey, Sr.  
Julie Ann Smith, D.D.S., M.D.  
Darren Huddleston, D.M.D.  
Jill Mason, M.P.H., R.D.H.  
Norman Magnuson, D.D.S.

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)  
Michelle Lawrence, D.M.D., Consultant (portion of meeting)  
Lisa Warwick, Office Specialist (portion of meeting)  
Stephen Prisby, Office Manager (portion of meeting)

ALSO PRESENT: Lori Lindley, Sr. Assistant Attorney General

VISITORS PRESENT: Donald Bretthauer, ODA; Beryl Fletcher, ODA; T. Boehm, CDC;  
Lynn Ironside, RDH, ODHA; Lisa Rowley, RDH, Pacific University;  
Steven Timm, DMD, ODA; Gary Allen, DMD, Advantage Dental;  
Pamela Lynch, RDH, ODHA; Robynne Peterson, ODAA

**Call to Order:** The meeting was called to order by the President at 7:30 a.m. at the Board office; 1600 SW 4<sup>th</sup> Ave., Suite 770, Portland, Oregon.

## **NEW BUSINESS**

### **MINUTES**

Ms. Mason moved and Dr. Magnuson seconded that the minutes of the December 14, 2012 Board meeting be approved as amended. The motion passed with Dr. Hongo, Dr. Schwindt, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

Ms. Mason moved and Dr. Magnuson seconded that the minutes of the January 7, 2013 Special Teleconference Board meeting be approved as amended. The motion passed with Dr. Hongo, Dr. Schwindt, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

## **ASSOCIATION REPORTS**

### **Oregon Dental Association**

Dr. Timms from the Oregon Dental Association introduced the new Executive Director, Don Bretthauer, who has been on staff for about three weeks. The Board extended a warm welcome to Mr. Bretthauer.

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

The ODHA had nothing to report.

### **Oregon Dental Assistants Association**

The ODAA had nothing to report.

## **COMMITTEE AND LIAISON REPORTS**

### **WREB Liaison Report**

Dr. Magnuson stated that he attended the WREB Board meeting a few weeks ago. WREB has added Illinois as a new member state. He added that WREB is currently thanking the long-term WREB examiners for their years of dedicated service and moving new examiners into circulation since recently there have been many new states joining as members.

Dr. Magnuson wanted to personally thank the board members who currently do examinations for WREB, as it's very important for the examination process.

### **AADB Liaison Report**

Dr. Parker reported that the Mid-Year meeting was being held in April this year and she would have a full report after that meeting.

### **ADEX Liaison Report**

Dr. Parker stated there was nothing new to report.

### **NERB Liaison Report**

Dr. Parker stated that she attended the NERB Annual meeting. She reported that many attendees had been discussing the need for a centralized service for providing background checks. In response the AADB has started polling states to find out if a central service to provide background checks would be something in demand.

Dr. Parker also stated that a comprehensive national occupational analysis has been done and based on those results, the scaling exercise from the ADEX exam is being removed as it was statistically insignificant with procedures performed by dentists. ADEX has now made the scaling exercise an optional part of the exam, and Dr. Parker clarified that there are still numerous parts of the exam that contain testing regarding perio, and it's just that the specific scaling portion was made optional.

Dr. Parker announced that she had been named the Chair of NERB's re-credentialing sub-committee, and that Dr. Smith will be moving to the steering committee, where Dr. Parker was previously serving.

Additionally she stated that there are two new member states: Mississippi and New Mexico and that NERB's attorney spoke about a new statute concerning nonprofit organizations. She also mentioned that the credentialing committee will also be focusing on moving new examiners into the rotation much like WREB will be.

### **Rules Oversight Committee Meeting Report**

Dr. Schwindt stated that the Rules Oversight Committee met on January 22<sup>nd</sup> and recommended the Board send the following rules to a public rulemaking hearing as published: 818-001-0002, 818-001-0087, 818-012-0005, 818-026-0000, 818-026-0020, 818-026-0060, 818-026-0065, 818-

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026-0070, 818-035-0030, 818-035-0066, 818-042-0040 & 818-042-0110.

**818-001-0002 Definitions**

Ms. Mason moved and Dr. Schwindt seconded that the Board send 818-001-0002 to a public rule-making hearing. The motion passed with Dr. Hongo, Dr. Schwindt, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

**818-012-0005 Scope of Practice**

Dr. Schwindt moved and Ms. Mason seconded that the Board send 818-012-0005 to a public rulemaking hearing. The motion passed with Dr. Hongo, Dr. Schwindt, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

**818-026-0000 Purpose**

Dr. Schwindt moved and Dr. Hongo seconded that the Board send 818-026-0000 to a public rulemaking hearing. The motion passed with Dr. Hongo, Dr. Schwindt, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

**818-026-0020 Presumption of Degree of Central Nervous System Depression**

Dr. Schwindt moved and Ms. Mason seconded that the Board send 818-026-0020 to a public rulemaking hearing. The motion passed with Dr. Hongo, Dr. Schwindt, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

**818-026-0060 Moderate Sedation Permit**

Dr. Schwindt moved and Ms. Mason seconded that the Board send 818-026-0060 to a public rulemaking hearing. The motion passed with Dr. Hongo, Dr. Schwindt, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

**818-026-0065 Deep Sedation**

Dr. Schwindt moved and Ms. Mason seconded that the Board send 818-026-0065 to a public rulemaking hearing. The motion passed with Dr. Hongo, Dr. Schwindt, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

**818-026-0065 (2)(h) and (7)(a) Deep Sedation**

Dr. Schwindt moved and Ms. Mason seconded that the Board send 818-026-0065 to a public rulemaking hearing. The motion passed with Dr. Hongo, Dr. Schwindt, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

**818-026-0070 General Anesthesia Permit**

Dr. Schwindt moved and Ms. Mason seconded that the Board send 818-026-0070 to a public rulemaking hearing. The motion passed with Dr. Hongo, Dr. Schwindt, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

**818-035-0030 Additional Functions of Dental Hygienists**

Dr. Schwindt moved and Ms. Mason seconded that the Board send 818-035-0030 to a public rulemaking hearing. The motion failed with Dr. Parker, Dr. Hongo, Dr. Huddleston and Ms. Mason voting aye and Dr. Schwindt, Mr. Harvey, Dr. Magnuson and Dr. Smith opposed.

Dr. Schwindt stated that silver nitrate is an irreversible procedure and in his opinion, is not consistent with the Board's prior decisions of only allowing reversible procedures. In addition there is a lack of supporting evidence that silver nitrate actually works.

### **818-042-0040 Prohibited Acts**

Dr. Schwindt moved that the Board send 818-042-0040 to a public rulemaking hearing. The motion died with no second.

### **818-042-0110 Certification- Expanded Functions orthodontic Assistants**

Dr. Schwindt moved and Dr. Hongo seconded that the Board send 818-042-0110 to a public rulemaking hearing. The motion passed with Dr. Hongo, Dr. Schwindt, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

### **818-001-0087 Fees**

Dr. Schwindt moved and Dr. Magnuson seconded that the Board send 818-001-0087 to a public rulemaking hearing. The motion passed with Dr. Hongo, Dr. Schwindt, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

### **818-035-0066 Addition Populations for Expanded Practice Dental Hygiene Permit Holders**

Dr. Schwindt moved and Ms. Mason seconded that the Board send 818-035-0066 to a public rulemaking hearing. The motion passed with Dr. Hongo, Dr. Schwindt, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

### **Rule Review**

Dr. Schwindt moved and Ms. Mason seconded that the Board accept the rule review of 818-042-0095 as recommended by the Rules Oversight Committee. The motion passed with Dr. Hongo, Dr. Schwindt, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

Dr. Schwindt moved and Dr. Magnuson seconded that the board accept the rule review of 818-035-0072 as recommended by the Rules Oversight Committee. The motion passed with Dr. Hongo, Dr. Schwindt, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

### **Implants**

Dr. Schwindt stated that there was recent discussion regarding implants and the maintenance of implant information requirements. This could possibly lead to providing the specific implant information to the patient to maintain and provide to the next dentist if and when needed. He stated that this will be discussed more fully at a future Rules Oversight Committee meeting.

### **Committee Meeting Dates**

There are no committee meeting dates scheduled.

## **EXECUTIVE DIRECTOR'S REPORT**

### **Budget Status Report**

Mr. Braatz stated that attached was the latest budget report for the 2011-2013 Biennium. The report runs from July 1, 2011 through December 31, 2012 and shows revenue of \$1,792,021.11 and expenditures of \$1,603,749.22. Mr. Braatz added that revenues continue to be on target and the expenditures to date are actually below what has been budgeted. He also stated that we have just begun the 2013 Online Dental License Renewals which is the last large revenue stream that we will have during the 2011 – 2013 Biennium and that the budget appears to be performing as expected.

### **Customer Service Survey Report**

Mr. Braatz attached a chart showing the OBD State Legislatively Mandated Customer Service Survey Results from July 1, 2012 through December 31, 2012.

He stated that the results of the survey show that the OBD continues to receive positive comments from the majority of those that return the surveys. A 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 as well.

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

Saturday, January 12, 2013 – Mr. Braatz made a presentation on “Corporate Dentistry” to the Northeast Regional Boards of Dental Examiners, Inc. Public Advocacy Committee in Orlando, Florida.

Wednesday, January 16, 2013 - Dr. Paul Kleinstub Dental Director/Chief Investigator made a presentation on the “Dental Practice Act/Jurisprudence Examination” to the Senior Dental Students at OHSU School of Dentistry, in Portland.

Friday, January 18, 2013 – Mr. Braatz made a presentation on “Record Keeping” to Advantage Dental in Redmond.

Wednesday, January 23, 2013 - Dr. Paul Kleinstub, Dental Director/Chief Investigator and Mr. Braatz made a presentation on the “Board of Dentistry” to the Senior Dental Students at OHSU School of Dentistry in Portland.

### **2013 Dental License Renewal**

Mr. Braatz stated that on January 23, 2013 the OBD mailed 1815 postcards informing dentists whose Oregon Dental License will expire March 31, 2013, that the on-line renewal was available. As of today, February 15, 673 dentists have renewed their licenses.

### **EPP Report**

Mr. Braatz stated that he has attached the full report of the EPP Dental Hygienist program in Oregon as a result of SB 738 that was implemented a little over one year ago.

### **OBD 2013-2015 Governor’s Balanced Budget**

Mr. Braatz stated that he has attached the 2013 – 2015 Governor’s Balanced Budget. OBD Board President Patricia Parker and Mr. Braatz appeared before the Oregon Legislature’s Education Subcommittee of the Joint Committee on Ways and Means on Monday, February 11, 2013 for the OBD Budget Hearing. If Board Members have questions about the OBD Budget, Mr. Braatz stated that he would be happy to answer them.

### **Legislative Update**

Mr. Braatz stated that he has attached a list of the Oregon Legislative Bills that the OBD is currently tracking that will have a direct impact on the Board or impact on the Board as a state agency.

Mr. Braatz reviewed some of the more significant bills, currently in circulation. He also indicated that the legislative session moves quickly and he would be closely monitoring the information coming from Salem as various bills are dropped, added or amended.

### **Board Member Appointment**

Mr. Braatz stated that Dr. Hongo was reappointed to the Board with her term ending April 1, 2016 and Dr. Schwindt has also been reappointed with his term ending April 1, 2017. The new Dental

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member of the Board will be Dr. Todd Beck of Portland with a term expiration of March 31, 2017 and the Board's new Public member will be Mr. James Morris of Portland with a term expiration of March 31, 2017. The Governor's Office is still working on replacing Ms. Mason's board hygiene seat.

### **Oregon Dental Conference**

Mr. Braatz stated that the ODC will be held at the Oregon Convention Center in Portland, April 4-6. He added that the OBD will once again have a presence at the ODC and we will have a table outside the Exhibit Hall. In addition, Mr. Braatz added that he and Dr. Kleinstub will be presenting as a part of the DBIC Risk Management Seminar on Thursday, April 4, 2013, as well as two other courses entitled "Record Keeping from the Board's Perspective" and "Ask the Board."

Mr. Braatz stated that Board staff has submitted all Board members' names to the ODA so those of you that have not registered will have name badges that allow you access to the Exhibit Hall. Mr. Braatz stated that he encourages all Board members to be available at the table and if possible, attend the course entitled "Ask the Board."

### **Smoking Cessation Prescriptions**

Ms. Mason asked the Board to review its policy on smoking cessation. Ms. Mason stated that this was brought up because OHSU wanted to increase its smoking cessation program as a tool for their dental students. In 1996 the Board's policy stated that tobacco cessation was within the scope of practice of dentistry, but since that time many other drugs have been introduced and felt it would be beneficial for the Board to review the policy. The Board could then either go on record stating that smoking cessation is within the scope of dentistry or possibly add a list of allowed prescriptions for dentists to prescribe for smoking cessation.

Dr. Smith stated that in her opinion, cessation counseling is clearly within the scope, but the actual prescribing should be referred to the patient's primary care physician as there are too many risks with the current drugs available. Dr. Schwindt agreed that the newer medications are different and include stronger and more varied reactions. He thought the Board should review its current policy.

Dr. Hongo moved and Dr. Schwindt seconded that the Licensing, Standards and Competency Committee should review and rewrite the policy as needed. The motion passed with Dr. Hongo, Dr. Schwindt, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

### **CAFR Gold Star Award 2012**

Mr. Braatz stated that the State Controller's Office has once again issued the OBD a FY 2012 Gold Star Certificate signifying that the OBD has provided accurate and complete fiscal year end information in a timely manner.

### **Governor's State of the State**

Mr. Braatz stated that attached was a copy of the Governor's State of the State Address that he wanted to share with the Board.

### **HPSP Satisfaction Survey**

Mr. Braatz stated that the most recent satisfaction survey from the HPSP program was attached for the Board's review.

### **Denturist Program**

HB 2145 passed in the 2011 Legislative session, which expanded the scope of practice for licensed denturists, including the placement of teeth whitening trays. The Board of Denture

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Technology is seeking out certain healthcare professionals to meet for a workgroup to discuss HB 2145's impact and repercussions in the healthcare community and on the public. They have proposed meeting dates of March 25, April 29 and July 22. Dr. Smith volunteered to attend one of the meetings.

### **Affirmative Action Report**

Mr. Braatz stated that he provided the Board with the most current Affirmative Action Report which has been accepted and approved by the Governor's Affirmative Action Office.

### **Newsletter**

Mr. Braatz stated that the newsletter is currently in production and that we are waiting to approve the final set of proofs. Mr. Braatz stated that his target date for mailing is the last week of February.

## **UNFINISHED BUSINESS**

### **CORRESPONDENCE**

#### **The Board received an email from Kristi Jacobo**

Ms. Jacobo sent an email to the Board regarding CDT code D0191, asking who can perform the functions described in this code. Mr. Braatz stated that his initial response was that a standard hygienist could not use this code, but an EPP hygienist as well as an EPP hygienist who has a collaborative agreement could, but he felt the Board needed to make a final decision on this. The Board directed Mr. Braatz to respond to Ms. Jacobo by stating that the Board has nothing to do with developing the CDT codes, but the functions described in CDT code D0191 can be performed by any licensed Oregon dental hygienist.

#### **The Board received a letter from Guy S. Shampaine, DDS - Chairman NERB**

Dr. Shampaine sent a letter to the board thanking Patrick Braatz for his participation in this year's Educational Conference.

## **OTHER BUSINESS**

#### **Request for Approval of EPP Dental Hygiene CE Provider – PCC Study Club**

Ms. Mason moved and Dr. Hongo seconded that the course be approved as presented. The motion passed with Dr. Hongo, Dr. Schwindt, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

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

No Articles

#### **Board Member Recognition**

Mr. Braatz presented plaques to Dr. Huddleston and Ms. Mason for their years of dedication to the Board.

**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 **2008-0256, 2005-0117, and 1997-0091.**

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

#### **2011-0208**

Dr. Schwindt moved and Ms. Mason seconded that the Board close the matter with a Letter of Concern addressing the issue of ensuring that when informed consent is obtained prior to providing treatment, PARQ or its equivalent, is documented in the patient records and that a dental diagnosis is documented to justify treatment that is subsequently provided. The motion passed with Dr. Hongo, Dr. Schwindt, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

#### **MARTIN, ELIZABETH J. R.D.H., 2012-0173**

Dr. Schwindt moved and Dr. Magnuson seconded that the Board issue a Notice of Proposed Disciplinary Action and offer a Consent Order incorporating a reprimand and a civil penalty in the amount of \$1,000.00. The motion passed with Dr. Hongo, Dr. Schwindt, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

**Dr. Schwindt left the meeting at 12:40 p.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.

#### **LICENSING ISSUES**

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

#### **CONSENT AGENDA**

**2013-0084** Dr. Hongo moved and Ms. Mason seconded that the referenced case be closed with No Further Action per the staff recommendations. The motion passed with Dr. Hongo, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

#### **COMPLETED CASES**

**2012-0087, 2013-0126, 2011-0076, 2012-0052, 2013-0120, 2012-0074, 2012-0165, 2013-0134, 2012-0045, 2013-0104, 2011-0201, 2012-0086, 2012-0124, 2012-0078, 2012-0061, 2011-0198, 2012-00161, 2012-0036 and 2012-0079** Dr. Hongo moved and Ms. Mason seconded that the above referenced cases be closed with a finding of No Violation of the Dental Practice Act or No Further Action per the Board recommendations. The motion passed with Dr. Hongo, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

**ANGLE, DARRELL, L. D.D.S., 2012-0031, 2012-0172 & 2013-0081**

Dr. Huddleston moved and Dr. Smith seconded that the Board issue a Notice of Proposed Disciplinary Action. The motion passed with Dr. Hongo, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

**BLACK, STEVEN W., D.D.S., 2013-0081**

Mr. Harvey moved and Dr. Magnuson seconded that the Board issue a Notice of Proposed Disciplinary Action and offer a Consent Order. The motion passed with Dr. Hongo, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

**2012-0080**

Dr. Smith moved and Dr. Hongo seconded that the Board close the matter with a STRONGLY worded Letter of Concern addressing the issues of ensuring that all treatment that is provided is completely documented in the patient records and that a dental diagnosis is documented in the patient records as justification for all treatment that is provided and for all prescriptions that are written. The motion passed with Dr. Hongo Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

**POOL, KARLA J., R.D.H., 2012-0226**

Ms. Mason moved and Dr. Magnuson seconded that the Board with respect to Respondent #1, move to close the matter with a determination of No Violation; and, with respect to Respondent #2, move to issue a Notice of Proposed License Suspension. The motion passed with Dr. Hongo, Mr. Harvey, Dr. Smith, Ms. Mason and Dr. Magnuson voting aye. Dr. Huddleston recused himself.

**2011-0224**

Dr. Magnuson moved and Dr. Hongo seconded that the Board close the matter with a STRONGLY worded Letter of Concern addressing the issue of ensuring that current radiographs are available prior to extracting multiple teeth and that when extracting multiple teeth, the condition of the patient's mouth corresponds to the current radiographs. The motion passed with Dr. Hongo, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

**KARLIN, HANNA, D.M.D., 2012-0077**

Dr. Huddleston moved and Ms. Mason seconded that the Board issue a Notice of Proposed Disciplinary Action and offer the Licensee a Consent Order in which the Licensee would agree to be reprimanded, to complete at least three hours of a Board approved course in record keeping, and make a restitution payment in the amount of \$961.00 to the patient. The motion passed with Dr. Hongo, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

**LEWIS, ANTHONY J., R.D.H., 2012-0177**

Mr. Harvey moved and Dr. Smith seconded that the Board issue a Notice of Proposed License Revocation. The motion passed with Dr. Hongo, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

**MOTLAGH, MARYAM M., D.M.D., & ZAVARI, BITA, D.M.D., 2012-0071**

Dr. Smith moved and Mr. Harvey seconded that the Board with regard to Respondent #1 issue a Notice of Proposed Disciplinary Action and offer a Consent Order incorporating a reprimand, and a civil penalty in the amount of \$1,000.00; with regard to Respondent #2 issue a Notice of Proposed Disciplinary Action and offer a Consent Order incorporating a reprimand, and a civil penalty in the amount of one thousand dollars \$1,000.00. The motion passed with Dr. Hongo, Mr.

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Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

**2013-0079**

Dr. Magnuson moved and Mr. Harvey seconded that the Board close the matter with a Letter of Concern reminding the Licensee that the Licensee is responsible for the content of marketing advertisements and how they comply with the Board rules. The motion passed with Dr. Hongo, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

**PREVIOUS CASES REQUIRING BOARD ACTION**

**BOLOURI, ALIREZA F., D.M.D, 2012-0224**

Dr. Huddleston moved and Dr. Hongo seconded the Board accept Licensee's proposal and offer Licensee a re-worded Consent Order incorporating a reprimand, three hours of continuing education in the area of record keeping, and cessation of placing posterior mandibular implants until completion of a Board approved continuing education course, with a hands-on facet, on implants. The motion passed with Dr. Hongo, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

**BURNS, TIMOTHY W., D.D.S., 2012-0083 & 2012-0167**

Mr. Harvey moved and Dr. Magnuson seconded that the Board move to deny Licensee's request and affirm the Board's action of 12/14/12. The motion passed with Dr. Hongo, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

**2011-0220**

Dr. Smith moved and Dr. Hongo seconded that the Board issue an Order of Dismissal dismissing the Notice of Proposed Disciplinary Action, dated 6/18/12, and close the matter with a Letter of Concern addressing the issue of ensuring that prior to providing treatment, informed consent is obtained from the patient or the patient's guardian, and the obtaining of informed consent is documented in the patient records. The motion passed with Dr. Hongo, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

**HENDY, JOHN A., D.D.S., 2011-0226**

Ms. Mason moved and Dr. Hongo seconded the Board deny Licensee's proposal and offer Licensee a Consent Order incorporating a \$4,334.00 restitution payment to patient PC. The motion passed with Dr. Hongo, Mr. Harvey, Dr. Smith, Ms. Mason and Dr. Magnuson voting aye. Dr. Huddleston recused himself.

**REGAN, MICHAEL C., D.M.D., 2010-0186**

Dr. Magnuson moved and Mr. Harvey seconded that the Board accept Licensee's proposal and offer Licensee a re-worded Consent Order incorporating a reprimand, a \$5,000.00 civil penalty, three hours of Board approved continuing education in the area of record keeping, and cessation of placing implants until completion of the Board approved 21 hour course, "Implant Mentoring I," or a comparable course including hands-on training. The motion passed with Dr. Hongo, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

**SCHWAM, STEPHEN P., D.D.S., 2009-0253**

Dr. Huddleston moved and Dr. Hongo seconded that the Board offer Licensee a Consent Order incorporating a reprimand; payment of \$9,936.00 in restitution to patient JM, to be paid within four months of the effective date of the Order; a \$2,500.00 civil penalty to be paid within six months of the effective date of the Order; and restriction from providing orthodontic treatment except under

the close supervision of a Board approved orthodontist. The motion passed with Dr. Hongo, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

**SULLENS, SHELLEY R., D.M.D., 1997-0091**

Ms. Mason moved and Dr. Hongo seconded that the Board grant Licensee's request and issue an Order of Dismissal, dismissing all Consent Orders related to this case. The motion passed with Dr. Hongo, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

**ZEHTAB, HAMID R., D.M.D., 2012-0203**

Dr. Hongo moved and Dr. Magnuson seconded that the Board reject Licensee's offer and affirm the Board's action of 8/3/12. The motion passed with Dr. Hongo, Mr. Harvey, Dr. Huddleston, Ms. Mason, Dr. Smith and Dr. Magnuson voting aye.

**LICENSURE AND EXAMINATION**

**Ratification of Licenses Issued**

Dr. Huddleston moved and Dr. Magnuson seconded that licenses issued be ratified as published. The motion passed with Dr. Hongo, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

**Dental Hygiene**

H6408	AMY L LUND, R.D.H.	11/27/2012
H6409	TRUDY ADELINE HOGG, R.D.H.	11/27/2012
H6410	DANIELLE M HOLT, R.D.H.	11/29/2012
H6411	KENDRA A BELL, R.D.H.	12/6/2012
H6412	LEANNE N CONZATTI, R.D.H.	12/6/2012
H6413	RACHEL A THOMAS, R.D.H.	12/6/2012
H6414	ASHLEY K ODOM, R.D.H.	12/11/2012
H6415	KORINE D SUESS, R.D.H.	12/11/2012
H6416	KELSEY J WILLIAMS, R.D.H.	12/13/2012
H6417	SHANNON G KIRBY, R.D.H.	12/27/2012
H6418	KATHERINE M PETERSON, R.D.H.	1/7/2013
H6419	LEEAH D TRAPALIS, R.D.H.	1/7/2013
H6420	NICOLETA BACIU, R.D.H.	1/7/2013
H6421	KATHLEEN J DRISSI, R.D.H.	1/7/2013
H6422	RACHEL MIDDLEBROOKS, R.D.H.	1/17/2013
H6423	SARAH R INSALL, R.D.H.	1/17/2013
H6424	CYNTHIA L PIERCE, R.D.H.	1/17/2013
H6425	AMANDA N OLIVER, R.D.H.	1/30/2013
H6426	ROSAURA REYES, R.D.H.	1/30/2013
H6427	COURTNEY E TRAHANES, R.D.H.	1/30/2013
H6428	DANIELLE M STEIN, R.D.H.	1/30/2013
H6429	SCOTT K AHRENS, R.D.H.	1/30/2013
H6430	FOUZIA BASHIR, R.D.H.	1/30/2013
H6431	RAVEN J MORRIS, R.D.H.	1/31/2013

**Dentists**

D9819	MELISA T SUSANTO, D.D.S.	11/29/2012
D9820	MONI AHMADIAN, D.M.D.	11/29/2012
D9821	CHRISTOPHER M JAMES, D.M.D.	12/6/2012
D9822	TRISTAN J PARRY, D.D.S.	12/6/2012
D9823	DESY P WILSON, D.D.S.	12/6/2012
D9824	DAVID R KRAWSKI, D.M.D.	12/6/2012
D9825	GRADY D SHAVER, D.M.D.	12/11/2012
D9826	GEORGE A MC KEE, D.D.S.	12/20/2012
D9827	PIPER L HUBER, D.D.S.	12/20/2012
D9828	TIMOTHY J MURPHY, D.D.S.	12/20/2012
D9829	ALYSON BARNES, D.D.S.	12/27/2012
D9830	MICHAEL B UFFENS, D.M.D.	1/7/2013
D9831	JENNIFER L HOUGH, D.M.D.	1/7/2013
D9832	AMARILDA B KANO, D.D.S.	1/17/2013
D9833	KEITH K KANO, D.D.S.	1/17/2013
D9834	ANDY R BURTON, D.M.D.	1/30/2013
D9835	RAMI S SAAH, D.D.S.	1/30/2013
D9836	KEVIN S DORIUS, D.M.D.	1/31/2013
D9837	JULIA GOURLEY, D.M.D.	1/31/2013

#### **License Reinstatement John D. Beals, DDS**

Dr. Huddleston moved and Ms. Mason seconded that the Board reinstate Dr. Beals' Oregon Dental License. The motion passed with Dr. Hongo, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

#### **License Reinstatement S. William Cheah, DDS**

Mr. Harvey moved and Ms. Mason seconded that the Board reinstate Dr. Cheah's Oregon Dental License. The motion passed with Dr. Hongo, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

#### **License Reinstatement Cindy L McKay, RDH**

Dr. Smith moved and Ms. Mason seconded that the Board reinstate Ms. McKay's' Oregon Dental Hygiene License. The motion passed with Dr. Hongo, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

#### **Non-Resident Permit Yusuke Suzuki, DMD**

Ms. Mason moved and Dr. Smith seconded that grant Ms. Suzuki a Non-Resident Permit. The motion passed with Dr. Hongo, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

#### **Request for Release of Investigative Files**

Dr. Magnuson moved and Dr. Smith seconded that the Board release investigative file for 2012-0024 pursuant to the law. The motion passed with Dr. Hongo, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

Dr. Magnuson moved and Dr. Smith seconded that for 2010-0216 the Board release the

investigative query information to Washington State Dental Quality Assurance Commission pursuant to law. The motion passed with Dr. Hongo, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason and Dr. Magnuson voting aye.

**Announcement**

No announcements

**ADJOURNMENT**

The meeting was adjourned at 1:26 p.m. Dr. Parker stated that the next Board meeting would take place April 19, 2013.

Approved by the April 19, 2013

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Patricia Parker, D.M.D.  
President

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# ASSOCIATION REPORTS

**Nothing to report under this tab**

# COMMITTEE REPORTS

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**REVISED**  
**Oregon Board of Dentistry**  
**Committee and Liaison Assignments**  
**May 2012 - April 2013**

**STANDING COMMITTEES**

**Communications**

Purpose: To enhance communications to all constituencies

*Committee:*

Jonna Hongo, D.M.D., Chair  
Darren Huddleston, D.M.D.  
Alton Harvey, Sr.

Barry Taylor, D.M.D., ODA Rep.  
Kelli Swanson-Jaeks, R.D.H., M.A., ODHA Rep.  
Linda Kihs, CDA, EFDA, MADAA, ODAA Rep.

*Subcommittees:*

- Newsletter – Jonna Hongo, D.M.D., Editor

**Dental Hygiene**

Purpose: To review issues related to Dental Hygiene

*Committee:*

Jill Mason, M.P.H., R.D.H., E.P.P., Chair  
Brandon Schwindt, D.M.D.  
Mary Davidson, M.P.H., R.D.H., E.P.P.

David J. Dowsett, D.M.D., ODA Rep.  
Kristen L. Simmons, R.D.H., B.S., ODHA Rep.  
Mary Harrison, CDA, EFDA, EFODA, ODAA Rep.

**Enforcement and Discipline**

Purpose: To improve the discipline process

*Committee:*

Darren Huddleston, D.M.D. - Chair  
Jill Mason, M.P.H., R.D.H., E.P.P.  
New Public Member

*Subcommittees:*

Evaluators

- Jonna Hongo, D.M.D., Senior Evaluator
- Brandon Schwindt, D.M.D., Evaluator

**Licensing, Standards and Competency**

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

*Committee:*

Norman Magnuson, D.D.S., Chair  
Julie Ann Smith, D.D.S., M.D.  
Mary Davidson, M.P.H., R.D.H., E.P.P.

Daren L. Goin, D.M.D., ODA Rep.  
Lisa J. Rowley, R.D.H. ODHA Rep.  
Mary Harrison, CDA, EFDA, EFODA, ODAA Rep.

**Rules Oversight**

Purpose: To review and refine OBD rules

*Committee:*

Brandon Schwindt, D.M.D., Chair  
Alton Harvey, Sr.  
Jill Mason, M.P.H., R.D.H., E.P.P.

Jill M. Price, D.M.D., ODA Rep.  
Lynn Ironside, R.D.H., ODHA Rep.  
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 – Patricia Parker, D.M.D.
- Hygiene Liaison – Jill Mason, M.P.H., R.D.H., E.P.P.

ADEX

- House of Delegates – Patricia Parker, D.M.D.
- Exam Committee – Jonna Hongo, D.M.D.
- Dental Hygiene Committee – Jill Mason, M.P.H., R.D.H., E.P.P.
- District 2 Dental Hygiene Representative - Mary Davidson, M.P.H., R.D.H., E.P.P.

North East Regional Board (NERB) Steering Committee

- Mary Davidson, M.P.H., R.D.H., E.P.P.
- Jonna Hongo, D.M.D.
- Julie Ann Smith, D.D.S, M.D.

Oregon Dental Association – Patricia Parker, D.M.D.

Oregon Dental Hygienists' Association – Jill Mason, M.P.H., R.D.H, E.P.P.

Western Regional Exam Board (WREB)

- Dental Exam Review Committee – Norman Magnuson, D.D.S.
- Hygiene Exam Review Committee - Mary Davidson, M.P.H., R.D.H., E.P.P.

## OTHER

### Administrative Workgroup

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

*Committee:*

Patricia Parker, D.M.D, Chair  
Mary Davidson, M.P.H., R.D.H., E.P.P.  
Alton Harvey, Sr.

*Subcommittee:*

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

- Patricia Parker, D.M.D.
- Jonna Hongo, D.M.D.
- Mary Davidson, M.P.H., R.D.H., E.P.P.

### 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.  
Henry Windell, D.M.D.  
Mark Mutschler, D.D.S.  
Jay Wylam, D.M.D.  
Richard Park, D.M.D.

**EXECUTIVE  
DIRECTORS  
REPORT**

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**EXECUTIVE DIRECTOR'S REPORT**  
**April 19, 2013**

**OBD Budget Status Report**

Attached is the latest budget report for the 2011-2013 Biennium. This report, which is from July 1, 2011 through February 28, 2013, shows revenue of \$2,209,539.65 and expenditures of \$1,924,603.08. Revenues continue to be on target and the expenditures to date are actually below what was budgeted. I would predict that we will take in more revenue and spend less money than budgeted. I would say the Budget appears to be performing as expected. If Board members have questions on this budget report format, please feel free to ask me.

**Attachment #1**

**Customer Service Survey**

Attached is a chart which shows the OBD State Legislatively Mandated Customer Service Survey Results from July 1, 2012 through March 31, 2013.

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**

**Board and Staff Speaking Engagements**

Teresa Haynes and I made a License Application Presentation to the graduating Dental Hygiene Students at OIT in Klamath Falls on Thursday, February 28, 2013.

Teresa Haynes and I made a License Application Presentation to the graduating Dental Hygiene Students at ODS/Dental Hygiene Program in La Grande on Monday, March 4, 2013.

Teresa Haynes and I made a License Application Presentation to the graduating Dental Hygiene Students at Carrington College in Portland on Tuesday, March 12, 2013.

I made an "OBD Updates" Presentation to the Gum Gardner's Study Club on Monday, March 25, 2013 at St. Vincent's Hospital in Beaverton. **Attachment #3**

I made a presentation on the OBD to graduating Dental Assistants at Portland Community College on Monday, April 1, 2013.

Dr. Paul Kleinstub Dental Director/Chief Investigator and I made a presentation on "Record Keeping" to the ODC on Thursday, April 4, 2013

Dr. Paul Kleinstub Dental Director/Chief Investigator and I made a presentation on "Ask the Board" to the ODC on Thursday, April 4, 2013

Dr. Paul Kleinstub Dental Director/Chief Investigator and I made a presentation on "Updates from the OBD" to the DBIC Risk Management Course at the ODC on Thursday, April 4, 2013

## **2013 Dental License Renewal**

On January 23, 2013 the OBD mailed 1815 postcards informing dentists whose Oregon Dental License will expire March 31, 2013 that the on-line renewal was available. As of 3/31/13, 1,637 dentists have renewed their license

## **Legislative Update**

Attached please find a list of the Oregon Legislative Bills that the OBD is currently tracking that will have a direct impact in the Board or impact on the Board as a state agency.

### **Attachment #4**

## **2014 OBD Meeting Dates**

Attached is a draft of the proposed meeting dates for 2014. The Board needs to adopt the dates. **Attachment #5**

## **Board Member Appointments**

Governor Kitzhaber reappointed Board Members Jonna Hongo, D.M.D for a term expired on April 1, 2016 and Brandon Schwindt, D.M.D. for a term to expire March 31, 2016. and appointed Todd Beck, DMD of Portland to succeed Dr. Darren Huddleston who served two terms on the Board for a term to expire March 31, 2017 and appointed Mr. James Morris of Portland as Public Member to replace Mr. David Smyth's who has resigned from the Board after having served two terms for a term to expire March 31, 2017. Members Hongo, Schwindt, Beck and Morris have all been confirmed by the Oregon State Senate.

Governor Kitzhaber appointed John M. Tripp, R.D.H., E.P.P. of Grants Pass as a Dental Hygiene Member to succeed Jill Mason, R.D.H., M.P.H., E.P.P., for a term that will expire April 30, 2017. Mr. Tripp will have a Confirmation Hearing on April 24, 2013 and is expected to begin serving on the Board effective 5/1/2013.

## **Office Lease**

I am in the process of negotiating a possible extension to the current OBD Lease with Portland State University (PSU) for an additional two years (our current lease expires 8/1/2013) at a rent price that was less than they originally wanted to charge us if we remained here for the next four years based upon our executing the option to renew the current lease for four years. The new lease will require us to vacate this space by August 1, 2015.

I recently met with another leasing company and we are looking at space in the Crown Plaza Center, two blocks from the current OBD Office. It is my hope that we would be able to complete negotiations to move into the new space with an occupation date of August 1<sup>st</sup> of this year, the date that our current OBD Lease expires. I will update the Board further on this issue at the Board Meeting.

## **Secretary of State's Audit**

We have recently been notified by the Secretary of State's Audit Division that they will be conducting a performance audit of all Oregon's Health Professional Licensing Boards.

### **Attachment #6**

## **Newsletter**

The newsletter was printed and mailed in March and I want to thank Stephen Prisby for a great job on helping to get it completed, which was his first one since joining the OBD.

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**BOARD OF DENTISTRY**  
**Fund 3400 BOARD OF DENTISTRY**  
**For the Month of FEBRUARY 2013**

**REVENUES**

<u>Budget</u>	<u>Budget Obj Title</u>	<u>Monthly Activity</u>	<u>Biennium to Date</u>	<u>Financial Plan</u>	<u>Unobligated Plan</u>	<u>Monthly Avg to</u>	<u>Monthly Avg to</u>
<u>Obj</u>			<u>Activity</u>			<u>Date</u>	<u>Spend</u>
0205	OTHER BUSINESS LICENSES	245,254.00	2,045,406.06	2,327,200.00	281,793.94	102,270.30	70,448.49
0210	OTHER NONBUSINESS LICENSES AND FEES	650.00	13,850.00	40,000.00	26,150.00	692.50	6,537.50
0410	CHARGES FOR SERVICES	0.00	0.00	5,000.00	5,000.00	0.00	1,250.00
0505	FINES AND FORFEITS	15,000.00	123,758.14	50,000.00	-73,758.14	6,187.91	-18,439.54
0605	INTEREST AND INVESTMENTS	302.28	6,446.72	10,000.00	3,553.28	322.34	888.32
0975	OTHER REVENUE	990.00	20,078.73	25,000.00	4,921.27	1,003.94	1,230.32
		<b>262,196.28</b>	<b>2,209,539.65</b>	<b>2,457,200.00</b>	<b>247,660.35</b>	<b>110,476.98</b>	<b>61,915.09</b>

**TRANSFER OUT**

<u>Budget</u>	<u>Budget Obj Title</u>	<u>Monthly Activity</u>	<u>Biennium to Date</u>	<u>Financial Plan</u>	<u>Unobligated Plan</u>	<u>Monthly Avg to</u>	<u>Monthly Avg to</u>
<u>Obj</u>			<u>Activity</u>			<u>Date</u>	<u>Spend</u>
2100	TRANSFER OUT TO DEPT OF HUMAN	0.00	0.00	0.00	0.00	0.00	0.00
2443	TRANSFER OUT TO OREGON HEALTH	0.00	104,145.00	208,000.00	103,855.00	5,207.25	25,963.75
		<b>0.00</b>	<b>104,145.00</b>	<b>208,000.00</b>	<b>103,855.00</b>	<b>5,207.25</b>	<b>25,963.75</b>

**PERSONAL SERVICES**

<u>Budget</u>	<u>Budget Obj Title</u>	<u>Monthly Activity</u>	<u>Biennium to Date</u>	<u>Financial Plan</u>	<u>Unobligated Plan</u>	<u>Monthly Avg to</u>	<u>Monthly Avg to</u>
<u>Obj</u>			<u>Activity</u>			<u>Date</u>	<u>Spend</u>
3110	CLASS/UNCLASS SALARY & PER DIEM	34,634.72	699,092.79	855,336.00	156,243.21	34,954.64	39,060.80
3160	TEMPORARY APPOINTMENTS	0.00	14,107.23	3,717.00	-10,390.23	705.36	-2,597.56
3170	OVERTIME PAYMENTS	166.95	11,459.07	3,575.00	-7,884.07	572.95	-1,971.02
3180	SHIFT DIFFERENTIAL	2.25	12.00	0.00	-12.00	0.60	-3.00
3210	ERB ASSESSMENT	8.50	159.80	287.00	127.20	7.99	31.80
3220	PUBLIC EMPLOYEES' RETIREMENT SYSTEM	5,231.95	98,525.21	123,464.00	24,938.79	4,926.26	6,234.70
3221	PENSION BOND CONTRIBUTION	2,165.95	39,945.88	49,432.00	9,486.12	1,997.29	2,371.53
3230	SOCIAL SECURITY TAX	2,840.31	55,243.44	71,160.00	15,916.56	2,762.17	3,979.14
3250	WORKERS' COMPENSATION ASSESSMENT	15.14	317.39	413.00	95.61	15.87	23.90
3260	MASS TRANSIT	204.35	4,039.00	5,581.00	1,542.00	201.95	385.50
3270	FLEXIBLE BENEFITS	8,328.14	155,234.61	201,638.00	46,403.39	7,761.73	11,600.85
		<b>53,598.26</b>	<b>1,078,136.42</b>	<b>1,314,603.00</b>	<b>236,466.58</b>	<b>53,906.82</b>	<b>59,116.65</b>

**SERVICES and SUPPLIES**

<u>Budget</u>	<u>Budget Obj Title</u>	<u>Monthly Activity</u>	<u>Biennium to Date</u>	<u>Financial Plan</u>	<u>Unobligated Plan</u>	<u>Monthly Avg to</u>	<u>Monthly Avg to</u>
<u>Obj</u>			<u>Activity</u>			<u>Date</u>	<u>Spend</u>
4100	INSTATE TRAVEL	3,835.30	41,933.29	46,655.00	4,721.71	2,096.66	1,180.43
4125	OUT-OF-STATE TRAVEL	-3,704.58	17,408.37	24,672.00	7,263.63	870.42	1,815.91
4150	EMPLOYEE TRAINING	1,720.00	7,975.00	6,617.00	-1,358.00	398.75	-339.50
4175	OFFICE EXPENSES	7,211.28	62,718.40	78,445.00	15,726.60	3,135.92	3,931.65
4200	TELECOMM/TECH SVC AND SUPPLIES	30.42	18,857.48	25,757.00	6,899.52	942.87	1,724.88
4225	STATE GOVERNMENT SERVICE CHARGES	341.36	66,057.45	78,170.00	12,112.55	3,302.87	3,028.14
4250	DATA PROCESSING	150.00	3,485.50	5,400.00	1,914.50	174.28	478.63
4275	PUBLICITY & PUBLICATIONS	489.89	12,060.26	13,084.00	1,023.74	603.01	255.94
4300	PROFESSIONAL SERVICES	3,886.30	72,334.33	79,219.00	6,884.67	3,616.72	1,721.17
4315	IT PROFESSIONAL SERVICES	0.00	16,100.00	50,000.00	33,900.00	805.00	8,475.00
4325	ATTORNEY GENERAL LEGAL FEES	3,886.37	128,708.82	188,592.00	59,883.18	6,435.44	14,970.80
4375	EMPLOYEE RECRUITMENT AND	0.00	0.00	621.00	621.00	0.00	155.25
4400	DUES AND SUBSCRIPTIONS	150.00	9,793.80	8,276.00	-1,517.80	489.69	-379.45
4425	FACILITIES RENT & TAXES	5,732.09	114,773.53	139,571.00	24,797.47	5,738.68	6,199.37
4475	FACILITIES MAINTENANCE	0.00	790.00	514.00	-276.00	39.50	-69.00
4575	AGENCY PROGRAM RELATED SVCS & SUPP	813.00	82,672.00	164,976.00	82,304.00	4,133.60	20,576.00
4650	OTHER SERVICES AND SUPPLIES	4,914.21	35,562.35	40,300.00	4,737.65	1,778.12	1,184.41
4700	EXPENDABLE PROPERTY \$250-\$5000	0.00	1,457.16	5,140.00	3,682.84	72.86	920.71
4715	IT EXPENDABLE PROPERTY	0.00	267.92	5,140.00	4,872.08	13.40	1,218.02
		<b>29,455.64</b>	<b>692,955.66</b>	<b>961,149.00</b>	<b>268,193.34</b>	<b>34,647.78</b>	<b>67,048.34</b>

**SPECIAL PAYMENTS**

<u>Budget</u>	<u>Budget Obj Title</u>	<u>Monthly Activity</u>	<u>Biennium to Date</u>	<u>Financial Plan</u>	<u>Unobligated Plan</u>	<u>Monthly Avg to</u>	<u>Monthly Avg to</u>
<u>Obj</u>			<u>Activity</u>			<u>Date</u>	<u>Spend</u>
6100	DISTRIBUTION TO DEPT OF HUMAN	0.00	0.00	0.00	0.00	0.00	0.00
6443	DIST TO OREGON HEALTH AUTHORITY	23,927.00	153,511.00	226,292.00	72,781.00	7,675.55	18,195.25
		<b>23,927.00</b>	<b>153,511.00</b>	<b>226,292.00</b>	<b>72,781.00</b>	<b>7,675.55</b>	<b>18,195.25</b>

**SUMMARY TOTALS**

3400
BOARD OF DENTISTRY

		<u>Month Activity</u>	<u>Biennium Activity</u>
REVENUES	REVENUE	262,196.28	2,209,539.65
	Total	262,196.28	2,209,539.65
EXPENDITURES	PERSONAL SERVICES	53,598.26	1,078,136.42
	SERVICES AND SUPPLIES	29,455.64	692,955.66
	Total	83,053.90	1,771,092.08
TRANSFER OUT	TRANSFER OUT	0.00	104,145.00
	Total	0.00	104,145.00

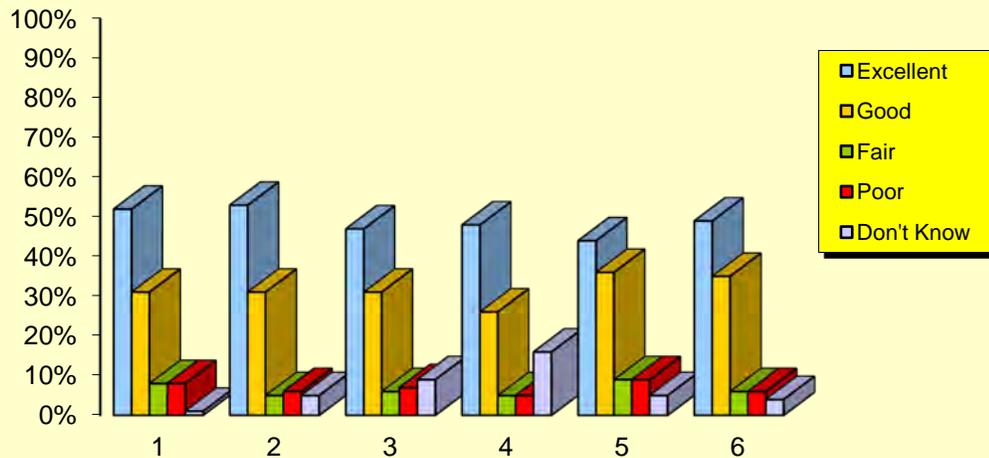
3400
BOARD OF DENTISTRY

		<u>Month Activity</u>	<u>Biennium Activity</u>
SPECIAL PAYMENTS	SPECIAL PAYMENTS	23,927.00	153,511.00
	Total	23,927.00	153,511.00

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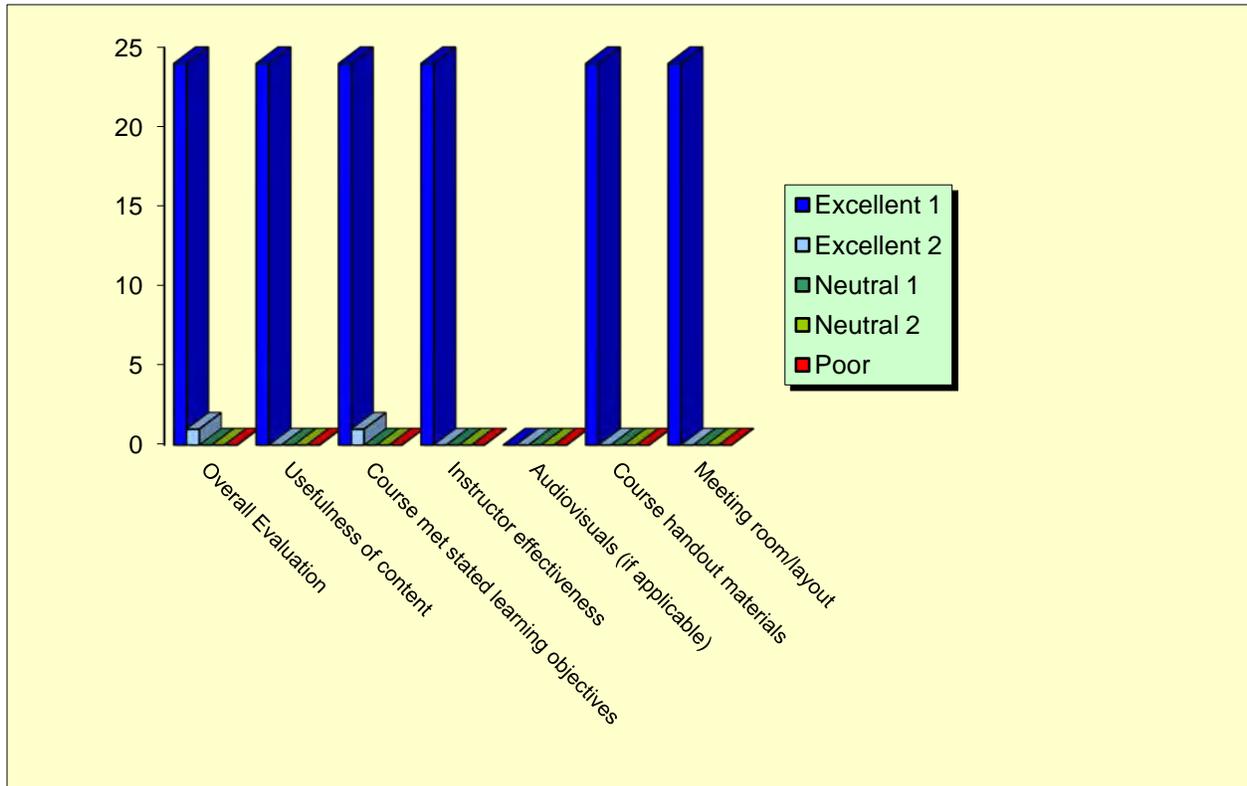
## Oregon Board of Dentistry Customer Service Survey July 1, 2012 - March 31, 2013



- 1 How do you rate the timeliness of the services provided by the OBD?  
E= 52% G= 31% F= 8% P= 8% DK= 1%
- 2 How do you rate the ability of the OBD to provide services correctly the first time?  
E= 53% G= 31% F= 5% P= 6% DK= 5%
- 3 How do you rate the helpfulness of the OBD?  
E= 47% G= 31% F= 6% P= 7% DK= 9%
- 4 How do you rate the knowledge and expertise of the OBD?  
E= 48% G= 26% F= 5% P= 5% DK= 16%
- 5 How do you rate the availability of information at the OBD?  
E= 44% G= 36% F= 9% P= 9% DK= 5%
- 6 How do you rate the overall quality of services provided by the OBD?  
E= 49% G= 35% F= 6% P= 6% DK= 4%

# GUM GARDNER'S STUDY CLUB PRESENTATION

March 25, 2013



# Bill Summary Detail Report

Report Date: Tue, Apr 9, 2013

Searched on: Unique Bills=44; Session Year=2013; Session Type=Session; Tracked=Tracked Active; Bill Version=Current; Sort By=Bill Number;

Bill #	Summary	(Label) Relating To	Last Three Actions	Next Hearing	First 2 Sponsors	Spr Rmg	At the Request of	Division	Prty	Bill Manager	Bill Posn	Tmy App
<b>HB2037A</b>	Requires, under specified circumstances, certain professional regulatory boards to issue authorization to practice profession to spouse or domestic partner of active member of Armed Forces who is subject of military transfer to Oregon. Requires	Relating to authorizations to engage in a profession; declaring an emergency.	04/15/13 - Public Hearing and Possible Work Session scheduled. 04/08/13 - Referred to Health Care by prior reference. 04/08/13 - Recommendation: Do pass with amendments, be printed A-Engrossed, and be referred to Health Care by prior reference.	Date: Mon, Apr 15, 2013 Time: 1:00 PM Loc: HR E Com: Health Care (H)	Pre-session filed.	0	Governor John A. Kitzhaber, M.D., for Oregon Military Department		3	Patrick Braatz		No
HB2065	Creates process through which licensee or applicant to practice dentistry may petition Oregon Board of Dentistry to expunge from board records information related to disciplinary hearings.	Relating to practice of dentistry.	04/17/13 - Public Hearing and Possible Work Session scheduled. 03/11/13 - Public Hearing held. 01/22/13 - Referred to Health Care.	Date: Wed, Apr 17, 2013 Time: 1:00 PM Loc: HR E Com: Health Care (H)	Pre-session filed. Vic Gilliam	0			2	Patrick Braatz		No
<b>HB2120</b>	Provides that health professional regulatory boards have discretion to authorize licensees regulated by board to self-refer to impaired health professional program in which board participates.	Relating to licensees who self-refer to the impaired health professional program.	02/21/13 - Referred to Health Care and Human Services. 02/19/13 - First reading. Referred to Presidents desk. 02/18/13 - Third reading. Carried by Kennemer. Passed.	No hearings scheduled at this time.	Pre-session filed.	0	House Interim Committee on Health Care		2	Patrick Braatz		No
<b>HB2124A</b>	Eliminates from impaired health professional program	Relating to the impaired health professional program	03/11/13 - Referred to Health Care and Human Services.	No hearings scheduled at this time.	Pre-session filed.	0	House Interim Committee on Health Care		2	Patrick Braatz		No

	requirement that employers of program participants establish minimum training requirements for supervisors of participants. Modifies provision requiring assessment of such employers. Remo	established by the Oregon Health Authority.	03/06/13 - First reading. Referred to Presidents desk. 03/05/13 - Third reading. Carried by Kennemer. Passed.							
HB2130A	Makes changes to impaired health professional program. Declares emergency, effective on passage.	Relating to the impaired health professional program; declaring an emergency.	03/11/13 - Referred to Health Care and Human Services. 03/06/13 - First reading. Referred to Presidents desk. 03/05/13 - Third reading. Carried by Thompson. Passed.	No hearings scheduled at this time.	Pre-session filed.	0	House Interim Committee on Health Care	2	Patrick Braatz	No
HB2161	Requires, under specified circumstances, boards, councils, commissions and other entities that examine applicants for licensure, registration, certification or other authorization to issue license, registration, certification or other authorization	Relating to authorizations to engage in a profession; declaring an emergency.	03/07/13 - Public Hearing held. 01/22/13 - Referred to Veterans and Emergency Preparedness with subsequent referral to Education. 01/14/13 - First reading. Referred to Speakers desk.	No hearings scheduled at this time.	Pre-session filed.	0	House Interim Committee on Veterans Affairs	3	Patrick Braatz	No
HB2170	Requires that final order of state agency in contested case proceeding include copy of statutes relating to appeal of order and notification of right of party to request leave to present additional evidence on appeal.	Relating to orders in contested cases.	01/22/13 - Referred to Judiciary. 01/14/13 - First reading. Referred to Speakers desk.	No hearings scheduled at this time.	Pre-session filed. Wayne Krieger	0		2	Patrick Braatz	No
HB2171	Provides that person has right to	Relating to civil penalties.	01/22/13 - Referred to	No hearings scheduled at	Pre-session filed.	0		2	Patrick Braatz	No

	trial in circuit court if agency proposes to impose civil penalty of \$2,000 or more against person. Requires that proceedings to impose civil penalty be treated as action at law.		Judiciary. 01/14/13 - First reading. Referred to Speakers desk.	this time.	Wayne Krieger					
HB2215	Provides that person holding appointive office in state government serves at pleasure of appointing authority.	Relating to persons holding appointive office in state government.	03/06/13 - Public Hearing held. 01/22/13 - Referred to Rules. 01/14/13 - First reading. Referred to Speakers desk.	No hearings scheduled at this time.	Pre-session filed.	0	Governor John A. Kitzhaber, M.D.	3	Patrick Braatz	No
HB2217	Establishes procedure and requirements for filing notice of adverse health care incident with Oregon Patient Safety Commission. Requires health care facilities, health care providers and patients to engage in discussion and mediation related to ad	Relating to resolution of matters related to health care; declaring an emergency.	01/22/13 - Referred to Judiciary with subsequent referral to Ways and Means. 01/14/13 - First reading. Referred to Speakers desk.	No hearings scheduled at this time.	Pre-session filed.	0	Governor John A. Kitzhaber, M.D.	3	Patrick Braatz	No
HB2272	Specifies that dental care organizations are major components of health care delivery system and thus must be part of governance structure of coordinated care organization. Declares emergency, effective on passage.	Relating to dental care organizations; declaring an emergency.	01/22/13 - Referred to Health Care. 01/14/13 - First reading. Referred to Speakers desk.	No hearings scheduled at this time.	Pre-session filed. Tim Freeman	0		3	Patrick Braatz	No
HB2429	Requires that public bodies develop and implement policies for securely removing personal information from digital data	Relating to electronic devices.	04/16/13 - Work Session scheduled. 02/26/13 - Public Hearing held. 01/22/13 - Referred to Consumer Protection and	Date: Tue, Apr 16, 2013 Time: 1:00 PM Loc: HR D Com: Consumer	Pre-session filed. Sara Gelsler	3		4	Patrick Braatz	No

	storage devices and other electronic data storage devices before selling, donating, recycling or otherwise disposing of device. P	Government Efficiency.	Protection and Government Efficiency (H)							
HB2450	Makes certain persons providing outreach services to individuals who are under supervision of corrections officer immune from civil liability. Requires certain regulatory boards to provide and make available information about how individuals who a	Relating to provision of services without compensation.	02/27/13 - Public Hearing held. 01/22/13 - Referred to Judiciary. 01/14/13 - First reading. Referred to Speakers desk.	No hearings scheduled at this time.	Pre-session filed. Kevin Cameron	0		3	Patrick Braatz	No
HB2519	Modifies provisions limiting liability of health clinics, volunteer health practitioners and volunteers providing outreach services to homeless individuals.	Relating to limitations on liability of persons providing volunteer services.	02/27/13 - Public Hearing held. 01/22/13 - Referred to Judiciary. 01/14/13 - First reading. Referred to Speakers desk.	No hearings scheduled at this time.	Pre-session filed. Jim Thompson	1		3	Patrick Braatz	No
HB2560	Prohibits agency from appointing person to serve on rulemaking advisory committee if person is also serving on public board, public commission, public committee or work group of public body, and rule would affect activities of board, commission, com	Relating to rulemaking advisory committees.	03/06/13 - Public Hearing held. 01/22/13 - Referred to Rules. 01/14/13 - First reading. Referred to Speakers desk.	No hearings scheduled at this time.	Pre-session filed.	0	House Interim Committee on Judiciary	2	Patrick Braatz	No
HB2611A	Directs certain health professional regulatory boards to adopt rules by January 1, 2017, requiring licensees to document	Relating to continuing education for health care professionals; declaring an emergency.	04/09/13 - Third reading. Carried by Keny-Guyer. Passed. 04/08/13 - Second reading.	No hearings scheduled at this time.	Pre-session filed. Michael Dembrow	12		2	Patrick Braatz	No

participation in continuing education opportunities relating to cultural competency approved by Oregon Health Authority.

04/05/13 - Recommendation: Do pass with amendments and be printed A-Engrossed.

HB2724	Exempts retainer dental practice from application of Insurance Code if certified by Department of Consumer and Business Services. Authorizes department to investigate and take enforcement actions with respect to dental provider maintaining or purp	Relating to health care offered through a retainer practice; declaring an emergency.	04/12/13 - Work Session scheduled. 03/01/13 - Public Hearing held. 02/11/13 - Referred to Health Care.	Date: Fri, Apr 12, 2013 Time: 1:00 PM Loc: HR E Com: Health Care (H)	Phil Barnhart Val Hoyle	0		4	Patrick Braatz	No
HB2946	Repeals sunset on prohibition against dental services contract restricting price charged by provider for service not covered by contract.	Relating to dental services contracts.	03/28/13 - Referred to Health Care and Human Services. 03/26/13 - First reading. Referred to Presidents desk. 03/25/13 - Read third time under Consent Calendar. Passed.	No hearings scheduled at this time.	Brian Clem	0	Oregon Dental Association	5	Patrick Braatz	No
HB2947	Repeals provision authorizing Oregon Health Authority to approve pilot projects under which dental health coordinators receive training and certification for purpose of educating communities on dental health. Becomes operative January 1, 2014. D	Relating to dental health pilot projects; declaring an emergency.	03/26/13 - Referred to Health Care and Human Services. 03/25/13 - First reading. Referred to Presidents desk. 03/21/13 - Third reading. Carried by Clem. Passed.	No hearings scheduled at this time.	Brian Clem	0	Oregon Dental Association	3	Patrick Braatz	No
HB2948A	Authorizes dentists licensed in other countries to participate in educational activities related to	Relating to dentists licensed in other countries.	03/28/13 - Referred to Health Care and Human Services. 03/26/13 - First reading. Referred	No hearings scheduled at this time.	Brian Clem	0	Oregon Dental Association	2	Patrick Braatz	No

	dentistry that occur in this state. Authorizes dentists licensed in other countries to practice dentistry in this state without compensation for limi		to Presidents desk. 03/25/13 - Read third time under Consent Calendar. Passed.						
HB3082	Requires State Board of Education to adopt rules requiring provision of fluoride rinse to certain students and children after certain meals. Requires Department of Education to solicit names of dentists who provide dental services at reduced rates	Relating to dental care for children.	04/15/13 - Work Session scheduled. 03/27/13 - Public Hearing held. 03/01/13 - Referred to Health Care with subsequent referral to Ways and Means.	Date: Mon, Apr 15, 2013 Time: 1:00 PM Loc: HR E Com: Health Care (H)	Mitch Greenlick Betty Komp	1	4	Patrick Braatz	No
HB3153	Establishes Task Force on the Consolidation of State Government Boards and Commissions. Directs task force to study functions and duties of state government boards and commissions and make recommendations to consolidate functions and improve efficie	Relating to government entities; declaring an emergency.	03/01/13 - Referred to Consumer Protection and Government Efficiency with subsequent referral to Ways and Means. 02/22/13 - First reading. Referred to Speakers desk.	No hearings scheduled at this time.	Consumer Protection and Government Efficiency (H)	0	2	Patrick Braatz	No
HB3330	Requires use of electronic fingerprint capture technology for purposes of conducting criminal records checks not related to administration of criminal justice system. Becomes operative January 1, 2014. Requires each agency designated by State of O	Relating to electronic fingerprint capture; declaring an emergency.	04/11/13 - Work Session scheduled. 03/21/13 - Public Hearing held. 03/01/13 - Referred to Consumer Protection and Government Efficiency with subsequent referral to Ways and Means.	Date: Thu, Apr 11, 2013 Time: 1:00 PM Loc: HR D Com: Consumer Protection and Government Efficiency (H)	Nancy Nathanson Sara Gelser	1	3	Patrick Braatz	No

HB3459	Establishes Office of Small Business Assistance in Office of Secretary of State for purpose of facilitating interactions between small businesses and state agencies with regulatory authority over small businesses. Establishes complaint and investiga	Relating to the Office of Small Business Assistance; appropriating money.	04/15/13 - Work Session scheduled. 04/08/13 - Public Hearing held. 03/21/13 - Referred to Business and Labor with subsequent referral to Ways and Means.	Date: Mon, Apr 15, 2013 Time: 8:00 AM Loc: HR E Com: Business and Labor (H)	Caddy McKeown David Gomberg	14	3	Patrick Braatz	No
SB45	Requires state agencies to notify parties in contested case hearing of rights that active duty servicemembers have to stay proceedings under federal law.	Relating to contested case hearings.	02/07/13 - Public Hearing held. 01/22/13 - Referred to Veterans and Emergency Preparedness, then Judiciary. 01/14/13 - Introduction and first reading. Referred to Presidents desk.	No hearings scheduled at this time.	Pre-session filed.	0	2	Patrick Braatz	No
SB52A	Directs state agencies to preserve final orders in contested cases issued by agency in digital format and to provide electronic copies to Oregon State Bar, or designee, upon request.	Relating to final orders.	04/09/13 - First reading. Referred to Speakers desk. 04/08/13 - Third reading. Carried by Prozanski. Passed. 04/04/13 - Second reading.	No hearings scheduled at this time.	Pre-session filed.	0	4	Patrick Braatz	No
SB86	States that electronic communication that is simultaneous and contemporaneous communication is subject to public meetings law. Provides that electronic mail is not simultaneous and contemporaneous communication.	Relating to public meetings.	01/18/13 - Referred to Judiciary. 01/14/13 - Introduction and first reading. Referred to Presidents desk.	No hearings scheduled at this time.	Pre-session filed.	0	3	Patrick Braatz	No

SB101A	Eliminates from impaired health professional program requirement that employers of program participants establish minimum training requirements for supervisors of participants. Modifies provision under which program assesses supervision of partic	Relating to the impaired health professional program established by the Oregon Health Authority.	03/14/13 - Referred to Health Care. 03/13/13 - First reading. Referred to Speakers desk. 03/12/13 - Third reading. Carried by Kruse. Passed.	No hearings scheduled at this time.	Pre-session filed.	0	Governor John A. Kitzhaber, M.D., for Oregon Health Authority	3	Patrick Braatz	No
SB125A	Requires state agency to provide notice to parties in contested case hearing describing rights that active duty servicemembers have to stay proceedings under federal law and providing contact information for legal resources. Exempts agenci	Relating to contested case hearings; declaring an emergency.	04/03/13 - Public Hearing held. 03/12/13 - Recommendation: Do pass with amendments and be referred to Judiciary by prior reference. (Printed A-Eng.) 03/07/13 - Work Session held.	Date: Wed, Apr 10, 2013 Time: 8:30 AM Loc: HR 343 Com: Judiciary (S)	Pre-session filed.	0	Senate Interim Committee on Veterans and Military Affairs for Oregon State Bar	2	Patrick Braatz	No
SB140	Directs state government bodies that request individuals to disclose Social Security numbers to inform individuals that Social Security numbers may be used in matching with other public records for purposes of state auditing.	Relating to use of Social Security numbers in public audits.	04/12/13 - Work Session scheduled. 04/05/13 - Public Hearing and Work Session held. 01/16/13 - Referred to General Government, Consumer and Small Business Protection.	Date: Fri, Apr 12, 2013 Time: 8:00 AM Loc: HR B Com: General Government, Consumer and Small Business Protection (S)	Pre-session filed.	0	Secretary of State Kate Brown	4	Patrick Braatz	No
SB171	Requires impaired health professional program to maintain physical location or locations in this state that are sufficient to allow enrolled licensees to physically meet with program representatives.	Relating to the impaired health professional program; declaring an emergency.	01/16/13 - Referred to Health Care and Human Services. 01/14/13 - Introduction and first reading. Referred to Presidents desk.	No hearings scheduled at this time.	Pre-session filed.	0	Senate Interim Committee on Health Care, Human Services and Rural Health Policy for Oregon Medical Association	3	Patrick Braatz	No

Requires Oregon Health Authority, at request of

SB291	Establishes Oregon Other Funds Reserve Fund. Transfers portion of June 30, 2013, ending balance from dedicated or continuously appropriated other funds accounts or funds to reserve fund. Transfers interest from reserve fund to State School Fund. Spe	Relating to state financial administration; declaring an emergency.	01/18/13 - Referred to Finance and Revenue, then Ways and Means. 01/14/13 - Introduction and first reading. Referred to Presidents desk.	No hearings scheduled at this time.	Pre-session filed. Brian Boquist	0		2	Patrick Braatz	No
SB300	Provides that certain persons appointed by Governor and certain persons appointed to positions in executive department serve at pleasure of Governor. Declares emergency, effective on passage.	Relating to persons who serve at the pleasure of the Governor; declaring an emergency.	01/16/13 - Referred to Rules. 01/14/13 - Introduction and first reading. Referred to Presidents desk.	No hearings scheduled at this time.	Pre-session filed. Betsy Johnson	0	John DiLorenzo	3	Patrick Braatz	No
SB333	Prohibits agencies from adopting any rule that becomes effective on or after effective date of Act and before July 1, 2014. Specifies exceptions. Establishes Joint Legislative Committee on Rule Review. Directs committee to review all rules adopted	Relating to administrative rules; declaring an emergency.	01/16/13 - Referred to Rules, then Ways and Means. 01/14/13 - Introduction and first reading. Referred to Presidents desk.	No hearings scheduled at this time.	Pre-session filed. Jackie Winters	0		3	Patrick Braatz	No
SB335	Directs Legislative Assembly to review state agencies and programs, taxes and fees administered by state agencies every six years.	Relating to periodic legislative review of state government.	01/16/13 - Referred to Rules, then Ways and Means. 01/14/13 - Introduction and first reading. Referred to	No hearings scheduled at this time.	Pre-session filed. Jackie Winters	0		3	Patrick Braatz	No

	Abolishes state agencies that are not continued by legislative Act enacted during year of review. Establishes Sunset		Presidents desk.						
SB373	Requires coordinated care organization to provide oral health care through contracts with dental care organizations unless no dental care organization provides care in geographic area served by coordinated care organization.	Relating to oral health care delivered by coordinated care organizations.	04/16/13 - Public Hearing and Possible Work Session scheduled. 01/16/13 - Referred to Health Care and Human Services. 01/14/13 - Introduction and first reading. Referred to Presidents desk.	Date: Tue, Apr 16, 2013 Time: 3:00 PM Loc: HR A Com: Health Care and Human Services (S)	Pre-session filed. Alan Bates	0	4	Patrick Braatz	No
SB399	Directs state agencies to deposit moneys agencies receive through imposition of civil penalties into General Fund and not into other funds account continuously appropriated to agency. Sunsets January 2, 2022.	Relating to state finance.	04/10/13 - Public Hearing Scheduled. 01/16/13 - Referred to Finance and Revenue, then Ways and Means. 01/14/13 - Introduction and first reading. Referred to Presidents desk.	Date: Wed, Apr 10, 2013 Time: 1:00 PM Loc: HR A Com: Finance and Revenue (S)	Pre-session filed. Larry George	0	2	Patrick Braatz	No
SB429	Directs state agencies to deposit moneys that agencies receive through imposition of fees, fines or civil penalties into General Fund and not into other funds account continuously appropriated to agency. Takes effect on 91st day following adjournm	Relating to state finance; prescribing an effective date; providing for revenue raising that requires approval by a three-fifths majority.	04/10/13 - Public Hearing Scheduled. 01/22/13 - Referred to Finance and Revenue, then Ways and Means. 01/14/13 - Introduction and first reading. Referred to Presidents desk.	Date: Wed, Apr 10, 2013 Time: 1:00 PM Loc: HR A Com: Finance and Revenue (S)	Pre-session filed. Larry George	0	2	Patrick Braatz	No
SB470A	Modifies, for purposes related to prescription monitoring program, definition of	Relating to the prescription monitoring program administered by the Oregon	03/27/13 - Referred to Health Care. 03/25/13 - First reading. Referred to Speakers desk.	No hearings scheduled at this time.	Jeff Kruse Laurie Monnes Anderson	1	3	Patrick Braatz	No

	practitioner. Authorizes State Board of Pharmacy to designate prescription drugs for inclusion in prescription monitoring program. Requires additional inf	Health Authority.	03/21/13 - Third reading. Carried by Kruse. Passed.							
SB483A	Authorizes health care facility, health care provider and patient to file notice of adverse health care incident with Oregon Patient Safety Commission. Sets forth procedures by which health care facilities, health care providers and patients may e	Relating to resolution of matters related to health care; and declaring an emergency.	03/25/13 - Effective date, March 18, 2013. 03/25/13 - Chapter 5, 2013 Laws. 03/13/13 - Speaker signed.	No hearings scheduled at this time.	Jeff Kruse Floyd Prozanski	4		2	Patrick Braatz	No
SB548	Modifies circumstances in which person issued dental instructors or dental hygiene instructors license may practice dentistry. Declares emergency, effective on passage.	Relating to dental instructors; declaring an emergency.	03/13/13 - Referred to Health Care. 03/11/13 - First reading. Referred to Speakers desk. 03/07/13 - Girod declared potential conflict of interest.	No hearings scheduled at this time.	Arnie Roblan	0	Oregon Health and Science University	3	Patrick Braatz	No
SB704	Authorizes dentist licensed to practice dentistry in this state to administer injections of botulinum toxin to face or neck of person.	Relating to injections of botulinum toxin.	02/28/13 - Referred to Health Care and Human Services. 02/26/13 - Introduction and first reading. Referred to Presidents desk.	No hearings scheduled at this time.	Fred Girod	0		2	Patrick Braatz	No
SB802	Provides that institution or program accredited by Commission on Dental Accreditation of American Dental Association does not need to name actively licensed	Relating to naming an actively licensed dentist as a dental director.	04/16/13 - Work Session scheduled. 04/08/13 - Public Hearing held. 03/07/13 - Referred to Health Care and Human Services.	Date: Tue, Apr 16, 2013 Time: 3:00 PM Loc: HR A Com: Health Care and Human	Laurie Monnes Anderson Rod Monroe	6	Oregon Community College Association	2	Patrick Braatz	No

## Services (S)

dentist as dental  
director of dental  
offices or clinics  
owned or operated  
by institution or

SB5516	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, 2013.	Relating to the financial administration of the Oregon Board of Dentistry; declaring an emergency.	02/11/13 - Public Hearing held. 01/23/13 - Assigned to Subcommittee On Education. 01/16/13 - Referred to Ways and Means.	No hearings scheduled at this time.	Presession filed.	0	Oregon Department of Administrative Services	1 Patrick Braatz	No
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**A-Engrossed**  
**House Bill 2037**

Ordered by the House April 8  
Including House Amendments dated April 8

Introduced and printed pursuant to House Rule 12.00. Pre-session filed (at the request of Governor John A. Kitzhaber, M.D., for Oregon Military Department)

**SUMMARY**

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

Requires, under specified circumstances, certain professional regulatory boards to issue authorization to practice profession to spouse or domestic partner of active member of Armed Forces who is subject of military transfer to Oregon.

**Requires Teacher Standards and Practices Commission to establish by rule expedited process by which military spouse or domestic partner who is licensed to teach in another state may apply for and obtain teaching license.**

Declares emergency, effective on passage.

**A BILL FOR AN ACT**

1  
2 Relating to authorizations to engage in a profession; creating new provisions; amending ORS 342.195;  
3 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) **"Authorization" means a license, registration, certificate or other authorization to**  
7 **engage in a profession.**

8 (b) **"Board" means a health professional regulatory board, as defined in ORS 676.160, or**  
9 **a board or council listed in ORS 676.606.**

10 (c) **"Military spouse or domestic partner" means a spouse or domestic partner of an ac-**  
11 **tive member of the Armed Forces of the United States who is the subject of a military**  
12 **transfer to Oregon.**

13 (2) **A board shall issue an authorization to a military spouse or domestic partner if the**  
14 **military spouse or domestic partner provides the board with:**

15 (a) **Evidence that the applicant is married to, or in a domestic partnership with, an active**  
16 **member of the Armed Forces of the United States who is assigned to a duty station located**  
17 **in Oregon by official active duty military order;**

18 (b) **Evidence that the military spouse or domestic partner is authorized by another state**  
19 **or territory of the United States to provide services regulated by the board; and**

20 (c) **Evidence that the military spouse or domestic partner:**

21 (A) **Has provided services or taught the subject matter regulated by the board for at least**  
22 **one year during the three years immediately preceding the date on which the military spouse**  
23 **or domestic partner submits an application for an authorization; and**

24 (B) **Has demonstrated competency, as determined by the board by rule, over services**  
25 **regulated by the board.**

**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       **(3) A board may issue a temporary authorization to an applicant who applies for an au-**  
2 **thorization under subsection (2) of this section before the board receives the evidence re-**  
3 **quired by subsection (2) of this section if the military spouse or domestic partner affirms on**  
4 **the application that the military spouse or domestic partner:**

5       **(a) Has requested evidence of authorization from the state or territory in which the**  
6 **military spouse or domestic partner is authorized; and**

7       **(b) Is not subject to disciplinary action in that state or territory for a matter related to**  
8 **services regulated by the board.**

9       **SECTION 2.** ORS 342.195, as amended by section 1a, chapter 43, Oregon Laws 2012, is amended  
10 to read:

11       342.195. **(1)** An otherwise qualified applicant for an initial or basic teaching license shall be  
12 granted the license upon payment of the required fees and the showing by proof satisfactory to the  
13 Teacher Standards and Practices Commission that:

14       [(1)] **(a)** While the applicant was in the Peace Corps program or was a volunteer under section  
15 603 of the Economic Opportunity Act of 1964 (Public Law 88-452), the applicant:

16       [(a)] **(A)** Completed two years of satisfactory service that emphasized teaching in any preprimary  
17 program or in any grade 1 through 12 in subjects regularly taught in public schools; and

18       [(b)(A)] **(B)(i)** Has completed an approved teacher education program; or

19       [(B)] **(ii)** Has earned at least a baccalaureate degree from an accredited institution of higher  
20 education and has completed a teacher training program provided under the auspices of the federal  
21 program; or

22       [(2)] **(b)** The applicant was a certified instructor for the Armed Forces of the United States, if  
23 the applicant provides the commission with documentation of military training or experience that  
24 the commission determines is substantially equivalent to the training required for an initial or basic  
25 teaching license.

26       **(2)(a) The commission shall establish by rule an expedited process by which a military**  
27 **spouse or domestic partner who is licensed to teach in another state may apply for and ob-**  
28 **tain a teaching license.**

29       **(b) As used in this subsection, “military spouse or domestic partner” means a spouse or**  
30 **domestic partner of an active member of the Armed Forces of the United States who is the**  
31 **subject of a military transfer to Oregon.**

32       **SECTION 3. This 2013 Act being necessary for the immediate preservation of the public**  
33 **peace, health and safety, an emergency is declared to exist, and this 2013 Act takes effect**  
34 **on its passage.**

35

# House Bill 2120

Introduced and printed pursuant to House Rule 12.00. Pre-session filed (at the request of House Interim Committee on Health Care)

## 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**.

Provides that health professional regulatory boards have discretion to authorize licensees regulated by board to self-refer to impaired health professional program in which board participates.

## A BILL FOR AN ACT

1  
2 Relating to licensees who self-refer to the impaired health professional program; creating new pro-  
3 visions; and amending ORS 676.190.

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

5 **SECTION 1.** ORS 676.190, as amended by section 1, chapter 2, Oregon Laws 2012, is amended  
6 to read:

7 676.190. (1) The Oregon Health Authority shall establish or contract to establish an impaired  
8 health professional program. The program must:

9 (a) Enroll licensees of participating health profession licensing boards who have been diagnosed  
10 with alcohol or substance abuse or a mental health disorder;

11 (b) Require that a licensee sign a written consent prior to enrollment in the program allowing  
12 disclosure and exchange of information between the program, the licensee's board, the licensee's  
13 employer, evaluators and treatment entities in compliance with ORS 179.505 and 42 C.F.R. part 2;

14 (c) Enter into diversion agreements with enrolled licensees;

15 (d) Assess and evaluate compliance with diversion agreements by enrolled licensees;

16 (e) Assess the ability of an enrolled licensee's employer to supervise the licensee and require  
17 an enrolled licensee's employer to establish minimum training requirements for supervisors of en-  
18 rolled licensees;

19 (f) Report substantial noncompliance with a diversion agreement to a noncompliant licensee's  
20 board within one business day after the program learns of the substantial noncompliance, including  
21 but not limited to information that a licensee:

22 (A) Engaged in criminal behavior;

23 (B) Engaged in conduct that caused injury, death or harm to the public, including engaging in  
24 sexual impropriety with a patient;

25 (C) Was impaired in a health care setting in the course of the licensee's employment;

26 (D) Received a positive toxicology test result as determined by federal regulations pertaining to  
27 drug testing;

28 (E) Violated a restriction on the licensee's practice imposed by the program or the licensee's  
29 board;

30 (F) Was admitted to the hospital for mental illness or adjudged to be mentally incompetent;

31 (G) Entered into a diversion agreement, but failed to participate in the program; 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 (H) Was referred to the program but failed to enroll in the program; and  
 2 (g) At least weekly, submit to licensees' boards:  
 3 (A) A list of licensees who were referred to the program by a health profession licensing board  
 4 and who are enrolled in the program; and  
 5 (B) A list of licensees who were referred to the program by a health profession licensing board  
 6 and who successfully complete the program.  
 7 (2) The lists submitted under subsection (1)(g) of this section are exempt from disclosure as a  
 8 public record under ORS 192.410 to 192.505.  
 9 (3) When the program reports noncompliance to a licensee's board, the report must include:  
 10 (a) A description of the noncompliance;  
 11 (b) A copy of a report from the independent third party who diagnosed the licensee under ORS  
 12 676.200 (2)(a) or subsection (6)(a) of this section stating the licensee's diagnosis;  
 13 (c) A copy of the licensee's diversion agreement; and  
 14 (d) The licensee's employment status.  
 15 (4) The program may not diagnose or treat licensees enrolled in the program.  
 16 (5) The diversion agreement required by subsection (1) of this section must:  
 17 (a) Require the licensee to consent to disclosure and exchange of information between the pro-  
 18 gram, the licensee's board, the licensee's employer, evaluators and treatment providers, in compli-  
 19 ance with ORS 179.505 and 42 C.F.R. part 2;  
 20 (b) Require that the licensee comply continuously with the agreement for at least two years to  
 21 successfully complete the program;  
 22 (c) Based on an individualized assessment, require that the licensee abstain from mind-altering  
 23 or intoxicating substances or potentially addictive drugs, unless the drug is approved by the pro-  
 24 gram and prescribed for a documented medical condition by a person authorized by law to prescribe  
 25 the drug to the licensee;  
 26 (d) Require the licensee to report use of mind-altering or intoxicating substances or potentially  
 27 addictive drugs within 24 hours;  
 28 (e) Require the licensee to agree to participate in a treatment plan approved by a third party;  
 29 (f) Contain limits on the licensee's practice of the licensee's health profession;  
 30 (g) Provide for employer monitoring of the licensee;  
 31 (h) Provide that the program may require an evaluation of the licensee's fitness to practice be-  
 32 fore removing the limits on the licensee's practice of the licensee's health profession;  
 33 (i) Require the licensee to submit to random drug or alcohol testing in accordance with federal  
 34 regulations;  
 35 (j) Require the licensee to report at least weekly to the program regarding the licensee's com-  
 36 pliance with the agreement;  
 37 (k) Require the licensee to report any arrest for or conviction of a misdemeanor or felony crime  
 38 to the program within three business days after the licensee is arrested or convicted;  
 39 (L) Require the licensee to report applications for licensure in other states, changes in employ-  
 40 ment and changes in practice setting; and  
 41 (m) Provide that the licensee is responsible for the cost of evaluations, toxicology testing and  
 42 treatment.  
 43 (6)(a) **If a board participating in the program establishes by rule an option for self-referral**  
 44 **to the program**, a licensee of [a] the board [*participating in the program*] may self-refer to the  
 45 program.

1 (b) The program shall require [*the*] a licensee **who self-refers to the program** to attest that  
2 the licensee is not, to the best of the licensee's knowledge, under investigation by the licensee's  
3 board. The program shall enroll the licensee on the date on which the licensee attests that the  
4 licensee, to the best of the licensee's knowledge, is not under investigation by the licensee's board.

5 (c) When a licensee self-refers to the program, the program shall:

6 (A) Require that an independent third party approved by the licensee's board to evaluate alcohol  
7 or substance abuse or mental health disorders evaluate the licensee for alcohol or substance abuse  
8 or mental health disorders; and

9 (B) Investigate to determine whether the licensee's practice while impaired has presented or  
10 presents a danger to the public.

11 (d) **When a licensee self-refers to the program**, the program may not report [*a self-referred*]  
12 **the** licensee's enrollment in or successful completion of the program to the licensee's board.

13 (7) The authority shall adopt rules establishing a fee to be paid by the boards participating in  
14 the impaired health professional program for administration of the program.

15 (8) The authority shall arrange for an independent third party to audit the program to ensure  
16 compliance with program guidelines. The authority shall report the results of the audit to the Leg-  
17 islative Assembly, the Governor and the health profession licensing boards. The report may not  
18 contain individually identifiable information about licensees.

19 (9) The authority may adopt rules to carry out this section.

20 **SECTION 2. The amendments to ORS 676.190 by section 1 of this 2013 Act apply to**  
21 **licensees who self-refer to the impaired health professional program on and after the effec-**  
22 **tive date of this 2013 Act.**

23

**A-Engrossed**  
**House Bill 2124**

Ordered by the House March 1  
Including House Amendments dated March 1

Introduced and printed pursuant to House Rule 12.00. Pre-session filed (at the request of House Interim Committee on Health Care)

**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.

Eliminates from impaired health professional program requirement that employers of program participants establish minimum training requirements for supervisors of participants. **Modifies provision requiring assessment of such employers.**

Removes admittance to hospital for mental illness and court ruling of mental incompetence from list of information that program must report as evidence of substantial noncompliance with diversion agreement entered into under program.

**A BILL FOR AN ACT**

1  
2 Relating to the impaired health professional program established by the Oregon Health Authority;  
3 amending ORS 676.190.

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

5 **SECTION 1.** ORS 676.190, as amended by section 1, chapter 2, Oregon Laws 2012, is amended  
6 to read:

7 676.190. (1) The Oregon Health Authority shall establish or contract to establish an impaired  
8 health professional program. The program must:

9 (a) Enroll licensees of participating health profession licensing boards who have been diagnosed  
10 with alcohol or substance abuse or a mental health disorder;

11 (b) Require that a licensee sign a written consent prior to enrollment in the program allowing  
12 disclosure and exchange of information between the program, the licensee's board, the licensee's  
13 employer, evaluators and treatment entities in compliance with ORS 179.505 and 42 C.F.R. part 2;

14 (c) Enter into diversion agreements with enrolled licensees;

15 (d) Assess and evaluate compliance with diversion agreements by enrolled licensees;

16 *[(e) Assess the ability of an enrolled licensee's employer to supervise the licensee and require an*  
17 *enrolled licensee's employer to establish minimum training requirements for supervisors of enrolled*  
18 *licensees;]*

19 **(e) If the enrolled licensee has a direct supervisor, assess the ability of the direct**  
20 **supervisor to supervise the licensee, including an assessment of any documentation of the**  
21 **direct supervisor's completion of specialized training that may be required by the relevant**  
22 **health profession licensing board;**

23 (f) Report substantial noncompliance with a diversion agreement to a noncompliant licensee's  
24 board within one business day after the program learns of the substantial noncompliance, including  
25 but not limited to information that a licensee:

**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) Engaged in criminal behavior;
- 2 (B) Engaged in conduct that caused injury, death or harm to the public, including engaging in  
3 sexual impropriety with a patient;
- 4 (C) Was impaired in a health care setting in the course of the licensee's employment;
- 5 (D) Received a positive toxicology test result as determined by federal regulations pertaining to  
6 drug testing;
- 7 (E) Violated a restriction on the licensee's practice imposed by the program or the licensee's  
8 board;
- 9 *[(F) Was admitted to the hospital for mental illness or adjudged to be mentally incompetent;]*  
10 *[(G)]* (F) Entered into a diversion agreement, but failed to participate in the program; or  
11 *[(H)]* (G) Was referred to the program but failed to enroll in the program; and
- 12 (g) At least weekly, submit to licensees' boards:
- 13 (A) A list of licensees who were referred to the program by a health profession licensing board  
14 and who are enrolled in the program; and
- 15 (B) A list of licensees who were referred to the program by a health profession licensing board  
16 and who successfully complete the program.
- 17 (2) The lists submitted under subsection (1)(g) of this section are exempt from disclosure as a  
18 public record under ORS 192.410 to 192.505.
- 19 (3) When the program reports noncompliance to a licensee's board, the report must include:
- 20 (a) A description of the noncompliance;
- 21 (b) A copy of a report from the independent third party who diagnosed the licensee under ORS  
22 676.200 (2)(a) or subsection (6)(a) of this section stating the licensee's diagnosis;
- 23 (c) A copy of the licensee's diversion agreement; and
- 24 (d) The licensee's employment status.
- 25 (4) The program may not diagnose or treat licensees enrolled in the program.
- 26 (5) The diversion agreement required by subsection (1) of this section must:
- 27 (a) Require the licensee to consent to disclosure and exchange of information between the pro-  
28 gram, the licensee's board, the licensee's employer, evaluators and treatment providers, in compli-  
29 ance with ORS 179.505 and 42 C.F.R. part 2;
- 30 (b) Require that the licensee comply continuously with the agreement for at least two years to  
31 successfully complete the program;
- 32 (c) Based on an individualized assessment, require that the licensee abstain from mind-altering  
33 or intoxicating substances or potentially addictive drugs, unless the drug is approved by the pro-  
34 gram and prescribed for a documented medical condition by a person authorized by law to prescribe  
35 the drug to the licensee;
- 36 (d) Require the licensee to report use of mind-altering or intoxicating substances or potentially  
37 addictive drugs within 24 hours;
- 38 (e) Require the licensee to agree to participate in a treatment plan approved by a third party;
- 39 (f) Contain limits on the licensee's practice of the licensee's health profession;
- 40 (g) Provide for employer monitoring of the licensee;
- 41 (h) Provide that the program may require an evaluation of the licensee's fitness to practice be-  
42 fore removing the limits on the licensee's practice of the licensee's health profession;
- 43 (i) Require the licensee to submit to random drug or alcohol testing in accordance with federal  
44 regulations;
- 45 (j) Require the licensee to report at least weekly to the program regarding the licensee's com-

1 pliance with the agreement;

2 (k) Require the licensee to report any arrest for or conviction of a misdemeanor or felony crime  
3 to the program within three business days after the licensee is arrested or convicted;

4 (L) Require the licensee to report applications for licensure in other states, changes in employ-  
5 ment and changes in practice setting; and

6 (m) Provide that the licensee is responsible for the cost of evaluations, toxicology testing and  
7 treatment.

8 (6)(a) A licensee of a board participating in the program may self-refer to the program.

9 (b) The program shall require the licensee to attest that the licensee is not, to the best of the  
10 licensee's knowledge, under investigation by the licensee's board. The program shall enroll the  
11 licensee on the date on which the licensee attests that the licensee, to the best of the licensee's  
12 knowledge, is not under investigation by the licensee's board.

13 (c) When a licensee self-refers to the program, the program shall:

14 (A) Require that an independent third party approved by the licensee's board to evaluate alcohol  
15 or substance abuse or mental health disorders evaluate the licensee for alcohol or substance abuse  
16 or mental health disorders; and

17 (B) Investigate to determine whether the licensee's practice while impaired has presented or  
18 presents a danger to the public.

19 (d) The program may not report a self-referred licensee's enrollment in or successful completion  
20 of the program to the licensee's board.

21 (7) The authority shall adopt rules establishing a fee to be paid by the boards participating in  
22 the impaired health professional program for administration of the program.

23 (8) The authority shall arrange for an independent third party to audit the program to ensure  
24 compliance with program guidelines. The authority shall report the results of the audit to the Leg-  
25 islative Assembly, the Governor and the health profession licensing boards. The report may not  
26 contain individually identifiable information about licensees.

27 (9) The authority may adopt rules to carry out this section.

28

**A-Engrossed  
House Bill 2130**

Ordered by the House March 1  
Including House Amendments dated March 1

Introduced and printed pursuant to House Rule 12.00. Pre-session filed (at the request of House Interim Committee on Health Care)

**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.

Makes changes to impaired health professional program.  
Declares emergency, effective on passage.

**A BILL FOR AN ACT**

1  
2 Relating to the impaired health professional program; creating new provisions; amending ORS  
3 676.185, 676.190 and 676.200; and declaring an emergency.

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

5 **SECTION 1.** ORS 676.185 is amended to read:

6 676.185. As used in ORS 676.185 to 676.200:

7 (1) "Health profession licensing board" means:

8 (a) A health professional regulatory board as defined in ORS 676.160; or

9 (b) The Oregon Health Licensing Agency for a board, council or program listed in ORS 676.606.

10 (2) "Impaired professional" means a licensee who is unable to practice with professional skill  
11 and safety by reason of habitual or excessive use or abuse of drugs, alcohol or other substances that  
12 impair ability or by reason of a mental health disorder.

13 (3) "Licensee" means a health professional licensed or certified by or registered with a health  
14 profession licensing board.

15 (4) "**Substantial noncompliance**" includes the following:

16 (a) **Criminal behavior;**

17 (b) **Conduct that causes injury, death or harm to the public, or a patient, including sexual**  
18 **impropriety with a patient;**

19 (c) **Impairment in a health care setting in the course of employment;**

20 (d) **A positive toxicology test result as determined by federal regulations pertaining to**  
21 **drug testing;**

22 (e) **Violation of a restriction on a licensee's practice imposed by the impaired health**  
23 **professional program established under ORS 676.190 or the licensee's health profession li-**  
24 **censing board;**

25 (f) **Civil commitment for mental illness;**

26 (g) **Failure to participate in the program after entering into a diversion agreement under**  
27 **ORS 676.190; or**

28 (h) **Failure to enroll in the program after being referred to the program.**

**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       **SECTION 2.** ORS 676.190, as amended by section 1, chapter 2, Oregon Laws 2012, is amended  
2 to read:

3       676.190. (1) The Oregon Health Authority shall establish or contract to establish an impaired  
4 health professional program. The program must:

5       (a) Enroll licensees of participating health profession licensing boards who have been diagnosed  
6 with alcohol or substance abuse or a mental health disorder;

7       (b) Require that a licensee sign a written consent prior to enrollment in the program allowing  
8 disclosure and exchange of information between the program, the licensee's board, the licensee's  
9 employer, evaluators and treatment entities in compliance with ORS 179.505 and 42 C.F.R. part 2;

10       (c) Enter into diversion agreements with enrolled licensees;

11       [(d) Assess and evaluate compliance with diversion agreements by enrolled licensees;]

12       [(e) Assess the ability of an enrolled licensee's employer to supervise the licensee and require an  
13 enrolled licensee's employer to establish minimum training requirements for supervisors of enrolled  
14 licensees;]

15       [(f)] (d) Report substantial noncompliance with a diversion agreement to a noncompliant  
16 licensee's board within one business day after the program learns of the substantial  
17 noncompliance[, including but not limited to information that a licensee:];

18       [(A) Engaged in criminal behavior;]

19       [(B) Engaged in conduct that caused injury, death or harm to the public, including engaging in  
20 sexual impropriety with a patient;]

21       [(C) Was impaired in a health care setting in the course of the licensee's employment;]

22       [(D) Received a positive toxicology test result as determined by federal regulations pertaining to  
23 drug testing;]

24       [(E) Violated a restriction on the licensee's practice imposed by the program or the licensee's  
25 board;]

26       [(F) Was admitted to the hospital for mental illness or adjudged to be mentally incompetent;]

27       [(G) Entered into a diversion agreement, but failed to participate in the program; or]

28       [(H) Was referred to the program but failed to enroll in the program; and]

29       **(e) If the enrolled licensee has a direct supervisor, assess the ability of the direct**  
30 **supervisor to supervise the licensee, including an assessment of any documentation of the**  
31 **direct supervisor's completion of specialized training that may be required by the relevant**  
32 **health profession licensing board; and**

33       [(g)] (f) At least weekly, submit to licensees' boards:

34       (A) A list of licensees who were referred to the program by a health profession licensing board  
35 and who are enrolled in the program; and

36       (B) A list of licensees who were referred to the program by a health profession licensing board  
37 and who successfully complete the program.

38       (2) The lists submitted under subsection [(1)(g)] (1)(f) of this section are exempt from disclosure  
39 as a public record under ORS 192.410 to 192.505.

40       (3) When the program reports **substantial** noncompliance **under subsection (1)(d) of this**  
41 **section** to a licensee's board, the report must include:

42       (a) A description of the **substantial** noncompliance;

43       (b) A copy of a report from the independent third party who diagnosed the licensee under ORS  
44 676.200 (2)(a) or subsection (6)(a) of this section stating the licensee's diagnosis;

45       (c) A copy of the licensee's diversion agreement; and

- 1 (d) The licensee's employment status.
- 2 (4) The program may not diagnose or treat licensees enrolled in the program.
- 3 (5) The diversion agreement required by subsection (1) of this section must:
- 4 (a) Require the licensee to consent to disclosure and exchange of information between the pro-
- 5 gram, the licensee's board, the licensee's employer, evaluators and treatment **programs or provid-**
- 6 **ers**, in compliance with ORS 179.505 and 42 C.F.R. part 2;
- 7 (b) Require that the licensee comply continuously with the agreement for at least two years to
- 8 successfully complete the program;
- 9 (c) [*Based on an individualized assessment,*] Require that the licensee abstain from mind-altering
- 10 or intoxicating substances or potentially addictive drugs, unless the drug is [*approved by the pro-*
- 11 *gram and*]:
- 12 (A) Prescribed for a documented medical condition by a person authorized by law to prescribe
- 13 the drug to the licensee; **and**
- 14 (B) **Approved by the program if the licensee's board has granted the program that au-**
- 15 **thority;**
- 16 (d) Require the licensee to report use of mind-altering or intoxicating substances or potentially
- 17 addictive drugs within 24 hours;
- 18 (e) Require the licensee to agree to participate in a **recommended** treatment plan [*approved by*
- 19 *a third party*];
- 20 (f) Contain limits on the licensee's practice of the licensee's health profession;
- 21 [*g*] *Provide for employer monitoring of the licensee;*
- 22 [*h*] *Provide that the program may require an evaluation of the licensee's fitness to practice before*
- 23 *removing the limits on the licensee's practice of the licensee's health profession;*
- 24 [*i*] (g) Require the licensee to submit to random drug or alcohol testing in accordance with
- 25 federal regulations, **unless the licensee is diagnosed with solely a mental health disorder and**
- 26 **the licensee's board does not otherwise require the licensee to submit to random drug or**
- 27 **alcohol testing;**
- 28 [*j*] (h) Require the licensee to report [*at least weekly*] to the program regarding the licensee's
- 29 compliance with the agreement;
- 30 [*k*] (i) Require the licensee to report any arrest for or conviction of a misdemeanor or felony
- 31 crime to the program within three business days after the licensee is arrested or convicted;
- 32 [*L*] (j) Require the licensee to report applications for licensure in other states, changes in
- 33 employment and changes in practice setting; and
- 34 [*m*] (k) Provide that the licensee is responsible for the cost of evaluations, toxicology testing
- 35 and treatment.
- 36 (6)(a) **If a health profession licensing board participating in the program establishes by**
- 37 **rule an option for self-referral to the program,** a licensee of [*a*] **the health profession licensing**
- 38 **board** [*participating in the program*] may self-refer to the program.
- 39 (b) The program shall require [*the*] a licensee **who self-refers to the program** to attest that
- 40 the licensee is not, to the best of the licensee's knowledge, under investigation by the licensee's
- 41 board. The program shall enroll the licensee on the date on which the licensee attests that the
- 42 licensee, to the best of the licensee's knowledge, is not under investigation by the licensee's board.
- 43 (c) When a licensee self-refers to the program, the program shall:
- 44 (A) Require that an independent third party approved by the licensee's board to evaluate alcohol
- 45 or substance abuse or mental health disorders evaluate the licensee for alcohol or substance abuse

1 or mental health disorders; and

2 (B) Investigate to determine whether the licensee's practice while impaired has presented or  
3 presents a danger to the public.

4 (d) **When a licensee self-refers to the program**, the program may not report [*a self-referred*]  
5 **the** licensee's enrollment in or successful completion of the program to the licensee's board.

6 (7) The authority shall adopt rules establishing a fee to be paid by the **health profession li-**  
7 **censing** boards participating in the [*impaired health professional*] program for administration of the  
8 program.

9 (8) The authority shall arrange for an independent third party to audit the program **every four**  
10 **years** to ensure compliance with program guidelines. The authority shall report the results of the  
11 audit to the Legislative Assembly, the Governor and the health profession licensing boards. The  
12 report may not contain individually identifiable information about licensees.

13 (9) The authority may adopt rules to carry out this section.

14 **SECTION 3.** ORS 676.200, as amended by section 2, chapter 2, Oregon Laws 2012, is amended  
15 to read:

16 676.200. (1)(a) A health profession licensing board that is authorized by law to take disciplinary  
17 action against licensees may adopt rules opting to participate in the impaired health professional  
18 program established under ORS 676.190 **and may contract with or designate one or more pro-**  
19 **grams to deliver therapeutic services to its licensees.**

20 (b) A board [*may only refer impaired professionals to the impaired health professional program*  
21 *established under ORS 676.190 and*] may not establish the board's own impaired health professional  
22 program **for the purpose of monitoring licensees of the board that have been referred to the**  
23 **program.**

24 (c) A board may adopt rules establishing additional requirements for licensees referred to the  
25 impaired health professional program established under ORS 676.190 **or a program with which the**  
26 **board has entered into a contract or designated to deliver therapeutic services under sub-**  
27 **section (1) of this section.**

28 (2) If a board participates in the impaired health professional program, the board shall establish  
29 by rule a procedure for referring licensees to the program. The procedure must provide that, before  
30 the board refers a licensee to the program, the board shall ensure that:

31 (a) An independent third party approved by the board to evaluate alcohol or substance abuse  
32 or mental health disorders has diagnosed the licensee with alcohol or substance abuse or a mental  
33 health disorder and provided the diagnosis and treatment options to the licensee and the board;

34 (b) The board has investigated to determine whether the licensee's professional practice while  
35 impaired has presented or presents a danger to the public; and

36 (c) The licensee has agreed to report any arrest for or conviction of a misdemeanor or felony  
37 crime to the board within three business days after the licensee is arrested or convicted.

38 (3) A board that participates in the impaired health professional program shall [*investigate*] **re-**  
39 **view** reports received from the program. If the board finds that a licensee is substantially  
40 noncompliant with a diversion agreement entered into under ORS 676.190, the board may suspend,  
41 restrict, modify or revoke the licensee's license or end the licensee's participation in the impaired  
42 health professional program.

43 (4) A board may not discipline a licensee solely because the licensee:

44 (a) Self-refers to or participates in the impaired health professional program;

45 (b) Has been diagnosed with alcohol or substance abuse or a mental health disorder; or

1 (c) Used controlled substances before entry into the impaired health professional program, if the  
2 licensee did not practice while impaired.

3 **SECTION 4. The amendments to ORS 676.185 and 676.190 by sections 1 and 2 of this 2013**  
4 **Act apply to:**

5 (1) **Diversion agreements between licensees and the impaired health professional program**  
6 **entered into on or after the effective date of this 2013 Act; and**

7 (2) **Licensees who self-refer to the impaired health professional program on or after the**  
8 **effective date of this 2013 Act.**

9 **SECTION 5. This 2013 Act being necessary for the immediate preservation of the public**  
10 **peace, health and safety, an emergency is declared to exist, and this 2013 Act takes effect**  
11 **on its passage.**

12 \_\_\_\_\_

**A-Engrossed  
House Bill 2611**

Ordered by the House April 5  
Including House Amendments dated April 5

Sponsored by Representative KENY-GUYER, Senator SHIELDS, Representative HOLVEY; Representatives DEMBROW, FREDERICK, GALLEGOS, GREENLICK, HARKER, MATTHEWS, Senators DINGFELDER, MONNES ANDERSON, WINTERS (Presession 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.

*[Directs certain health professional regulatory boards to adopt rules by January 1, 2017, requiring licensees to document participation in continuing education opportunities relating to cultural competency approved by Oregon Health Authority.]*

**Provides that certain boards may adopt rules under which board may require person authorized to practice profession regulated by board to receive cultural competency continuing education. Requires boards to document participation in such education. Becomes operative January 1, 2017.**

Requires authority to *[collaborate with boards to define "cultural competency,"]* develop list of approved continuing education opportunities and provide list to boards on or before January 1, 2015.

**Provides that public universities and community colleges may require persons authorized to practice profession regulated by board, and who provide services to students at health care facilities located on campus of public university or community college, to provide proof of participating in continuing education opportunity relating to cultural competency. Becomes operative January 1, 2017.**

Declares emergency, effective on passage.

**A BILL FOR AN ACT**

1  
2 Relating to continuing education for health care professionals; creating new provisions; amending  
3 ORS 675.140, 675.330, 675.597, 675.805, 676.625, 677.290, 678.170, 679.260, 681.480, 683.290, 684.171,  
4 685.201, 687.071, 688.201 and 688.585; and declaring an emergency.

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

6 **SECTION 1. (1) As used in this section, "board" means the:**

7 **(a) State Board of Examiners for Speech-Language Pathology and Audiology;**

8 **(b) State Board of Chiropractic Examiners;**

9 **(c) State Board of Licensed Social Workers;**

10 **(d) Oregon Board of Licensed Professional Counselors and Therapists;**

11 **(e) Oregon Board of Dentistry;**

12 **(f) Board of Licensed Dietitians;**

13 **(g) State Board of Massage Therapists;**

14 **(h) Oregon Board of Naturopathic Medicine;**

15 **(i) Oregon State Board of Nursing;**

16 **(j) Nursing Home Administrators Board;**

17 **(k) Oregon Board of Optometry;**

18 **(L) State Board of Pharmacy;**

19 **(m) Oregon Medical Board;**

**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 (n) Occupational Therapy Licensing Board;
- 2 (o) Physical Therapist Licensing Board;
- 3 (p) State Board of Psychologist Examiners;
- 4 (q) Board of Medical Imaging;
- 5 (r) State Board of Direct Entry Midwifery;
- 6 (s) State Board of Denture Technology;
- 7 (t) Respiratory Therapist and Polysomnographic Technologist Licensing Board;
- 8 (u) Home Care Commission; and
- 9 (v) Oregon Health Authority, to the extent that the authority licenses emergency medical
- 10 service providers.

11 (2)(a) In collaboration with the Oregon Health Authority, a board may adopt rules under  
12 which the board may require a person authorized to practice the profession regulated by the  
13 board to receive cultural competency continuing education approved by the authority under  
14 section 2 of this 2013 Act.

15 (b) Cultural competency continuing education courses may be taken in addition to or, if  
16 a board determines that the cultural competency continuing education fulfills existing con-  
17 tinuing education requirements, instead of any other continuing education requirement im-  
18 posed by the board.

19 (3)(a) A board, or the Oregon Health Licensing Agency for those boards for which the  
20 agency issues and renews authorizations to practice the profession regulated by the board,  
21 shall document participation in cultural competency continuing education by persons au-  
22 thorized to practice a profession regulated by the board.

23 (b) For purposes of documenting participation under this subsection, a board may adopt  
24 rules requiring persons authorized to practice the profession regulated by the board to sub-  
25 mit documentation to the board, or to the agency for those boards for which the agency is-  
26 sues and renews authorizations to practice the profession regulated by the board, of  
27 participation in cultural competency continuing education.

28 (4) A board shall report biennially to the authority on the participation documented un-  
29 der subsection (3) of this section.

30 (5) The authority, on or before August 1 of each even-numbered year, shall report to the  
31 interim committees of the Legislative Assembly related to health care on the information  
32 submitted to the authority under subsection (4) of this section.

33 **SECTION 2.** (1) The Oregon Health Authority shall approve continuing education oppor-  
34 tunities relating to cultural competency.

35 (2) The authority shall develop a list of continuing education opportunities relating to  
36 cultural competency and make the list available to each board, as defined in section 1 of this  
37 2013 Act.

38 (3) The continuing education opportunities may include, but need not be limited to:

- 39 (a) Courses delivered either in person or electronically;
- 40 (b) Experiential learning such as cultural or linguistic immersion;
- 41 (c) Service learning; or
- 42 (d) Specially designed cultural experiences.

43 (4) The continuing education opportunities must teach attitudes, knowledge and skills  
44 that enable a health care professional to care effectively for patients from diverse cultures,  
45 groups and communities, including but not limited to:

1 (a) Applying linguistic skills to communicate effectively with patients from diverse cul-  
2 tures, groups and communities;

3 (b) Using cultural information to establish therapeutic relationships; and

4 (c) Eliciting, understanding and applying cultural and ethnic data in the process of clin-  
5 ical care.

6 (5) The authority may accept gifts, grants or contributions from any public or private  
7 source for the purpose of carrying out this section. Moneys received by the authority under  
8 this subsection shall be deposited into the Oregon Health Authority Fund established by ORS  
9 413.101.

10 (6) The authority may contract with or award grant funding to a public or private entity  
11 to develop the list of or offer approved continuing education opportunities relating to cultural  
12 competency. The authority is not subject to the requirements of ORS chapters 279A, 279B  
13 and 279C with respect to contracts entered into under this subsection.

14 **SECTION 3.** ORS 675.140 is amended to read:

15 675.140. On or before the 10th day of each month, the State Board of Psychologist Examiners  
16 shall pay into the State Treasury all moneys received by the board during the preceding calendar  
17 month. The State Treasurer shall credit the moneys to the State Board of Psychologist Examiners  
18 Account. The moneys in the State Board of Psychologist Examiners Account are continuously ap-  
19 propriated to the board for the purpose of paying the expenses of administering and enforcing ORS  
20 675.010 to 675.150 **and section 1 of this 2013 Act.**

21 **SECTION 4.** ORS 675.330 is amended to read:

22 675.330. (1) The Occupational Therapy Licensing Board Account is established in the State  
23 Treasury, separate and distinct from the General Fund. All moneys received by the Occupational  
24 Therapy Licensing Board under ORS 675.210 to 675.340 shall be deposited into the account and are  
25 continuously appropriated to the board to be used only for the administration and enforcement of  
26 ORS 675.210 to 675.340 and 675.990 (2) **and section 1 of this 2013 Act.** Any interest or other income  
27 from moneys in the account shall be credited to the account.

28 (2) All civil penalties collected or received for violations of or in prosecutions under ORS  
29 675.210 to 675.340 shall be deposited into the Occupational Therapy Licensing Board Account and  
30 shall be used only for the administration and enforcement of ORS 675.210 to 675.340.

31 **SECTION 5.** ORS 675.597 is amended to read:

32 675.597. The State Board of Licensed Social Workers Account is established in the State  
33 Treasury, separate and distinct from the General Fund. Interest earned by the State Board of Li-  
34 censed Social Workers Account shall be credited to the account. Moneys in the account are con-  
35 tinuously appropriated to the board for the administration and enforcement of ORS 675.510 to  
36 675.600 **and section 1 of this 2013 Act.**

37 **SECTION 6.** ORS 675.805 is amended to read:

38 675.805. All moneys received by the Oregon Board of Licensed Professional Counselors and  
39 Therapists under ORS 675.715 to 675.835 shall be paid into the General Fund in the State Treasury  
40 and placed to the credit of the Oregon Board of Licensed Professional Counselors and Therapists  
41 Account, which is hereby established. Such moneys are appropriated continuously and shall be used  
42 only for the administration and enforcement of ORS 675.715 to 675.835 **and section 1 of this 2013**  
43 **Act.**

44 **SECTION 7.** ORS 676.625 is amended to read:

45 676.625. (1) The Oregon Health Licensing Agency shall establish by rule and shall collect fees

1 and charges to carry out the agency's responsibilities under ORS 676.605 to 676.625 and 676.992 **and**  
2 **section 1 of this 2013 Act** and any responsibility imposed on the agency pertaining to the boards,  
3 councils and programs administered and regulated by the agency pursuant to ORS 676.606.

4 (2) The Oregon Health Licensing Agency Account is established in the General Fund of the  
5 State Treasury. The account shall consist of the moneys credited to the account by the Legislative  
6 Assembly. All moneys in the account are appropriated continuously to and shall be used by the  
7 Oregon Health Licensing Agency for payment of expenses of the agency in carrying out the duties,  
8 functions and obligations of the agency, and for payment of the expenses of the boards, councils and  
9 programs administered and regulated by the agency pursuant to ORS 676.606. The agency shall keep  
10 a record of all moneys credited to the account and report the source from which the moneys are  
11 derived and the activity of each board, council or program that generated the moneys.

12 (3) Subject to prior approval of the Oregon Department of Administrative Services and a report  
13 to the Emergency Board prior to adopting fees and charges credited to the account, the fees and  
14 charges may not exceed the cost of administering the agency and the boards, councils and programs  
15 within the agency, as authorized by the Legislative Assembly within the agency's budget, as the  
16 budget may be modified by the Emergency Board.

17 (4) All moneys credited to the account pursuant to ORS 675.405, 676.617, 680.525, 687.435,  
18 688.728, 688.834, 690.235, 690.415, 691.479, 694.185 and 700.080, and moneys credited to the account  
19 from other agency and program fees established by the agency by rule, are continuously appropri-  
20 ated to the agency for carrying out the duties, functions and powers of the agency under ORS  
21 676.605 to 676.625 and 676.992 **and section 1 of this 2013 Act**.

22 (5) The moneys received from civil penalties assessed under ORS 676.992 shall be deposited and  
23 accounted for as are other moneys received by the agency and shall be for the administration and  
24 enforcement of the statutes governing the boards, councils and programs administered by the  
25 agency.

26 **SECTION 8.** ORS 677.290 is amended to read:

27 677.290. (1) All moneys received by the Oregon Medical Board under this chapter shall be paid  
28 into the General Fund in the State Treasury and placed to the credit of the Oregon Medical Board  
29 Account which is established. Such moneys are appropriated continuously and shall be used only for  
30 the administration and enforcement of this chapter **and section 1 of this 2013 Act**.

31 (2) Notwithstanding subsection (1) of this section, the board may maintain a revolving account  
32 in a sum not to exceed \$50,000 for the purpose of receiving and paying pass-through moneys relating  
33 to peer review pursuant to its duties under ORS 441.055 (4) and (5) and in administering programs  
34 pursuant to its duties under this chapter relating to the education and rehabilitation of licensees in  
35 the areas of chemical substance abuse, inappropriate prescribing and medical competence. The cre-  
36 ation of and disbursement of moneys from the revolving account shall not require an allotment or  
37 allocation of moneys pursuant to ORS 291.234 to 291.260. All moneys in the account are continuously  
38 appropriated for purposes set forth in this subsection.

39 (3) Each year \$10 shall be paid to the Oregon Health and Science University for each in-state  
40 physician licensed under this chapter, which amount is continuously appropriated to the Oregon  
41 Health and Science University to be used in maintaining a circulating library of medical and surgi-  
42 cal books and publications for the use of practitioners of medicine in this state, and when not so in  
43 use to be kept at the library of the School of Medicine and accessible to its students. The balance  
44 of the money received by the board is appropriated continuously and shall be used only for the ad-  
45 ministration and enforcement of this chapter, but any part of the balance may, upon the order of the

1 board, be paid into the circulating library fund.

2 **SECTION 9.** ORS 678.170 is amended to read:

3 678.170. (1) All money received by the Oregon State Board of Nursing under ORS 678.010 to  
4 678.445 shall be paid into the General Fund in the State Treasury and placed to the credit of the  
5 Oregon State Board of Nursing Account. Such moneys are appropriated continuously and shall be  
6 used only for the administration and enforcement of ORS 678.010 to 678.445 **and section 1 of this**  
7 **2013 Act.**

8 (2) The board shall keep a record of all moneys deposited in the Oregon State Board of Nursing  
9 Account. This record shall indicate by separate cumulative accounts the source from which the  
10 moneys are derived and the individual activity or program against which each withdrawal is  
11 charged.

12 (3) The board may maintain a petty cash fund in compliance with ORS 293.180 in the amount  
13 of \$1,000.

14 **SECTION 10.** ORS 679.260 is amended to read:

15 679.260. (1) The Oregon Board of Dentistry Account is established in the State Treasury sepa-  
16 rate and distinct from the General Fund.

17 (2) All moneys received by the Oregon Board of Dentistry under this chapter shall be paid to  
18 the State Treasury and credited to the Oregon Board of Dentistry Account. Any interest or other  
19 income derived from moneys paid into the account shall be credited monthly to the account.

20 (3) Moneys in the Oregon Board of Dentistry Account are appropriated continuously and shall  
21 be used only for the administration and enforcement of ORS 680.010 to 680.205 and this chapter **and**  
22 **section 1 of this 2013 Act.**

23 (4) Ten percent of the annual license fee to be paid by each licensee of the Oregon Board of  
24 Dentistry shall be used by the board to ensure the continued professional competence of licensees.  
25 Such activities shall include the development of performance standards and professional peer review.

26 **SECTION 11.** ORS 681.480 is amended to read:

27 681.480. The State Board of Examiners for Speech-Language Pathology and Audiology Account  
28 is established in the State Treasury, separate and distinct from the General Fund. All moneys re-  
29 ceived by the State Board of Examiners for Speech-Language Pathology and Audiology under this  
30 chapter shall be deposited into the account and are continuously appropriated to the board for the  
31 administration and enforcement of this chapter **and section 1 of this 2013 Act.** Any interest or  
32 other income from moneys in the account shall be credited to the account.

33 **SECTION 12.** ORS 683.290 is amended to read:

34 683.290. (1) All moneys received by the Oregon Board of Optometry under ORS 683.010 to  
35 683.340 shall be deposited into an account established by the board as provided under ORS 182.470.  
36 Moneys deposited into the account hereby are appropriated continuously to the board and shall be  
37 used only for the administration and enforcement of ORS 182.456 to 182.472 and 683.010 to 683.340  
38 **and section 1 of this 2013 Act.**

39 (2) Notwithstanding subsection (1) of this section and ORS 182.470, all civil penalties collected  
40 or received for violations of or in prosecutions under ORS 683.010 to 683.340 shall be paid to the  
41 account described under subsection (1) of this section.

42 (3) In addition to making expenditures for the administration and enforcement of ORS 683.010  
43 to 683.340, the Oregon Board of Optometry may make expenditures for educational purposes out of  
44 funds available.

45 **SECTION 13.** ORS 684.171 is amended to read:

1 684.171. All moneys received by the State Board of Chiropractic Examiners under this chapter  
2 shall be paid into the General Fund in the State Treasury and placed to the credit of the State  
3 Board of Chiropractic Examiners Account which is hereby established and such moneys are appro-  
4 priated continuously and shall be used only for the administration and enforcement of this chapter  
5 **and section 1 of this 2013 Act.**

6 **SECTION 14.** ORS 685.201 is amended to read:

7 685.201. The Oregon Board of Naturopathic Medicine Account is established in the State  
8 Treasury, separate and distinct from the General Fund. All moneys received by the Oregon Board  
9 of Naturopathic Medicine under this chapter shall be deposited into the account and are contin-  
10 uously appropriated to the board to be used only for the administration and enforcement of this  
11 chapter **and section 1 of this 2013 Act.** Any interest or other income from moneys in the account  
12 shall be credited to the account.

13 **SECTION 15.** ORS 687.071 is amended to read:

14 687.071. (1) The State Board of Massage Therapists shall impose fees for the following:

- 15 (a) Massage therapist license issuance or renewal.
- 16 (b) Examinations and reexaminations.
- 17 (c) Inactive status.
- 18 (d) Delinquency in renewal of a license.
- 19 (e) Temporary practice permit.
- 20 (f) Application for massage license examination.

21 (2) If the effective period of the initial massage therapist license is to be less than 12 months  
22 by reason of the expiration date established by rule of the board, the required license fee shall be  
23 prorated to represent one-half of the biennial rate.

24 (3) The board shall examine or reexamine any applicant for a massage therapist license who  
25 pays a fee for each examination and who meets the requirements of ORS 687.051.

26 (4) All moneys received by the board shall be paid into the account created by the board under  
27 ORS 182.470 and are appropriated continuously to the board and shall be used only for the admin-  
28 istration and enforcement of ORS 687.011 to 687.250, 687.895 and 687.991 **and section 1 of this 2013**  
29 **Act.**

30 **SECTION 16.** ORS 688.201 is amended to read:

31 688.201. All moneys received under ORS 688.010 to 688.201 shall be paid into the account es-  
32 tablished by the Physical Therapist Licensing Board under ORS 182.470. Those moneys hereby are  
33 appropriated continuously to the board and shall be used only for the administration and enforce-  
34 ment of ORS 688.010 to 688.201 **and section 1 of this 2013 Act.**

35 **SECTION 17.** ORS 688.585 is amended to read:

36 688.585. (1) The Board of Medical Imaging Account is established in the State Treasury, separate  
37 and distinct from the General Fund. Except for moneys otherwise designated by statute, all fees,  
38 contributions and other moneys received by the Board of Medical Imaging must be paid into the  
39 State Treasury and credited to the account. All moneys in the account are continuously appropri-  
40 ated to the board to be used by the board for purposes of ORS 688.405 to 688.605 **and section 1 of**  
41 **this 2013 Act.** Any interest or other income from moneys in the account shall be credited to the  
42 account.

43 (2) The board shall keep a record of all moneys deposited in the account. The record shall in-  
44 dicate by separate cumulative accounts the source from which the moneys are derived and the in-  
45 dividual activity or program for which each withdrawal is charged.

1       **SECTION 18.** Each public university listed in ORS 352.002 and each community college,  
2 as defined in ORS 341.005, may require persons authorized to practice a profession regulated  
3 by a board, as defined in section 1 of this 2013 Act, who provide services to students at health  
4 care facilities located on a campus of the public university or community college to provide  
5 proof of participating at least once every two years in a continuing education opportunity  
6 relating to cultural competency approved by the Oregon Health Authority under section 2  
7 of this 2013 Act.

8       **SECTION 19.** (1) Section 2 of this 2013 Act becomes operative on January 1, 2015.

9       (2) The Oregon Health Authority may take any action necessary before the operative date  
10 specified in subsection (1) of this section to enable the authority to exercise, on and after the  
11 operative date specified in subsection (1) of this section, all the duties, functions and powers  
12 conferred on the authority by section 2 of this 2013 Act.

13       **SECTION 20.** (1) Sections 1 and 18 of this 2013 Act and the amendments to statutes by  
14 sections 3 to 17 of this 2013 Act become operative on January 1, 2017.

15       (2) A board, as defined in section 1 of this 2013 Act, may take any action necessary before  
16 the operative date specified in subsection (1) of this section to enable the board to exercise,  
17 on and after the operative date specified in subsection (1) of this section, all the duties,  
18 functions and powers conferred on the board by sections 1 and 18 of this 2013 Act and the  
19 amendments to statutes by sections 3 to 17 of this 2013 Act.

20       **SECTION 21.** This 2013 Act being necessary for the immediate preservation of the public  
21 peace, health and safety, an emergency is declared to exist, and this 2013 Act takes effect  
22 on its passage.  
23

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**A-Engrossed**  
**House Bill 2948**

Ordered by the House March 20  
Including House Amendments dated March 20

Sponsored by Representative CLEM (at the request of Oregon Dental Association)

**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.

Authorizes dentists licensed in other countries to participate in educational activities related to dentistry that occur in this state. Authorizes dentists licensed in other countries to practice dentistry in this state without compensation for limited duration. [*Authorizes dentists licensed in other countries to be granted staff privileges at hospital located in this state upon written request by authorized officer of hospital.*]

**A BILL FOR AN ACT**

1  
2 Relating to dentists licensed in other countries; amending ORS 679.025 and 679.050.

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

4 **SECTION 1.** ORS 679.025, as amended by section 1, chapter 80, Oregon Laws 2012, is amended  
5 to read:

6 679.025. (1) A person may not practice dentistry or purport to be a dentist without a valid li-  
7 cense to practice dentistry issued by the Oregon Board of Dentistry.

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

9 (a) Dentists licensed in another state **or country** making a clinical presentation sponsored by  
10 a bona fide dental society or association or an accredited dental educational institution approved  
11 by the board.

12 (b) Bona fide full-time students of dentistry who, during the period of their enrollment and as a  
13 part of the course of study in an Oregon accredited dental education program, engage in clinical  
14 studies on the premises of such institution or in a clinical setting located off the premises of the  
15 institution if the facility, the instructional staff and the course of study to be pursued at the off-  
16 premises location meet minimum requirements prescribed by the rules of the board and the clinical  
17 study is performed under the direct supervision of a member of the faculty.

18 (c) Bona fide full-time students of dentistry who, during the period of their enrollment and as a  
19 part of the course of study in a dental education program located outside of Oregon that is accred-  
20 ited by the Commission on Dental Accreditation of the American Dental Association or its successor  
21 agency, engage in community-based or clinical studies as an elective or required rotation in a clin-  
22 ical setting located in Oregon if the community-based or clinical studies meet minimum requirements  
23 prescribed by the rules of the board and are performed under the direct supervision of a member  
24 of the faculty of the Oregon Health and Science University School of Dentistry.

25 (d) Candidates who are preparing for a licensure examination to practice dentistry and whose  
26 application has been accepted by the board or its agent, if such clinical preparation is conducted in

**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 clinic located on premises approved for that purpose by the board and if the procedures are lim-  
2 ited to examination only. This exception shall exist for a period not to exceed two weeks imme-  
3 diately prior to a regularly scheduled licensure examination.

4 (e) Dentists practicing in the discharge of official duties as employees of the United States  
5 Government and any of its agencies.

6 (f) Instructors of dentistry, whether full- or part-time, while exclusively engaged in teaching ac-  
7 tivities and while employed in accredited dental educational institutions.

8 (g) Dentists employed by public health agencies who are not engaged in the direct delivery of  
9 clinical dental services to patients.

10 (h) Persons licensed to practice medicine in the State of Oregon in the regular discharge of their  
11 duties.

12 (i) Persons qualified to perform services relating to general anesthesia or sedation under the  
13 direct supervision of a licensed dentist.

14 (j) Dentists licensed in another state **or country** and in good standing, while practicing  
15 dentistry without compensation for no more than five consecutive days in any 12-month period,  
16 provided the dentist submits an application to the board at least 10 days before practicing dentistry  
17 under this paragraph and the application is approved by the board.

18 (k) Persons practicing dentistry upon themselves as the patient.

19 (L) Dental hygienists, dental assistants or dental technicians performing services under the  
20 supervision of a licensed dentist in accordance with the rules adopted by the board.

21 (m) A person licensed as a denturist under ORS 680.500 to 680.565 engaged in the practice of  
22 denture technology.

23 (n) An expanded practice dental hygienist who renders services authorized by a permit issued  
24 by the board pursuant to ORS 680.200.

25 **SECTION 2.** ORS 679.050 is amended to read:

26 679.050. (1) If a reputable and duly licensed practitioner in dentistry of another state **or country**  
27 is asked to appear and demonstrate, receive or give instruction in the practice of dentistry before  
28 any qualified dental college or dental organization or dental study group recognized by the Oregon  
29 Board of Dentistry, the secretary of the board shall issue on written request of an authorized officer  
30 of such college or dental organization or dental study group, without fee, a permit for such purpose.  
31 A permit shall be issued upon such terms as the board shall prescribe.

32 (2) If a reputable and duly licensed practitioner in dentistry of another state has been granted  
33 staff privileges, either limited, special or general, by any duly licensed hospital in this state, the  
34 secretary of the board shall issue on written request and verification of an authorized officer of such  
35 hospital, a permit for such nonresident practitioner to practice dentistry in said hospital.

36

**A-Engrossed**  
**Senate Bill 101**

Ordered by the Senate March 8  
Including Senate Amendments dated March 8

Printed pursuant to Senate Interim Rule 213.28 by order of the President of the Senate in conformance with pre-session filing rules, indicating neither advocacy nor opposition on the part of the President (at the request of Governor John A. Kitzhaber, M.D., for Oregon Health Authority)

**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.

Eliminates from impaired health professional program requirement that employers of program participants establish minimum training requirements for supervisors of participants. **Modifies provision under which program assesses supervision of participants.**

Removes admittance to hospital for mental illness and court ruling of mental incompetence from list of information that program must report as evidence of substantial noncompliance with diversion agreement entered into under program.

**A BILL FOR AN ACT**

1  
2 Relating to the impaired health professional program established by the Oregon Health Authority;  
3 amending ORS 676.190.

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

5 **SECTION 1.** ORS 676.190, as amended by section 1, chapter 2, Oregon Laws 2012, is amended  
6 to read:

7 676.190. (1) The Oregon Health Authority shall establish or contract to establish an impaired  
8 health professional program. The program must:

9 (a) Enroll licensees of participating health profession licensing boards who have been diagnosed  
10 with alcohol or substance abuse or a mental health disorder;

11 (b) Require that a licensee sign a written consent prior to enrollment in the program allowing  
12 disclosure and exchange of information between the program, the licensee's board, the licensee's  
13 employer, evaluators and treatment entities in compliance with ORS 179.505 and 42 C.F.R. part 2;

14 (c) Enter into diversion agreements with enrolled licensees;

15 (d) Assess and evaluate compliance with diversion agreements by enrolled licensees;

16 *[(e) Assess the ability of an enrolled licensee's employer to supervise the licensee and require an*  
17 *enrolled licensee's employer to establish minimum training requirements for supervisors of enrolled*  
18 *licensees;]*

19 **(e) If the enrolled licensee has a direct supervisor, assess the ability of the direct**  
20 **supervisor to supervise the licensee, including an assessment of any documentation of the**  
21 **direct supervisor's completion of specialized training that may be required by the relevant**  
22 **health profession licensing board;**

23 (f) Report substantial noncompliance with a diversion agreement to a noncompliant licensee's  
24 board within one business day after the program learns of the substantial noncompliance, including  
25 but not limited to information that a licensee:

**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) Engaged in criminal behavior;
- 2 (B) Engaged in conduct that caused injury, death or harm to the public, including engaging in  
3 sexual impropriety with a patient;
- 4 (C) Was impaired in a health care setting in the course of the licensee's employment;
- 5 (D) Received a positive toxicology test result as determined by federal regulations pertaining to  
6 drug testing;
- 7 (E) Violated a restriction on the licensee's practice imposed by the program or the licensee's  
8 board;
- 9 *[(F) Was admitted to the hospital for mental illness or adjudged to be mentally incompetent;]*  
10 *[(G)]* (F) Entered into a diversion agreement, but failed to participate in the program; or  
11 *[(H)]* (G) Was referred to the program but failed to enroll in the program; and
- 12 (g) At least weekly, submit to licensees' boards:
- 13 (A) A list of licensees who were referred to the program by a health profession licensing board  
14 and who are enrolled in the program; and
- 15 (B) A list of licensees who were referred to the program by a health profession licensing board  
16 and who successfully complete the program.
- 17 (2) The lists submitted under subsection (1)(g) of this section are exempt from disclosure as a  
18 public record under ORS 192.410 to 192.505.
- 19 (3) When the program reports noncompliance to a licensee's board, the report must include:
- 20 (a) A description of the noncompliance;
- 21 (b) A copy of a report from the independent third party who diagnosed the licensee under ORS  
22 676.200 (2)(a) or subsection (6)(a) of this section stating the licensee's diagnosis;
- 23 (c) A copy of the licensee's diversion agreement; and
- 24 (d) The licensee's employment status.
- 25 (4) The program may not diagnose or treat licensees enrolled in the program.
- 26 (5) The diversion agreement required by subsection (1) of this section must:
- 27 (a) Require the licensee to consent to disclosure and exchange of information between the pro-  
28 gram, the licensee's board, the licensee's employer, evaluators and treatment providers, in compli-  
29 ance with ORS 179.505 and 42 C.F.R. part 2;
- 30 (b) Require that the licensee comply continuously with the agreement for at least two years to  
31 successfully complete the program;
- 32 (c) Based on an individualized assessment, require that the licensee abstain from mind-altering  
33 or intoxicating substances or potentially addictive drugs, unless the drug is approved by the pro-  
34 gram and prescribed for a documented medical condition by a person authorized by law to prescribe  
35 the drug to the licensee;
- 36 (d) Require the licensee to report use of mind-altering or intoxicating substances or potentially  
37 addictive drugs within 24 hours;
- 38 (e) Require the licensee to agree to participate in a treatment plan approved by a third party;
- 39 (f) Contain limits on the licensee's practice of the licensee's health profession;
- 40 (g) Provide for employer monitoring of the licensee;
- 41 (h) Provide that the program may require an evaluation of the licensee's fitness to practice be-  
42 fore removing the limits on the licensee's practice of the licensee's health profession;
- 43 (i) Require the licensee to submit to random drug or alcohol testing in accordance with federal  
44 regulations;
- 45 (j) Require the licensee to report at least weekly to the program regarding the licensee's com-

1 pliance with the agreement;

2 (k) Require the licensee to report any arrest for or conviction of a misdemeanor or felony crime  
3 to the program within three business days after the licensee is arrested or convicted;

4 (L) Require the licensee to report applications for licensure in other states, changes in employ-  
5 ment and changes in practice setting; and

6 (m) Provide that the licensee is responsible for the cost of evaluations, toxicology testing and  
7 treatment.

8 (6)(a) A licensee of a board participating in the program may self-refer to the program.

9 (b) The program shall require the licensee to attest that the licensee is not, to the best of the  
10 licensee's knowledge, under investigation by the licensee's board. The program shall enroll the  
11 licensee on the date on which the licensee attests that the licensee, to the best of the licensee's  
12 knowledge, is not under investigation by the licensee's board.

13 (c) When a licensee self-refers to the program, the program shall:

14 (A) Require that an independent third party approved by the licensee's board to evaluate alcohol  
15 or substance abuse or mental health disorders evaluate the licensee for alcohol or substance abuse  
16 or mental health disorders; and

17 (B) Investigate to determine whether the licensee's practice while impaired has presented or  
18 presents a danger to the public.

19 (d) The program may not report a self-referred licensee's enrollment in or successful completion  
20 of the program to the licensee's board.

21 (7) The authority shall adopt rules establishing a fee to be paid by the boards participating in  
22 the impaired health professional program for administration of the program.

23 (8) The authority shall arrange for an independent third party to audit the program to ensure  
24 compliance with program guidelines. The authority shall report the results of the audit to the Leg-  
25 islative Assembly, the Governor and the health profession licensing boards. The report may not  
26 contain individually identifiable information about licensees.

27 (9) The authority may adopt rules to carry out this section.

28

# Senate Bill 399

Sponsored by Senator GEORGE (Presession 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**.

Directs state agencies to deposit moneys agencies receive through imposition of civil penalties into General Fund and not into other funds account continuously appropriated to agency.  
Sunsets January 2, 2022.

## A BILL FOR AN ACT

1  
2 Relating to state finance.

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

4 **SECTION 1. (1) Notwithstanding any other provision of law, a state agency may not de-**  
5 **posit moneys the agency receives through the imposition, by the agency, of civil penalties**  
6 **into an other funds account that is continuously appropriated to the agency by statute for**  
7 **the uses and purposes of the agency. A state agency shall deposit moneys described in this**  
8 **subsection into the General Fund.**

9 (2) Subsection (1) of this section does not apply to:

10 (a) Funds or accounts that receive moneys appropriated from the General Fund;

11 (b) Funds or accounts established by the Oregon Constitution or whose expenditures are  
12 limited or otherwise directed by provisions of the Oregon Constitution;

13 (c) Federal funds or lottery funds deposited in any fund or account that includes dedi-  
14 cated or continuously appropriated moneys; or

15 (d) Dedicated or continuously appropriated moneys in an other funds account that are  
16 authorized by law to be expended without limitation.

17 (3) As used in this section:

18 (a) "Other funds account" means a statutory fund or account that includes fees, moneys  
19 or other revenues, including Miscellaneous Receipts, but excluding lottery funds and federal  
20 funds, collected or received by a state agency that are dedicated or continuously appropriated  
21 to the agency by statute for the uses and purposes of the agency.

22 (b) "State agency" has the meaning given that term in ORS 291.322.

23 **SECTION 2. Section 1 of this 2013 Act is repealed January 2, 2022.**  
24

**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.

# Senate Bill 429

Sponsored by Senator GEORGE (Presession 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**.

Directs state agencies to deposit moneys that agencies receive through imposition of fees, fines or civil penalties into General Fund and not into other funds account continuously appropriated to agency.

Takes effect on 91st day following adjournment sine die.

## A BILL FOR AN ACT

1  
2 Relating to state finance; prescribing an effective date; and providing for revenue raising that re-  
3 quires approval by a three-fifths majority.

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

5 **SECTION 1. (1) Notwithstanding any other provision of law, a state agency may not de-**  
6 **posit the following moneys into an other funds account:**

7 (a) Moneys the agency receives through the collection of fees paid to the agency pursuant  
8 to law or rule; or

9 (b) Moneys the agency receives through the imposition, by the agency, of fines or civil  
10 penalties.

11 (2) A state agency shall deposit moneys described in subsection (1) of this section into  
12 the General Fund.

13 (3) Subsections (1) and (2) of this section do not apply to:

14 (a) Moneys appropriated from the General Fund to an other funds account;

15 (b) Moneys in funds or accounts established by the Oregon Constitution or whose  
16 expenditures are limited or otherwise directed by provisions of the Oregon Constitution;

17 (c) Federal funds or lottery funds deposited in any fund or account that includes dedi-  
18 cated or continuously appropriated moneys;

19 (d) Dedicated or continuously appropriated moneys in an other funds account that are  
20 authorized by law to be expended without limitation;

21 (e) Moneys paid as tuition to a public university listed in ORS 352.002 or to a community  
22 college as defined in ORS 341.005;

23 (f) Revenues from taxes imposed under ORS chapter 657; or

24 (g) Moneys from the tax on motor vehicle fuel or aircraft fuel imposed under ORS 319.020  
25 or moneys from the tax on fuel used in motor vehicles imposed under ORS 319.530.

26 (4) As used in this section:

27 (a) "Other funds account" means a statutory fund or account that includes fees, moneys  
28 or other revenues, including Miscellaneous Receipts, but excluding lottery funds and federal  
29 funds, collected or received by a state agency that are dedicated or continuously appropriated  
30 to the agency by statute for the uses and purposes of the agency.

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       **(b) “State agency” has the meaning given that term in ORS 291.322.**

2       **SECTION 2.** **This 2013 Act takes effect on the 91st day after the date on which the 2013**  
3 **regular session of the Seventy-seventh Legislative Assembly adjourns sine die.**

4

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# A-Engrossed Senate Bill 470

Ordered by the Senate March 18  
Including Senate Amendments dated March 18

Sponsored by Senators KRUSE, MONNES ANDERSON; Senator BATES

## 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.

**Modifies, for purposes related to prescription monitoring program, definition of "practitioner."**

**Authorizes State Board of Pharmacy to designate prescription drugs for inclusion in prescription monitoring program.**

Requires additional information related to dispensed prescription drugs to be reported to Oregon Health Authority under prescription monitoring program.

Directs authority to disclose information received pursuant to program under specified circumstances.

Makes information reported to authority under program, information disclosed by authority under program and all information related to such disclosures exempt from public disclosure.

## A BILL FOR AN ACT

1  
2 Relating to the prescription monitoring program administered by the Oregon Health Authority;  
3 creating new provisions; and amending ORS 192.502, 431.960, 431.962, 431.964, 431.966 and  
4 431.970.

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

6 **SECTION 1.** ORS 431.960 is amended to read:

7 431.960. As used in ORS 431.962 to 431.978 and 431.992:

8 (1) "Dispense" and "dispensing" have the meanings given those terms in ORS 689.005.

9 (2) "Drug outlet" has the meaning given that term in ORS 689.005.

10 (3) "Health professional regulatory board" has the meaning given that term in ORS 676.160.

11 [(4) "Practitioner" has the meaning given that term in ORS 689.005.]

12 (4) **"Practitioner" means:**

13 (a) **A practitioner as defined in ORS 689.005; or**

14 (b) **An individual licensed to practice a profession in California, Idaho or Washington, if**  
15 **the requirements for licensure are similar, as determined by the Oregon Health Authority,**  
16 **to the requirements for being licensed as a practitioner as defined in ORS 689.005.**

17 (5) "Prescription" has the meaning given that term in ORS 475.005.

18 (6) "Prescription drug" has the meaning given that term in ORS 689.005.

19 **SECTION 2.** ORS 431.962 is amended to read:

20 431.962. (1)(a) The Oregon Health Authority, in consultation with the Prescription Monitoring  
21 Program Advisory Commission, shall establish and maintain a prescription monitoring program for  
22 monitoring and reporting prescription drugs dispensed by pharmacies in Oregon that are:

23 (A) Classified in schedules II through IV under the federal Controlled Substances Act, 21 U.S.C.

**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.

1 811 and 812, as modified by the State Board of Pharmacy by rule under ORS 475.035; and

2 **(B) Other prescription drugs designated by the board by rule for inclusion in the pre-**  
3 **scription monitoring program.**

4 (b)(A) To fulfill the requirements of this subsection, the authority shall establish, maintain and  
5 operate an electronic system to monitor and report drugs described in paragraph (a) of this sub-  
6 section that are dispensed by prescription.

7 (B) The system must operate and be accessible by practitioners and pharmacies 24 hours a day,  
8 seven days a week.

9 (C) The authority may contract with a state agency or private entity to ensure the effective  
10 operation of the electronic system.

11 (2) In consultation with the commission, the authority shall adopt rules for the operation of the  
12 electronic prescription monitoring program established under subsection (1) of this section, including  
13 but not limited to standards for:

14 (a) Reporting data;

15 (b) Providing maintenance, security and disclosure of data;

16 (c) Ensuring accuracy and completeness of data;

17 (d) Complying with the federal Health Insurance Portability and Accountability Act of 1996 (P.L.  
18 104-191) and regulations adopted under it, including 45 C.F.R. parts 160 and 164, federal alcohol and  
19 drug treatment confidentiality laws and regulations adopted under those laws, including 42 C.F.R.  
20 part 2, and state health and mental health confidentiality laws, including ORS 179.505, 192.517 and  
21 192.553 to 192.581;

22 (e) Ensuring accurate identification of persons or entities requesting information from the da-  
23 tabase;

24 (f) Accepting printed or nonelectronic reports from pharmacies that do not have the capability  
25 to provide electronic reports; and

26 (g) Notifying a patient, before or when a drug [*classified in schedules II through IV*] **included**  
27 **in the prescription monitoring program** is dispensed to the patient, about the prescription moni-  
28 toring program and the entry of the prescription in the system.

29 (3) The authority shall submit an annual report to the commission regarding the prescription  
30 monitoring program established under this section.

31 **SECTION 3.** ORS 431.964 is amended to read:

32 431.964. (1) Not later than one week after dispensing a prescription drug **that is** subject to the  
33 prescription monitoring program established under ORS 431.962, a pharmacy shall electronically  
34 report to the Oregon Health Authority [*the*]:

35 [*(a) Name, address and date of birth of the patient;*]

36 [*(b) Identification of the pharmacy dispensing the prescription drug;*]

37 [*(c) Identification of the practitioner who prescribed the drug;*]

38 [*(d) Identification of the prescription drug by a national drug code number;*]

39 [*(e) Date of origin of the prescription;*]

40 [*(f) Date the drug was dispensed; and*]

41 [*(g) Quantity of drug dispensed.*]

42 **(a) The name, address, date of birth and sex of the patient for whom the prescription**  
43 **drug was prescribed;**

44 **(b) The identity of the pharmacy that dispensed the prescription drug and the date on**  
45 **which the prescription drug was dispensed;**

1 (c) **The identity of the practitioner who prescribed the prescription drug and the date on**  
2 **which the prescription drug was prescribed;**

3 (d) **The national drug code number for the prescription drug;**

4 (e) **The prescription number assigned to the prescription drug;**

5 (f) **The quantity of the prescription drug dispensed;**

6 (g) **The number of days for which the prescription drug was dispensed; and**

7 (h) **The number of refills of the prescription authorized by the practitioner and the**  
8 **number of the refill that the pharmacy dispensed.**

9 (2) Notwithstanding subsection (1) of this section, the authority may not:

10 (a) Require the reporting of prescription drugs administered directly to a patient or dispensed  
11 pursuant to ORS 127.800 to 127.897; or

12 (b) Collect or use Social Security numbers in the prescription monitoring program.

13 (3) Upon receipt of the data reported pursuant to subsection (1) of this section, the authority  
14 shall record the data in the electronic system operated pursuant to the prescription monitoring  
15 program.

16 (4)(a) The authority may grant a pharmacy a waiver of the electronic submission requirement  
17 of subsection (1) of this section for good cause as determined by the authority. The waiver shall  
18 state the format, method and frequency of the alternate nonelectronic submissions from the phar-  
19 macy and the duration of the waiver.

20 (b) As used in this subsection, “good cause” includes financial hardship.

21 (5) This section does not apply to pharmacies in institutions as defined in ORS 179.010.

22 **SECTION 4.** ORS 431.966 is amended to read:

23 431.966. (1)(a) Except as provided under subsection (2) of this section, prescription monitoring  
24 information submitted under ORS 431.964 to the prescription monitoring program established in ORS  
25 431.962:

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

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

28 (b) Except as provided under subsection [(2)(a)(D)] **(2)(a)(E)** of this section, prescription moni-  
29 toring information submitted under ORS 431.964 to the prescription monitoring program may not be  
30 used to evaluate a practitioner’s professional practice.

31 (2)(a) **To the extent that the law or regulation is applicable to the prescription monitoring**  
32 **program**, if a disclosure of prescription monitoring information complies with the federal Health  
33 Insurance Portability and Accountability Act of 1996 (P.L. 104-191) and regulations adopted under  
34 it, including 45 C.F.R. parts 160 and 164, federal alcohol and drug treatment confidentiality laws  
35 and regulations adopted under those laws, including 42 C.F.R. part 2, and state health and mental  
36 health confidentiality laws, including ORS 179.505, 192.517 and 192.553 to 192.581, the Oregon Health  
37 Authority shall disclose the information:

38 (A) *[To a practitioner or pharmacist who certifies]* **To a practitioner or pharmacist, or, if a**  
39 **practitioner or pharmacist authorizes the authority to disclose the information to a member**  
40 **of the practitioner’s or pharmacist’s staff, to a member of the practitioner’s or pharmacist’s**  
41 **staff. To receive information under this subparagraph, or to authorize the receipt of infor-**  
42 **mation by a staff member under this subparagraph, a practitioner or pharmacist must cer-**  
43 **tify** that the requested information is for the purpose of evaluating the need for or providing medical  
44 or pharmaceutical treatment for a patient to whom the practitioner or pharmacist anticipates pro-  
45 viding, is providing or has provided care.

1       **(B) To a practitioner in a form that catalogs all prescription drugs prescribed by the**  
2 **practitioner according to the number assigned to the practitioner by the Drug Enforcement**  
3 **Administration of the United States Department of Justice.**

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

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

10       [(D)] (E) To a health professional regulatory board that certifies in writing that the requested  
11 information is necessary for an investigation related to licensure, renewal or disciplinary action in-  
12 volving the applicant, licensee or registrant to whom the requested information pertains.

13       [(E)] (F) To a prescription monitoring program of another state if the confidentiality, security  
14 and privacy standards of the requesting state are determined by the authority to be equivalent to  
15 those of the authority.

16       **(G) To the State Medical Examiner or designee of the State Medical Examiner, for the**  
17 **purpose of conducting medicolegal investigation or autopsy.**

18       **(H) To a practitioner or pharmacist, as part of an automated system integrated into the**  
19 **prescription monitoring program by the authority that is designed to notify the practitioner**  
20 **or pharmacist of a potentially dangerous drug interaction, or of prescriptions made by mul-**  
21 **tipl practitioners, for a patient of that practitioner or pharmacist.**

22       (b) The authority may disclose information from the prescription monitoring program that does  
23 not identify a patient, practitioner or drug outlet:

24       (A) For educational, research or public health purposes; *[and]*

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

26       [(B)] (C) To officials of the authority who are conducting special epidemiologic morbidity and  
27 mortality studies in accordance with ORS 432.060 and rules adopted under ORS 431.110.

28       (c) The authority shall disclose information relating to a patient maintained in the electronic  
29 system operated pursuant to the prescription monitoring program established under ORS 431.962 to  
30 that patient at no cost to the patient within 10 business days after the authority receives a request  
31 from the patient for the information.

32       (d)(A) A patient may request the authority to correct any information about the patient that is  
33 erroneous. The authority shall grant or deny a request to correct information within 10 business  
34 days after the authority receives the request.

35       (B) If the authority denies a patient's request to correct information under this paragraph, or  
36 fails to grant a patient's request to correct information under this paragraph within 10 business days  
37 after the authority receives the request, the patient may appeal the denial or failure to grant the  
38 request. Upon receipt of an appeal under this subparagraph, the authority shall conduct a contested  
39 case hearing as provided in ORS chapter 183. Notwithstanding ORS 183.450, in the contested case  
40 hearing, the authority has the burden of establishing that the information included in the pre-  
41 scription monitoring program is correct.

42       (e) The information in the prescription monitoring program may not be used for any commercial  
43 purpose.

44       (f) In accordance with ORS 192.553 to 192.581 and federal privacy regulations, any person au-  
45 thorized to prescribe or dispense a prescription drug and who is entitled to access a patient's pre-

1 prescription monitoring information may discuss or release the information to other health care  
2 providers involved with the patient's care, in order to provide safe and appropriate care coordi-  
3 nation.

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

6 (A) The identity of each person who requests or receives information from the program and the  
7 organization, if any, the person represents;

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

9 (C) The date and time the information was requested and the date and time the information was  
10 provided.

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

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

15 (5) The authority shall notify the Attorney General and each affected individual of an improper  
16 disclosure of information from the prescription monitoring program.

17 (6)(a) If the authority or a person or entity required to report or authorized to receive or release  
18 [*controlled substance*] prescription **drug** information under this section violates this section or ORS  
19 431.964 or 431.968, a person injured by the violation may bring a civil action against the authority,  
20 person or entity and may recover damages in the amount of \$1,000 or actual damages, whichever is  
21 greater.

22 (b) Notwithstanding paragraph (a) of this subsection, the authority and a person or entity re-  
23 quired to report or authorized to receive or release [*controlled substance*] prescription **drug** infor-  
24 mation under this section are immune from civil liability for violations of this section or ORS  
25 431.964 or 431.968 unless the authority, person or entity acts with malice, criminal intent, gross  
26 negligence, recklessness or willful intent.

27 (7) Nothing in ORS 431.962 to 431.978 and 431.992 requires a practitioner or pharmacist who  
28 prescribes or dispenses a prescription drug to obtain information about a patient from the pre-  
29 scription monitoring program. A practitioner or pharmacist who prescribes or dispenses a pre-  
30 scription drug may not be held liable for damages in any civil action on the basis that the  
31 practitioner or pharmacist did or did not request or obtain information from the prescription moni-  
32 toring program.

33 **SECTION 5.** ORS 431.970 is amended to read:

34 431.970. If a practitioner or pharmacist authorized to obtain [*controlled substance*] prescription  
35 **drug** information from the prescription monitoring system established under ORS 431.962 discloses  
36 or uses information obtained from the system in violation of ORS 431.966, the Oregon Health Au-  
37 thority shall report the individual to the appropriate health professional regulatory board.

38 **SECTION 6.** ORS 192.502, as amended by section 26, chapter 45, Oregon Laws 2012, and  
39 sections 19 and 30, chapter 90, Oregon Laws 2012, is amended to read:

40 192.502. The following public records are exempt from disclosure under ORS 192.410 to 192.505:

41 (1) Communications within a public body or between public bodies of an advisory nature to the  
42 extent that they cover other than purely factual materials and are preliminary to any final agency  
43 determination of policy or action. This exemption shall not apply unless the public body shows that  
44 in the particular instance the public interest in encouraging frank communication between officials  
45 and employees of public bodies clearly outweighs the public interest in disclosure.

1 (2) Information of a personal nature such as but not limited to that kept in a personal, medical  
2 or similar file, if public disclosure would constitute an unreasonable invasion of privacy, unless the  
3 public interest by clear and convincing evidence requires disclosure in the particular instance. The  
4 party seeking disclosure shall have the burden of showing that public disclosure would not consti-  
5 tute an unreasonable invasion of privacy.

6 (3) Public body employee or volunteer addresses, Social Security numbers, dates of birth and  
7 telephone numbers contained in personnel records maintained by the public body that is the em-  
8 ployer or the recipient of volunteer services. This exemption:

9 (a) Does not apply to the addresses, dates of birth and telephone numbers of employees or vol-  
10 unteers who are elected officials, except that a judge or district attorney subject to election may  
11 seek to exempt the judge's or district attorney's address or telephone number, or both, under the  
12 terms of ORS 192.445;

13 (b) Does not apply to employees or volunteers to the extent that the party seeking disclosure  
14 shows by clear and convincing evidence that the public interest requires disclosure in a particular  
15 instance;

16 (c) Does not apply to a substitute teacher as defined in ORS 342.815 when requested by a pro-  
17 fessional education association of which the substitute teacher may be a member; and

18 (d) Does not relieve a public employer of any duty under ORS 243.650 to 243.782.

19 (4) Information submitted to a public body in confidence and not otherwise required by law to  
20 be submitted, where such information should reasonably be considered confidential, the public body  
21 has obliged itself in good faith not to disclose the information, and when the public interest would  
22 suffer by the disclosure.

23 (5) Information or records of the Department of Corrections, including the State Board of Parole  
24 and Post-Prison Supervision, to the extent that disclosure would interfere with the rehabilitation of  
25 a person in custody of the department or substantially prejudice or prevent the carrying out of the  
26 functions of the department, if the public interest in confidentiality clearly outweighs the public in-  
27 terest in disclosure.

28 (6) Records, reports and other information received or compiled by the Director of the Depart-  
29 ment of Consumer and Business Services in the administration of ORS chapters 723 and 725 not  
30 otherwise required by law to be made public, to the extent that the interests of lending institutions,  
31 their officers, employees and customers in preserving the confidentiality of such information out-  
32 weighs the public interest in disclosure.

33 (7) Reports made to or filed with the court under ORS 137.077 or 137.530.

34 (8) Any public records or information the disclosure of which is prohibited by federal law or  
35 regulations.

36 (9)(a) Public records or information the disclosure of which is prohibited or restricted or other-  
37 wise made confidential or privileged under Oregon law.

38 (b) Subject to ORS 192.423, paragraph (a) of this subsection does not apply to factual information  
39 compiled in a public record when:

40 (A) The basis for the claim of exemption is ORS 40.225;

41 (B) The factual information is not prohibited from disclosure under any applicable state or fed-  
42 eral law, regulation or court order and is not otherwise exempt from disclosure under ORS 192.410  
43 to 192.505;

44 (C) The factual information was compiled by or at the direction of an attorney as part of an  
45 investigation on behalf of the public body in response to information of possible wrongdoing by the

1 public body;

2 (D) The factual information was not compiled in preparation for litigation, arbitration or an  
3 administrative proceeding that was reasonably likely to be initiated or that has been initiated by  
4 or against the public body; and

5 (E) The holder of the privilege under ORS 40.225 has made or authorized a public statement  
6 characterizing or partially disclosing the factual information compiled by or at the attorney's di-  
7 rection.

8 (10) Public records or information described in this section, furnished by the public body ori-  
9 ginally compiling, preparing or receiving them to any other public officer or public body in con-  
10 nection with performance of the duties of the recipient, if the considerations originally giving rise  
11 to the confidential or exempt nature of the public records or information remain applicable.

12 (11) Records of the Energy Facility Siting Council concerning the review or approval of security  
13 programs pursuant to ORS 469.530.

14 (12) Employee and retiree address, telephone number and other nonfinancial membership records  
15 and employee financial records maintained by the Public Employees Retirement System pursuant to  
16 ORS chapters 238 and 238A.

17 (13) Records of or submitted to the State Treasurer, the Oregon Investment Council or the  
18 agents of the treasurer or the council relating to active or proposed publicly traded investments  
19 under ORS chapter 293, including but not limited to records regarding the acquisition, exchange or  
20 liquidation of the investments. For the purposes of this subsection:

21 (a) The exemption does not apply to:

22 (A) Information in investment records solely related to the amount paid directly into an invest-  
23 ment by, or returned from the investment directly to, the treasurer or council; or

24 (B) The identity of the entity to which the amount was paid directly or from which the amount  
25 was received directly.

26 (b) An investment in a publicly traded investment is no longer active when acquisition, exchange  
27 or liquidation of the investment has been concluded.

28 (14)(a) Records of or submitted to the State Treasurer, the Oregon Investment Council, the  
29 Oregon Growth Account Board or the agents of the treasurer, council or board relating to actual  
30 or proposed investments under ORS chapter 293 or 348 in a privately placed investment fund or a  
31 private asset including but not limited to records regarding the solicitation, acquisition, deployment,  
32 exchange or liquidation of the investments including but not limited to:

33 (A) Due diligence materials that are proprietary to an investment fund, to an asset ownership  
34 or to their respective investment vehicles.

35 (B) Financial statements of an investment fund, an asset ownership or their respective invest-  
36 ment vehicles.

37 (C) Meeting materials of an investment fund, an asset ownership or their respective investment  
38 vehicles.

39 (D) Records containing information regarding the portfolio positions in which an investment  
40 fund, an asset ownership or their respective investment vehicles invest.

41 (E) Capital call and distribution notices of an investment fund, an asset ownership or their re-  
42 spective investment vehicles.

43 (F) Investment agreements and related documents.

44 (b) The exemption under this subsection does not apply to:

45 (A) The name, address and vintage year of each privately placed investment fund.

1 (B) The dollar amount of the commitment made to each privately placed investment fund since  
2 inception of the fund.

3 (C) The dollar amount of cash contributions made to each privately placed investment fund since  
4 inception of the fund.

5 (D) The dollar amount, on a fiscal year-end basis, of cash distributions received by the State  
6 Treasurer, the Oregon Investment Council, the Oregon Growth Account Board or the agents of the  
7 treasurer, council or board from each privately placed investment fund.

8 (E) The dollar amount, on a fiscal year-end basis, of the remaining value of assets in a privately  
9 placed investment fund attributable to an investment by the State Treasurer, the Oregon Investment  
10 Council, the Oregon Growth Account Board or the agents of the treasurer, council or board.

11 (F) The net internal rate of return of each privately placed investment fund since inception of  
12 the fund.

13 (G) The investment multiple of each privately placed investment fund since inception of the fund.

14 (H) The dollar amount of the total management fees and costs paid on an annual fiscal year-end  
15 basis to each privately placed investment fund.

16 (I) The dollar amount of cash profit received from each privately placed investment fund on a  
17 fiscal year-end basis.

18 (15) The monthly reports prepared and submitted under ORS 293.761 and 293.766 concerning the  
19 Public Employees Retirement Fund and the Industrial Accident Fund may be uniformly treated as  
20 exempt from disclosure for a period of up to 90 days after the end of the calendar quarter.

21 (16) Reports of unclaimed property filed by the holders of such property to the extent permitted  
22 by ORS 98.352.

23 (17)(a) The following records, communications and information submitted to the Oregon Business  
24 Development Commission, the Oregon Business Development Department, the State Department of  
25 Agriculture, the Oregon Growth Account Board, the Port of Portland or other ports as defined in  
26 ORS 777.005, or a county or city governing body and any board, department, commission, council  
27 or agency thereof, by applicants for investment funds, grants, loans, services or economic develop-  
28 ment moneys, support or assistance including, but not limited to, those described in ORS 285A.224:

29 (A) Personal financial statements.

30 (B) Financial statements of applicants.

31 (C) Customer lists.

32 (D) Information of an applicant pertaining to litigation to which the applicant is a party if the  
33 complaint has been filed, or if the complaint has not been filed, if the applicant shows that such  
34 litigation is reasonably likely to occur; this exemption does not apply to litigation which has been  
35 concluded, and nothing in this subparagraph shall limit any right or opportunity granted by discov-  
36 ery or deposition statutes to a party to litigation or potential litigation.

37 (E) Production, sales and cost data.

38 (F) Marketing strategy information that relates to applicant's plan to address specific markets  
39 and applicant's strategy regarding specific competitors.

40 (b) The following records, communications and information submitted to the State Department  
41 of Energy by applicants for tax credits or for grants awarded under ORS 469B.256:

42 (A) Personal financial statements.

43 (B) Financial statements of applicants.

44 (C) Customer lists.

45 (D) Information of an applicant pertaining to litigation to which the applicant is a party if the

1 complaint has been filed, or if the complaint has not been filed, if the applicant shows that such  
2 litigation is reasonably likely to occur; this exemption does not apply to litigation which has been  
3 concluded, and nothing in this subparagraph shall limit any right or opportunity granted by discov-  
4 ery or deposition statutes to a party to litigation or potential litigation.

5 (E) Production, sales and cost data.

6 (F) Marketing strategy information that relates to applicant's plan to address specific markets  
7 and applicant's strategy regarding specific competitors.

8 (18) Records, reports or returns submitted by private concerns or enterprises required by law  
9 to be submitted to or inspected by a governmental body to allow it to determine the amount of any  
10 transient lodging tax payable and the amounts of such tax payable or paid, to the extent that such  
11 information is in a form which would permit identification of the individual concern or enterprise.  
12 Nothing in this subsection shall limit the use which can be made of such information for regulatory  
13 purposes or its admissibility in any enforcement proceedings. The public body shall notify the tax-  
14 payer of the delinquency immediately by certified mail. However, in the event that the payment or  
15 delivery of transient lodging taxes otherwise due to a public body is delinquent by over 60 days, the  
16 public body shall disclose, upon the request of any person, the following information:

17 (a) The identity of the individual concern or enterprise that is delinquent over 60 days in the  
18 payment or delivery of the taxes.

19 (b) The period for which the taxes are delinquent.

20 (c) The actual, or estimated, amount of the delinquency.

21 (19) All information supplied by a person under ORS 151.485 for the purpose of requesting ap-  
22 pointed counsel, and all information supplied to the court from whatever source for the purpose of  
23 verifying the financial eligibility of a person pursuant to ORS 151.485.

24 (20) Workers' compensation claim records of the Department of Consumer and Business Services,  
25 except in accordance with rules adopted by the Director of the Department of Consumer and Busi-  
26 ness Services, in any of the following circumstances:

27 (a) When necessary for insurers, self-insured employers and third party claim administrators to  
28 process workers' compensation claims.

29 (b) When necessary for the director, other governmental agencies of this state or the United  
30 States to carry out their duties, functions or powers.

31 (c) When the disclosure is made in such a manner that the disclosed information cannot be used  
32 to identify any worker who is the subject of a claim.

33 (d) When a worker or the worker's representative requests review of the worker's claim record.

34 (21) Sensitive business records or financial or commercial information of the Oregon Health and  
35 Science University that is not customarily provided to business competitors.

36 (22) Records of Oregon Health and Science University regarding candidates for the position of  
37 president of the university.

38 (23) The records of a library, including:

39 (a) Circulation records, showing use of specific library material by a named person;

40 (b) The name of a library patron together with the address or telephone number of the patron;  
41 and

42 (c) The electronic mail address of a patron.

43 (24) The following records, communications and information obtained by the Housing and Com-  
44 munity Services Department in connection with the department's monitoring or administration of  
45 financial assistance or of housing or other developments:

- 1 (a) Personal and corporate financial statements and information, including tax returns.
- 2 (b) Credit reports.
- 3 (c) Project appraisals.
- 4 (d) Market studies and analyses.
- 5 (e) Articles of incorporation, partnership agreements and operating agreements.
- 6 (f) Commitment letters.
- 7 (g) Project pro forma statements.
- 8 (h) Project cost certifications and cost data.
- 9 (i) Audits.
- 10 (j) Project tenant correspondence.
- 11 (k) Personal information about a tenant.
- 12 (L) Housing assistance payments.
- 13 (25) Raster geographic information system (GIS) digital databases, provided by private forestland  
14 owners or their representatives, voluntarily and in confidence to the State Forestry Department,  
15 that is not otherwise required by law to be submitted.
- 16 (26) Sensitive business, commercial or financial information furnished to or developed by a  
17 public body engaged in the business of providing electricity or electricity services, if the information  
18 is directly related to a transaction described in ORS 261.348, or if the information is directly related  
19 to a bid, proposal or negotiations for the sale or purchase of electricity or electricity services, and  
20 disclosure of the information would cause a competitive disadvantage for the public body or its re-  
21 tail electricity customers. This subsection does not apply to cost-of-service studies used in the de-  
22 velopment or review of generally applicable rate schedules.
- 23 (27) Sensitive business, commercial or financial information furnished to or developed by the  
24 City of Klamath Falls, acting solely in connection with the ownership and operation of the Klamath  
25 Cogeneration Project, if the information is directly related to a transaction described in ORS 225.085  
26 and disclosure of the information would cause a competitive disadvantage for the Klamath  
27 Cogeneration Project. This subsection does not apply to cost-of-service studies used in the develop-  
28 ment or review of generally applicable rate schedules.
- 29 (28) Personally identifiable information about customers of a municipal electric utility or a  
30 people's utility district or the names, dates of birth, driver license numbers, telephone numbers,  
31 electronic mail addresses or Social Security numbers of customers who receive water, sewer or  
32 storm drain services from a public body as defined in ORS 174.109. The utility or district may re-  
33 lease personally identifiable information about a customer, and a public body providing water, sewer  
34 or storm drain services may release the name, date of birth, driver license number, telephone num-  
35 ber, electronic mail address or Social Security number of a customer, if the customer consents in  
36 writing or electronically, if the disclosure is necessary for the utility, district or other public body  
37 to render services to the customer, if the disclosure is required pursuant to a court order or if the  
38 disclosure is otherwise required by federal or state law. The utility, district or other public body  
39 may charge as appropriate for the costs of providing such information. The utility, district or other  
40 public body may make customer records available to third party credit agencies on a regular basis  
41 in connection with the establishment and management of customer accounts or in the event such  
42 accounts are delinquent.
- 43 (29) A record of the street and number of an employee's address submitted to a special district  
44 to obtain assistance in promoting an alternative to single occupant motor vehicle transportation.
- 45 (30) Sensitive business records, capital development plans or financial or commercial information

1 of Oregon Corrections Enterprises that is not customarily provided to business competitors.

2 (31) Documents, materials or other information submitted to the Director of the Department of  
3 Consumer and Business Services in confidence by a state, federal, foreign or international regulatory  
4 or law enforcement agency or by the National Association of Insurance Commissioners, its affiliates  
5 or subsidiaries under ORS 86A.095 to 86A.198, 697.005 to 697.095, 697.602 to 697.842, 705.137, 717.200  
6 to 717.320, 717.900 or 717.905, ORS chapter 59, 723, 725 or 726, the Bank Act or the Insurance Code  
7 when:

8 (a) The document, material or other information is received upon notice or with an under-  
9 standing that it is confidential or privileged under the laws of the jurisdiction that is the source of  
10 the document, material or other information; and

11 (b) The director has obligated the Department of Consumer and Business Services not to dis-  
12 close the document, material or other information.

13 (32) A county elections security plan developed and filed under ORS 254.074.

14 (33) Information about review or approval of programs relating to the security of:

15 (a) Generation, storage or conveyance of:

16 (A) Electricity;

17 (B) Gas in liquefied or gaseous form;

18 (C) Hazardous substances as defined in ORS 453.005 (7)(a), (b) and (d);

19 (D) Petroleum products;

20 (E) Sewage; or

21 (F) Water.

22 (b) Telecommunication systems, including cellular, wireless or radio systems.

23 (c) Data transmissions by whatever means provided.

24 (34) The information specified in ORS 25.020 (8) if the Chief Justice of the Supreme Court des-  
25 ignates the information as confidential by rule under ORS 1.002.

26 (35)(a) Employer account records of the State Accident Insurance Fund Corporation.

27 (b) As used in this subsection, "employer account records" means all records maintained in any  
28 form that are specifically related to the account of any employer insured, previously insured or un-  
29 der consideration to be insured by the State Accident Insurance Fund Corporation and any infor-  
30 mation obtained or developed by the corporation in connection with providing, offering to provide  
31 or declining to provide insurance to a specific employer. "Employer account records" includes, but  
32 is not limited to, an employer's payroll records, premium payment history, payroll classifications,  
33 employee names and identification information, experience modification factors, loss experience and  
34 dividend payment history.

35 (c) The exemption provided by this subsection may not serve as the basis for opposition to the  
36 discovery documents in litigation pursuant to applicable rules of civil procedure.

37 (36)(a) Claimant files of the State Accident Insurance Fund Corporation.

38 (b) As used in this subsection, "claimant files" includes, but is not limited to, all records held  
39 by the corporation pertaining to a person who has made a claim, as defined in ORS 656.005, and all  
40 records pertaining to such a claim.

41 (c) The exemption provided by this subsection may not serve as the basis for opposition to the  
42 discovery documents in litigation pursuant to applicable rules of civil procedure.

43 (37) Except as authorized by ORS 408.425, records that certify or verify an individual's discharge  
44 or other separation from military service.

45 (38) Records of or submitted to a domestic violence service or resource center that relate to the

1 name or personal information of an individual who visits a center for service, including the date of  
2 service, the type of service received, referrals or contact information or personal information of a  
3 family member of the individual. As used in this subsection, “domestic violence service or resource  
4 center” means an entity, the primary purpose of which is to assist persons affected by domestic or  
5 sexual violence by providing referrals, resource information or other assistance specifically of ben-  
6 efit to domestic or sexual violence victims.

7 **(39) Information reported to the Oregon Health Authority under ORS 431.964, information**  
8 **disclosed by the authority under ORS 431.966 and any information related to disclosures**  
9 **made by the authority under ORS 431.966, including information identifying the recipient of**  
10 **the information.**

11 **SECTION 7. (1) The amendments to ORS 431.964 by section 3 of this 2013 Act apply to**  
12 **prescription drugs dispensed on or after the effective date of this 2013 Act.**

13 **(2) The amendments to ORS 192.502 and 431.966 by sections 4 and 6 of this 2013 Act apply**  
14 **to information related to prescription drugs dispensed before, on or after the effective date**  
15 **of this 2013 Act.**

16

# Senate Bill 548

Sponsored by Senator ROBLAN (at the request of Oregon Health and Science University)

## 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**.

Modifies circumstances in which person issued dental instructor's or dental hygiene instructor's license may practice dentistry.

Declares emergency, effective on passage.

## A BILL FOR AN ACT

1  
2 Relating to dental instructors; amending ORS 679.115 and 680.082; and declaring an emergency.

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 [*the*] 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 [*the*] Oregon Health  
19 and 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 license issued to an applicant qualifying for a dental instructor's license is restricted to 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 *practice of dentistry in a facility devoted to dental care on the campus of the Oregon Health and Sci-*  
 2 *ence University.] A person issued a dental instructor's license is restricted to the practice of*  
 3 **dentistry for or on behalf of Oregon Health and Science University.**

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

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

9 **SECTION 2.** ORS 680.082 is amended to read:

10 680.082. (1) Notwithstanding any other provision of ORS 680.010 to 680.205, the Oregon Board  
 11 of Dentistry shall issue a dental hygiene instructor's license to any person who:

12 (a) Is or will be a full-time instructor of dental hygiene engaged in the practice of dental hy-  
 13 giene, including but not limited to participation in a faculty practice plan within the scope of the  
 14 applicant's employment at *[the]* Oregon Health and Science University;

15 (b) Is a graduate of a dental hygiene program accredited by the Commission on Dental Accred-  
 16 itation of the American Dental Association or its successor agency, if any; and

17 (c) Is licensed to practice dental hygiene in another state or a Canadian province.

18 (2) The board shall by rule establish standards, procedures and fees for the issuance, suspension,  
 19 revocation and renewal of a dental hygiene instructor's license.

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

22 (a) Who has been convicted of an offense or disciplined by a dental licensing body in a manner  
 23 that bears, in the judgment of the board, a demonstrable relationship to the ability of the applicant  
 24 or licensee to practice dental hygiene in accordance with the provisions of ORS 680.010 to 680.205;

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

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

27 (4) *[An applicant who receives]* **A person issued** a dental hygiene instructor's license is re-  
 28 stricted to the practice of dental hygiene *[in a facility devoted to dental care on the campus of the*  
 29 *Oregon Health and Science University]* **for or on behalf of Oregon Health and Science**  
 30 **University.**

31 (5) An applicant who receives a dental hygiene instructor's license is subject to the professional  
 32 ethics, standards and discipline of ORS 680.010 to 680.205.

33 **SECTION 3. This 2013 Act being necessary for the immediate preservation of the public**  
 34 **peace, health and safety, an emergency is declared to exist, and this 2013 Act takes effect**  
 35 **on its passage.**

# Senate Bill 802

Sponsored by Senator MONNES ANDERSON; Senators MONROE, WINTERS, Representatives DEMBROW, GORSEK, HUFFMAN, JOHNSON, WHISNANT (at the request of Oregon Community College Association)

## 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**.

Provides that institution or program accredited by Commission on Dental Accreditation of American Dental Association does not need to name actively licensed dentist as dental director of dental offices or clinics owned or operated by institution or program.

## A BILL FOR AN ACT

1  
2 Relating to naming an actively licensed dentist as a dental director; amending ORS 679.020.

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

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

5 679.020. (1) A person may not practice dentistry without a license.

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

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

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

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

17 (c) Public universities listed in ORS 352.002.

18 (d) Local governments.

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

21 (f) Nonprofit corporations organized under Oregon law to provide dental services to rural areas  
22 and medically underserved populations of migrant, rural community or homeless individuals under  
23 42 U.S.C. 254b or 254c or health centers qualified under 42 U.S.C. 1396d(1)(2)(B) operating in com-  
24 pliance with other applicable state and federal law.

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

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

**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) **Except as provided in subsection (5) of this section**, name an actively licensed dentist  
2 as its dental director, who shall be subject to the provisions of ORS 679.140 in the capacity as dental  
3 director. The dental director, or an actively licensed dentist designated by the director, shall have  
4 responsibility for the clinical practice of dentistry, which includes, but is not limited to:

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

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

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

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

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

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

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

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

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

19 **(5) Subsection (4)(a) of this section does not apply to an institution or program described**  
20 **in subsection (3)(e) of this section.**

21 [(5)] (6) Subsections (1) and (2) of this section do not apply to an expanded practice dental  
22 hygienist who renders services authorized by a permit issued by the board pursuant to ORS 680.200.

23 [(6)] (7) Nothing in this chapter precludes a person or entity not licensed by the board from:

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

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

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

30 [(7)] (8) If all of the ownership interests of a dentist or dentists in a dental office or clinic are  
31 held by an administrator, executor, personal representative, guardian, conservator or receiver of the  
32 estate of a former shareholder, member or partner, the administrator, executor, personal represen-  
33 tative, guardian, conservator or receiver may retain the ownership interest for a period of 12 months  
34 following the creation of the ownership interest. The board shall extend the ownership period for  
35 an additional 12 months upon 30 days' notice and may grant additional extensions upon reasonable  
36 request.

37

\_\_\_\_\_

# 2013 Calendar

## January

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## March

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## April

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## May

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## June

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## July

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## August

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## September

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## October

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## November

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## December

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29	30	31				

### HOLIDAYS

- Jan 1 New Year's Day
- Jan 21 Martin Luther King Day
- Feb 18 Presidents' Day
- Mar 31 Easter Sunday
- May 27 Memorial Day
- Jul 4 Independence Day
- Sep 2 Labor Day
- Sep 5 Rosh Hashana
- Sep 14 Yom Kippur
- Oct 14 Columbus Day
- Nov 11 Veterans Day
- Nov 28 Thanksgiving Day
- Nov 29 OBD Staff Holiday
- Nov 28-Dec 5 Chanukah
- Dec 25 Christmas Day

### OTHER SIGNIFICANT EVENTS

- Feb 1 Give Kids a Smile Day
- Sep 6-7 ODA House of Delegates

### IMPORTANT OBD DATES

- Evaluator's Meeting
- Board Meeting
- Jan 10-12 NERB Annual Conference
- Apr 4-6 ODC Conference
- Apr 21-22 AADB Conference
- Oct 28-31 AADA & AADB Conference

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**From:** [Patrick Braatz](#)  
**To:** [Lisa Warwick](#)  
**Subject:** FW: Health Professional Licensing Boards Audit  
**Date:** Tuesday, April 09, 2013 12:13:28 PM

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ED Report

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**Patrick D. Braatz, Executive Director**  
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*“Our Constitution works; our great Republic is a government of laws and not of men. Here the people rule.” President Gerald R. Ford*

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

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**From:** TAYLOR, Kathleen [mailto:kathleen.taylor@state.or.us]  
**Sent:** Wednesday, April 03, 2013 12:15 PM  
**To:** WALSH Anne; EKLUND Becky; MCTEAGUE Dave \* BCE; CONLOW Ed; HOLGATE Felicia M; SCHNABEL Gary A; MERCER Holly \* OHLA ASD; HEIDER James; MACLEAN Karen S; COFFEY Kate; Kathleen Haley; MAKINEN Lori; PITTIONI Martin; GAINES Michelle; nancy.sellers@oregonobo.org; Patrick Braatz; LEYBOLD Sandy; KOLMER Sean P \* GOV  
**Cc:** FLEMING, Shelby; BLASI, Sheronne  
**Subject:** Health Professional Licensing Boards Audit

Dear Executive Directors of Oregon's Health Professional Licensing Boards,

The Oregon Secretary of State Audits Division has recently started a performance audit of Oregon's Health Professional Licensing Boards. Performance Audits are an independent and systematic assessment of a program's performance against objective criteria. We are in the preliminary survey phase and the scope of the audit has not been determined at this point. In addition, depending on the results of our initial survey phase, we may select a subset of Health Professional Licensing Boards to audit.

As part of our initial survey phase, we are trying to gain a better understanding of your licensing and complaint statistics. If possible, will you please send us your general licensing statistics (e.g. number of applicants, number of licenses issued, number denied, renewal information, etc.) and complaint information/reports (e.g. number of complaints, type of complaints, board and/or disciplinary actions, etc.) for the past five calendar years?

Please feel free to let us know if you have any questions or if you do not have this information available.

Lastly, if possible, please send us this information by Wednesday, April 10.

Thank you and we look forward to hearing from you.

Sincerely,  
Kathleen Taylor

Principal Auditor  
Oregon Secretary of State  
Audits Division  
503-986-2261

**Applications/Issued –**

**Dental**

	<b>Applications Received</b>	<b>Applications Incomplete</b>	<b>Licenses Issued</b>	<b>Licenses Denied</b>
<b>2008</b>	151	14	137	0
<b>2009</b>	124	11	114	0
<b>2010</b>	149	8	141	0
<b>2011</b>	142	12	129	1
<b>2012</b>	149	12	137	0

**Dental Hygiene**

	<b>Applications Received</b>	<b>Applications Incomplete</b>	<b>Licenses Issued</b>	<b>Licenses Denied</b>
<b>2008</b>	202	10	191	1
<b>2009</b>	188	11	177	0
<b>2010</b>	204	10	194	0
<b>2011</b>	236	7	229	0
<b>2012</b>	238	11	227	0

**Renewed**

**Dental**

<b>2008</b>	1592
<b>2009</b>	1649
<b>2010</b>	1754
<b>2011</b>	1666
<b>2012</b>	1792

**Dental Hygiene**

<b>2008</b>	1704
<b>2009</b>	1694
<b>2010</b>	1728
<b>2011</b>	1751
<b>2012</b>	1814

**Total Licensed**

**Dental**

<b>2008</b>	3169
<b>2009</b>	3306
<b>2010</b>	3421
<b>2011</b>	3562
<b>2012</b>	3702

**Dental Hygiene**

<b>2008</b>	3197
<b>2009</b>	3374
<b>2010</b>	3568
<b>2011</b>	3797
<b>2012</b>	4024

**Currently Licensed: 7673**

<b>Dental</b>	3613
<b>Hygiene</b>	4060

### 2008 - Investigation - Action Report

Case Type	#
Advertising	13
Unprofessional Conduct	24
Diversion	19
Discipline Another State	5
Improper Prescribing	1
No Apparent Jurisdiction	36
Narcotics/Alcohol Abuse	2
Sex	1
Unacceptable Patient Care	194
Work without License	24
<b>Grand Total</b>	<b>319*</b>

### 2009 - Investigation - Action Report

Case Type	#
Advertising	1
Applicant	1
Failure to comply with CE Requirements	4
Unprofessional Conduct	31
Diversion	8
Discipline Another State	0
Improper Prescribing	2
Misc.	1
No Apparent Jurisdiction	23
Narcotics/Alcohol Abuse	2
Sex	2
Unacceptable Patient Care	175
Work without License	32
<b>Grand Total</b>	<b>282*</b>

### 2010 - Investigation - Action Report

Case Type	#
Advertising	31
Applicant	1
Failure to comply with CE Requirements	4
Unprofessional Conduct	20
Diversion	14
Discipline Another State	3
Improper Prescribing	1
Misc.	1
No Apparent Jurisdiction	28
Narcotics/Alcohol Abuse	1
Sex	3
Unacceptable Patient Care	162
Work without License	13
<b>Grand Total</b>	<b>282*</b>

### 2008 - Disposition

Disposition	#
Cases Open	309
Cases Closed	327
Discipline	46
Letter of Concerned	104
No Violation	113
No Further Action	64

### 2009 - Disposition

Disposition	#
Cases Open	269
Cases Closed	213
Discipline	33
Letter of Concerned	75
No Violation	66
No Further Action	39

### 2010- Disposition

Disposition	#
Cases Open	268
Cases Closed	237
Discipline	37
Letter of Concerned	63
No Violation	78
No Further Action	59

### 2011 - Investigation - Action Report

Case Type	#
Advertising	1
Applicant	1
Failure to comply with CE Requirements	1
Unprofessional Conduct	24
Diversion	11
Discipline Another State	2
Improper Prescribing	1
Misc.	0
No Apparent Jurisdiction	24
Narcotics/Alcohol Abuse	2
Sex	1
Unacceptable Patient Care	165
Work without License	13
<b>Grand Total</b>	<b>246*</b>

### 2012 - Investigation - Action Report

Case Type	#
Advertising	6
Applicant	1
Failure to comply with CE Requirements	1
Unprofessional Conduct	23
Diversion	14
Discipline Another State	3
Improper Prescribing	0
Misc.	0
No Apparent Jurisdiction	30
Narcotics/Alcohol Abuse	0
Sex	1
Unacceptable Patient Care	164
Work without License	7
<b>Grand Total</b>	<b>250*</b>

### 2011 - Disposition

Disposition	#
Cases Open	239
Cases Closed	217
Discipline	36
Letter of Concerned	56
No Violation	67
No Further Action	58

### 2012 - Disposition

Disposition	#
Cases Open	240
Cases Closed	218
Discipline	61
Letter of Concerned	37
No Violation	72
No Further Action	48

\*May have multiple allegations

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UNFINISHED  
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RULES

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1 **DIVISION 1**

2 **PROCEDURES**

3 **818-001-0002**

4 **Definitions**

5 As used in OAR Chapter 818:

6 (1) "Board" means the Oregon Board of Dentistry, the members of the Board, its employees, its  
7 agents, and its consultants.

8 (2) "Dental Practice Act" means ORS Chapter 679 and ORS 680.010 to 680.170 and the rules  
9 adopted pursuant thereto.

10 (3) "Dentist" means a person licensed pursuant to ORS Chapter 679 to practice dentistry.

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

14 (5) "General Supervision" means supervision requiring that a dentist authorize the procedures,  
15 but not requiring that a dentist be present when the authorized procedures are performed. The  
16 authorized procedures may also be performed at a place other than the usual place of practice of  
17 the dentist.

18 (6) "Hygienist" means a person licensed pursuant to ORS 680.010 to 680.170 to practice dental  
19 hygiene.

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

22 (8) "Informed Consent" means the consent obtained following a thorough and easily understood  
23 explanation to the patient, or patient's guardian, of the proposed procedures, any available

24 alternative procedures and any risks associated with the procedures. Following the explanation,  
25 the licensee shall ask the patient, or the patient's guardian, if there are any questions. The  
26 licensee shall provide thorough and easily understood answers to all questions asked.

27 (9) "Licensee" means a dentist or hygienist.

28 (a) "Volunteer Licensee" is a dentist or dental hygienist licensed according to rule to provide  
29 dental health care without receiving or expecting to receive compensation.

30 (10) "Limited Access Patient" means a patient who, due to age, infirmity, or handicap is unable  
31 to receive regular dental hygiene treatment in a dental office.

32 (11) "Specialty." Specialty areas of dentistry are as defined by the American Dental Association,  
33 Council on Dental Education. The specialty definitions are added to more clearly define the  
34 scope of the practice as it pertains to the specialty areas of dentistry.

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

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

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

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

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

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

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

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

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

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

83

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

87

88 Stat. Auth.: ORS 679 & 680

89 Stats. Implemented: ORS 679.010 & 680.010

90 **818-001-0087**

91 **Fees**

92 (1) The Board adopts the following fees:

93 (a) Biennial License Fees:

94 (A) Dental -- \$315;

95 (B) Dental -- retired -- \$0;

96 (C) Dental Faculty -- \$260;

97 (D) Volunteer Dentist -- \$0;

98 (E) Dental Hygiene -- \$155;

99 (F) Dental Hygiene -- retired -- \$0;

100 (G) Volunteer Dental Hygienist -- \$0.

101 (b) Biennial Permits, Endorsements or Certificates:

102 (A) Nitrous Oxide Permit -- \$40;

103 (B) Minimal Sedation Permit -- \$75;

104 (C) Moderate Sedation Permit -- \$75;

105 (D) Deep Sedation Permit -- \$75;

106 (E) General Anesthesia Permit -- \$140;

107 (F) Radiology -- \$75;

108 (G) Expanded Function Dental Assistant -- \$50;

109 (H) Expanded Function Orthodontic Assistant -- \$50;

110 (I) Instructor Permits -- \$40;

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

112 (K) Restorative Functions Dental Assistant -- \$50;

113 (L) Anesthesia Dental Assistant -- \$50;

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

- 115 (c) Applications for Licensure:
- 116 (A) Dental -- General and Specialty -- \$345;
- 117 (B) Dental Faculty -- \$305;
- 118 (C) Dental Hygiene -- \$180;
- 119 (D) Licensure Without Further Examination -- Dental and Dental Hygiene -- \$790.
- 120 (d) Examinations:
- 121 (A) Jurisprudence -- \$0;
- 122 (B) Dental Specialty:
- 123 ~~[(i) \$750 at the time of application; and~~
- 124 ~~(ii) If only one candidate applies for the exam, an additional \$1,250 due ten days prior to~~
- 125 ~~the scheduled exam date;~~
- 126 ~~(iii) If two candidates apply for the exam, an additional \$250 (per candidate) due ten days~~
- 127 ~~prior to the scheduled exam date;~~
- 128 ~~(iv) If three or more candidates apply for the exam, no additional fee will be required.]~~
- 129 (i) If only one candidate applies for the exam, a fee of \$2,000.00 will be required at the time
- 130 of application; and
- 131 (ii) If two candidates apply for the exam, a fee of \$1,000.00 will be required at the time of
- 132 application; and
- 133 (iii) If three or more candidates apply for the exam, a fee of \$750.00 will be required at the
- 134 time of application.
- 135 (e) Duplicate Wall Certificates -- \$50.
- 136 (2) Fees must be paid at the time of application and are not refundable.

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

140

141 Stat. Auth.: ORS 679 & 680

142 Stats. Implemented: ORS 293.445, 679.060, 679.115, 679.120, 679.250, 680.050, 680.075,

143 680.200 & 680.205

1 DIVISION 12

2 STANDARDS OF PRACTICE

3 818-012-0005

4 Scope of Practice

5 ~~[(1) The Board determines that the practice of dentistry includes the following procedures~~  
6 ~~which the Board finds are included in the curricula of dental schools accredited by the~~  
7 ~~American Dental Association, Commission on Dental Accreditation, post-graduate training~~  
8 ~~programs or continuing education courses:~~

9 ~~(a) Rhinoplasty;~~

10 ~~(b) Blepharoplasty;~~

11 ~~(c) Rhydtidectomy;~~

12 ~~(e) Submental liposuction;~~

13 ~~(f) Laser resurfacing;~~

14 ~~(g) Browlift, either open or endoscopic technique;~~

15 ~~(h) Platysmal muscle plication;~~

16 ~~(i) Dermabrasion;~~

17 ~~(j) Otoplasty;~~

18 ~~(k) Lip augmentation;~~

19 ~~(l) Hair transplantation, not as an isolated procedure for male pattern baldness; and~~

20 ~~(m) Harvesting bone extra-orally for dental procedures, including oral and maxillofacial~~  
21 ~~procedures.]~~

22  
23 ([2]1) No [licensee] dentist may perform any of the procedures listed below

- 24 (a) Rhinoplasty;
- 25 (b) Blepharoplasty;
- 26 (c) Rhytidectomy;
- 27 **(d) Submental liposuction;**
- 28 **(e) Laser resurfacing;**
- 29 **(f) Browlift, either open or endoscopic technique;**
- 30 **(g) Platysmal muscle plication;**
- 31 **(h) Dermabrasion;**
- 32 **(i) Otoplasty;**
- 33 **(j) Lip augmentation;**
- 34 **(k) Hair transplantation, not as an isolated procedure for male pattern baldness; and**
- 35 **(l) Harvesting bone extra orally for dental procedures, including oral and maxillofacial**
- 36 **procedures.**
- 37
- 38 **unless the dentist:**
- 39
- 40 **(a)A** Has successfully completed a residency in Oral and Maxillofacial Surgery accredited by
- 41 the American Dental Association, Commission on Dental Accreditation (CODA); and
- 42 **(b)B** Has successfully completed a clinical fellowship, of at least one continuous year in
- 43 duration, in esthetic (cosmetic) surgery recognized by the American Association of Oral and
- 44 Maxillofacial Surgeons or by the American Dental Association Commission on Dental
- 45 Accreditation; or
- 46 **(c)C** Holds privileges either:

47 (~~A~~1) Issued by a credentialing committee of a hospital accredited by the Joint Commission on  
48 Accreditation of Healthcare Organizations (JCAHO) to perform these procedures in a hospital  
49 setting; or

50 (~~B~~2) Issued by a credentialing committee for an ambulatory surgical center licensed by the  
51 State of Oregon and accredited by either the JCAHO or the American Association for  
52 Ambulatory Health Care (AAAHC).

53

54 (2) A dentist may utilize Botulinum Toxin Type A to treat a condition that can be treated  
55 within the scope of the practice of dentistry after completing a minimum of 16 hours in  
56 courses approved by American Dental Association Continuing Education Recognition  
57 Program (ADA CERP) or the Academy of General Dentistry (AGD).

58

59 Stat. Auth.: ORS 679 & 680

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

1 **DIVISION 26**

2 **ANESTHESIA**

3 **818-026-0000**

4 **Purpose**

5 (1) These rules apply to the administration of substances that produce general anesthesia, deep  
6 sedation, moderate sedation, minimal sedation or nitrous oxide sedation in patients being treated  
7 by licensees [~~in facilities not accredited by the Joint Commission on Accreditation of Health~~  
8 ~~Care Organizations (JCAHO/TJC), the Accreditation Association for Ambulatory Health~~  
9 ~~Care (AAAHC), the American Association for Accreditation of Ambulatory Surgical~~  
10 ~~Facilities (AAAASF), the American Osteopathic Association (AOA) or their successor~~  
11 ~~organizations~~]. These regulations are not intended to prohibit training programs for licensees or  
12 to prevent persons from taking necessary action in case of an emergency.

13 (2) Nothing in this Division relieves a licensee from the standards imposed by ORS  
14 679.140(1)(e) and 679.140(4).

15  
16 Stat. Auth.: ORS 679 & 680

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

18  
19 **818-026-0020**

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

21 (1) In any hearing where a question exists as to the degree of central nervous system depression a  
22 licensee has induced (i.e., general anesthesia, deep sedation, moderate sedation, minimal  
23 sedation or nitrous oxide sedation), the Board may base its findings on, among other things, the

24 types, dosages and routes of administration of drugs administered to the patient and what result  
25 can reasonably be expected from those drugs in those dosages and routes administered in a  
26 patient of that physical and psychological status.

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

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

31 (b) Alkylphenols -- propofol (Diprivan) including precursors or derivatives;

32 (c) Neuroleptic agents;

33 (d) Dissociative agents -- ketamine;

34 (e) Etomidate;

35 (f) Rapidly acting steroid preparations; and

36 (g) Volatile inhalational agents.

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

39

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

43

44 Stat. Auth.: ORS 679 & 680

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

46

47 **818-026-0060**

48 **Moderate Sedation Permit**

49 Moderate sedation, minimal sedation, and nitrous oxide sedation.

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

51 (a) Is a licensed dentist in Oregon;

52 (b) Either holds a current Advanced Cardiac Life Support (ACLS) or Pediatric Advanced Life  
53 Support (PALS) certificate, whichever is appropriate for the patient being sedated, or  
54 successfully completes the American Dental Association's course "*Recognition and*  
55 *Management of Complications during Minimal and Moderate Sedation*" at least every two years;  
56 and

57 (c) Satisfies one of the following criteria:

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

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

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

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

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

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

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

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

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

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

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

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

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

90 (h) Sphygmomanometer, precordial/pretracheal stethoscope ~~[or]~~, capnograph, pulse oximeter,  
91 oral and nasopharyngeal airways, laryngeal mask airways, intravenous fluid administration  
92 equipment, automated external defibrillator (AED); and

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

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

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

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

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

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

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

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

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

113 (a) Patients must have continuous monitoring using pulse oximetry and End-tidal CO<sub>2</sub>  
114 monitors. The patient's blood pressure, heart rate, and respiration shall be recorded at regular  
115 intervals but at least every 15 minutes, and these recordings shall be documented in the patient

116 record. The record must also include documentation of preoperative and postoperative vital  
117 signs, all medications administered with dosages, time intervals and route of administration. If  
118 this information cannot be obtained, the reasons shall be documented in the patient's record. A  
119 patient under moderate sedation shall be continuously monitored;

120 (b) During the recovery phase, the patient must be monitored by an individual trained to monitor  
121 patients recovering from moderate sedation.

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

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

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

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

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

130 (d) The patient can sit up unaided;

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

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

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

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

138 (12) Permit renewal. In order to renew a Moderate Sedation Permit, the permit holder must

139 provide documentation of having current ACLS or PALS certification or current certification of  
140 successful completion of the American Dental Association’s course “*Recognition and*  
141 *Management of Complications during Minimal and Moderate Sedation*” and must complete 14  
142 hours of continuing education in one or more of the following areas every two years: sedation,  
143 physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or  
144 pharmacology of drugs and agents used in sedation. Training taken to maintain current ACLS or  
145 PALS certification or successful completion of the American Dental Association’s course  
146 “*Recognition and Management of Complications during Minimal and Moderate Sedation*” may  
147 be counted toward this requirement. Continuing education hours may be counted toward  
148 fulfilling the continuing education requirement set forth in OAR 818-021-0060.

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

150

151 Stat. Auth.: ORS 679

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

153

154 **818-026-0065**

155 **Deep Sedation**

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

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

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

160 (b) Holds a current Advanced Cardiac Life Support (ACLS) or Pediatric Advanced Life Support  
161 (PALS) certificate, whichever is appropriate for the patient being sedated.

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

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

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

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

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

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

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

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

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

185 and

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

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

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

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

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

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

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

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

203 (7) The patient shall be monitored as follows: (a) Patients must have continuous monitoring  
204 using pulse oximetry, electrocardiograph monitors (ECG) and End-tidal CO2 monitors. The  
205 patient's heart rhythm shall be continuously monitored and the patient's blood pressure, heart  
206 rate, and respiration shall be recorded at regular intervals but at least every 5 minutes, and these  
207 recordings shall be documented in the patient record. The record must also include

208 documentation of preoperative and postoperative vital signs, all medications administered with  
209 dosages, time intervals and route of administration. If this information cannot be obtained, the  
210 reasons shall be documented in the patient's record. A patient under deep sedation shall be  
211 continuously monitored;

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

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

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

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

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

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

222 (d) The patient can sit up unaided;

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

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

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

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

230 (12) Permit renewal. In order to renew a Deep Sedation Permit, the permit holder must provide

231 documentation of having current ACLS or PALS certification and must complete 14 hours of  
232 continuing education in one or more of the following areas every two years: sedation, physical  
233 evaluation, medical emergencies, monitoring and the use of monitoring equipment, or  
234 pharmacology of drugs and agents used in sedation. Training taken to maintain current ACLS or  
235 PALS certification may be counted toward this requirement. Continuing education hours may be  
236 counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060.

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

238

239 Stat. Auth.: ORS 679

240 Stats.Implemented:ORS679.250(7)&679.250(10)

241

242 **818-026-0070**

243 **General Anesthesia Permit**

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

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

247 (a) Is a licensed dentist in Oregon;

248 (b) Holds a current Advanced Cardiac Life Support (ACLS) Certificate or Pediatric Advanced  
249 Life Support (PALS) Certificate, whichever is appropriate for the patient being sedated; and

250 (c) Satisfies one of the following criteria:

251 (A) Completion of an advanced training program in anesthesia and related subjects beyond the  
252 undergraduate dental curriculum that satisfies the requirements described in the *ADA Guidelines*  
253 *for Teaching Pain Control and Sedation to Dentists and Dental Students (2007)* consisting of a

254 minimum of 2 years of a postgraduate anesthesia residency at the time training was commenced.

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

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

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

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

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

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

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

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

276 (f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate

277 continuous oxygen delivery and a scavenger system;

278 (g) A recovery area that has available oxygen, adequate lighting, suction and electrical outlets.

279 The recovery area can be the operating room;

280 (h) Sphygmomanometer, precordial/pretracheal stethoscope ~~[or]~~ ,capnograph, pulse oximeter,

281 electrocardiograph monitor (ECG), automated external defibrillator (AED), oral and

282 nasopharyngeal airways, laryngeal mask airways, intravenous fluid administration equipment;

283 and

284 (i) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the

285 drugs used, vasopressors, corticosteroids, bronchodilators, intravenous medications for treatment

286 of cardiac arrest, narcotic antagonist, antihistaminic, antiarrhythmics, antihypertensives and

287 anticonvulsants.

288 (3) No permit holder shall have more than one person under general anesthesia, deep sedation,

289 moderate sedation, minimal sedation or nitrous oxide sedation at the same time.

290 (4) During the administration of deep sedation or general anesthesia, and at all times while the

291 patient is under deep sedation or general anesthesia, an anesthesia monitor and one other person

292 holding a Health Care Provider BLS/CPR level certificate, or its equivalent, shall be present in

293 the operatory in addition to the dentist performing the dental procedures.

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

295 general anesthesia shall:

296 (a) Evaluate the patient and document, using the American Society of Anesthesiologists Patient

297 Physical Status Classifications, that the patient is an appropriate candidate for general anesthesia

298 or deep sedation;

299 (b) Give written preoperative and postoperative instructions to the patient or, when appropriate

300 due to age or psychological status of the patient, the patient's guardian; and

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

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

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

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

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

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

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

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

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

323 preoperative psychological status;

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

325 (d) The patient can sit up unaided;

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

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

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

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

330 discharged.

331 (11) After adequate training, an assistant, when directed by a dentist, may introduce additional

332 anesthetic agents to an infusion line under the direct visual supervision of a dentist.

333 (12) Permit renewal. In order to renew a General Anesthesia Permit, the permit holder must

334 provide documentation of having current ACLS or PALS certification and complete 14 hours of

335 continuing education in one or more of the following areas every two years: deep sedation and/or

336 general anesthesia, physical evaluation, medical emergencies, monitoring and the use of

337 monitoring equipment, pharmacology of drugs and agents used in anesthesia. Training taken to

338 maintain current ACLS or PALS certification may be counted toward this requirement.

339 Continuing education hours may be counted toward fulfilling the continuing education

340 requirement set forth in OAR 818-021-0060.

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

342

343 Stat. Auth.: ORS 679

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

1 **DIVISION 35**

2 **DENTAL HYGIENE**

3 **818-035-0020**

4 **Authorization to Practice**

5 (1) A dental hygienist may practice dental hygiene in the places specified by ORS 680.150 under  
6 general supervision upon authorization of a supervising dentist.

7 (2) A dentist who authorizes a dental hygienist to practice dental hygiene on a limited access  
8 patient must review the hygienist's findings.

9 (3) A supervising dentist, without first examining a new patient, may authorize a dental  
10 hygienist:

11 (a) To take a health history from a patient;

12 (b) To take dental radiographs;

13 (c) To perform periodontal probings and record findings;

14 (d) To gather data regarding the patient; and

15 ~~[(e) To perform a prophylaxis.]~~

16 ~~(f)e~~ To diagnose, ~~[and]~~ treatment plan and provide ~~[for]~~ dental hygiene services.

17 (4) When hygiene services are provided pursuant to subsection (3), the supervising dentist need  
18 not be on the premises when the services are provided.

19 (5) When hygiene services are provided pursuant to subsection (3), the patient must be scheduled  
20 to be examined by the supervising dentist within fifteen business days following the day the  
21 hygiene services are provided.

22 ~~[(6) A supervising dentist may not authorize a dental hygienist and a dental hygienist may~~  
23 ~~not perform periodontal procedures unless the supervising dentist has examined the~~

24 ~~patient and diagnosed the condition to be treated.]~~

25

26 ([7]6) If a new patient has not been examined by the supervising dentist subsequent to receiving  
27 dental hygiene services pursuant to subsection (3), no further dental hygiene services may be  
28 provided until an examination is done by the supervising dentist.

29

30 Stat. Auth.: ORS 679 & 680

31 Stats. Implemented: ORS 680.150

32

33 **818-035-0066**

34 **Additional Populations for Expanded Practice Dental Hygiene Permit Holders**

35 A dental hygienist with an Expanded Practice Permit may practice without supervision at  
36 locations and on persons as described in ORS 680.205 (1)(a) through (e) and on the following  
37 additional populations: Low-income persons, as defined by earning up to 200% of the Federal  
38 Poverty Level[-]

39 or on specific population groups designated by the Dental Health Professional Shortage

40 Areas (DHPSA) that lack access to care and that are underserved.

41

42 Stat. Auth: ORS 679 & 680

43 Stats. Implemented: 680.205 & 679.250(9)

44

45 **818-035-0072**

46 **Restorative Functions of Dental Hygienists**

47 (1) The Board shall issue a Restorative Functions Endorsement (RFE) to a dental hygienist who

48 holds an unrestricted Oregon license, and has successfully completed:

49 (a) A Board approved curriculum from a program accredited by the Commission on Dental  
50 Accreditation of the American Dental Association or other course of instruction approved by the  
51 Board, and successfully passed the Western Regional Examining Board's Restorative  
52 Examination or other equivalent examinations approved by the Board within the last five years;  
53 or

54 (b) If successful passage of the Western Regional Examining Board's Restorative Examination  
55 or other equivalent examinations approved by the Board occurred over five years from the date  
56 of application, the applicant must submit verification from another state or jurisdiction where the  
61 applicant is legally authorized to perform restorative functions and certification from the  
62 supervising dentist of successful completion of at least 25 restorative procedures within the  
63 immediate five years from the date of application.

64 (2) A dental hygienist may perform the placement and finishing of direct alloy and direct  
65 ~~anterior~~ composite restorations, under the indirect supervision of a licensed dentist, after the  
66 supervising dentist has prepared the tooth (teeth) for restoration(s):

67 (a) These functions can only be performed after the patient has given informed consent for the  
68 procedure and informed consent for the placement of the restoration(s) by a Restorative  
69 Functions Endorsement dental hygienist;

70 (b) Before the patient is released, the final restoration(s) shall be checked by a dentist and  
71 documented in the chart.

72

73 Stat. Auth.: ORS 679 & 680

74 Stats. Implemented: ORS 679.010(3) & 679.250(7)

1 **DIVISION 42**

2 **DENTAL ASSISTING**

3  
4 **818-042-0090**

5 **Additional Functions of EFDAs**

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

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

15 (2) Apply temporary soft relines to full dentures.

16  
17 Stat. Auth.: ORS 679

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

19  
20 **818-042-0095**

21 **Restorative Functions of Dental Assistants**

22 (1) The Board shall issue a Restorative Functions Certificate (RFC) to a dental assistant who  
23 holds an Oregon EFDA Certificate, and has successfully completed:

24 (a) A Board approved curriculum from a program accredited by the Commission on Dental  
25 Accreditation of the American Dental Association or other course of instruction approved by the  
26 Board, and successfully passed the Western Regional Examining Board's Restorative  
27 Examination or other equivalent examinations approved by the Board within the last five years,  
28 or

29 (b) If successful passage of the Western Regional Examining Board's Restorative Examination  
30 or other equivalent examinations approved by the Board occurred over five years from the date  
31 of application, the applicant must submit verification from another state or jurisdiction where the  
32 applicant is legally authorized to perform restorative functions and certification from the  
33 supervising dentist of successful completion of at least 25 restorative procedures within the  
34 immediate five years from the date of application.

35 (2) A dental assistant may perform the placement and finishing of direct alloy or direct  
36 **[anterior]** composite restorations, under the indirect supervision of a licensed dentist, after the  
37 supervising dentist has prepared the tooth (teeth) for restoration(s):

38 (a) These functions can only be performed after the patient has given informed consent for the  
39 procedure and informed consent for the placement of the restoration by a Restorative Functions  
40 dental assistant.

41 (b) Before the patient is released, the final restoration(s) shall be checked by a dentist and  
42 documented in the chart.

43

44 Stat. Auth.: ORS 679

45 Stats. Implemented: ORS 679.010 & 679.250(7)

46

47 **818-042-0110**

48 **Certification – Expanded Functions Orthodontic Assistant**

49 The Board may certify a dental assistant as an expanded function orthodontic assistant

50 (1) By credential in accordance with OAR 818-042-0120, or

51 (2) Completion of an application, payment of fee and satisfactory evidence of;

52 (a) Completion of a course of instruction in a program in dental assisting accredited by the

53 American Dental Association Commission on Dental Accreditation; or

54 (b) Passage of the Basic, CDA or COA examination, and Expanded Function Orthodontic

55 Assistant examination, or equivalent successor examinations, administered by the Dental

56 Assisting National Board, Inc. (DANB), or any other testing entity authorized by the Board; and

57 certification by a licensed dentist that the applicant has successfully removed cement from bands

58 using an ultrasonic or hand scaler, or a slow speed hand piece, on six (6) patients and recemented

59 loose orthodontic bands, fit and adjust headgear, remove fixed orthodontic appliances and

60 take impressions for four (4) patients.

61

62 Stat. Auth.: ORS 679

63 Stats. Implemented: ORS 679.250(7)

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# CORRESPONDENCE

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**From:** [Patrick Braatz](#)  
**To:** [Lisa Warwick](#)  
**Subject:** FW: record keeping  
**Date:** Tuesday, March 26, 2013 1:15:11 PM  
**Attachments:** [ODA on OBD.pdf](#)

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**From:** Dr Krump, Clackamas Jaw Surgery PC [<mailto:drkrump@drkrump.com>]  
**Sent:** Monday, March 25, 2013 10:32 AM  
**To:** OBD Info  
**Subject:** RE: record keeping

The enclosed article clearly does not represent the decision-making of the Oregon Board of Dentistry. Nonetheless, this article makes it appear that it will be incumbent upon dental implant patients to maintain their own records with regard to the name and size of the dental implants they had placed beyond the seven years of the usual record-keeping we are required to have.

I assert in the age of electronic dentistry, that it is incumbent upon the dentist to maintain these records. I have all of my hard copy records of all of my dental implant patients going back to 1984 to include film radiographs. There is no reason why an electronic database of this information cannot be kept indefinitely at the dental office even if it is subsequently sold to new practitioner.

And the "updating requirement for oral surgeons providing care in hospitals and other clinics" is a little strange. I have been on multiple hospital staffs in the state of Oregon for over 30 years and am unaware that the Oregon Board of Dentistry has any business in my hospital privileges. Please clarify.

John L Krump DDS PC  
9775 SE Sunnyside Road  
Clackamas, Oregon 97015  
Phone: 503 652-8080  
Fax: 503 652-8992  
[jawsurgery@drkrump.com](mailto:jawsurgery@drkrump.com)

## Update as of February 8, 2013

Steven E. Timm, DMD, ODA Vice President, Board liaison • Beryl Fletcher, Director of Professional Affairs, staff liaison

**T**HE OREGON BOARD OF DENTISTRY Rules Committee met January 22, 2013, sending several controversial issues back to the Board for final determination on whether they will go to a public hearing in the spring. The Board will meet on February 14 for action on the following issues:

- Silver Nitrate application by dental hygienists and dental assistants under general supervision (without the dentist in the office).
- Adding populations listed in Dental HPSAs (Health Professional Shortage Areas) to those that EPPs (Expanded Practice Permit dental hygienists) may provide treatment.
- Botox treatment for dentally related issues allowed for all dentists provided they take at least 16 hours of CERP accredited or AGD accredited training.
- Addition of a definition for "dentist of record" to facilitate compliance with the current laws relating to dentist supervision at colleges and university clinics. The proposal clarifies who is responsible for treatment.
- Updating requirement for oral surgeons providing care in hospitals and other clinics.
- Anesthesia rules changes requiring additional monitoring equipment for moderate, general, and deep sedation permits, and also requiring a moderate sedation permit if administering Benzodiazepines or narcotics to children under age six.
- Addition of some exam requirements for orthodontic assistants.

### Records Retention for patient implants

Dr. John Krump's request for a rule requiring dentists to retain records regarding implants longer than the currently required 7 years was reviewed by the Board Rules Committee. The committee recommended rule language be drafted to instruct dentists to give the implant information to the patient for safekeeping rather than have the dentist continue to maintain a record past the 7 year requirement.

### ADEX Exam to allow clinical periodontal portion of exam to be optional

After a complete review of the exam, ADEX determined that the actual "scaling exercise" portion of the periodontal exam will be optional. Candidates will still have to take the written portion of the periodontal exam. They will still have to pay for it in the initial exam whether they take it at that time or opt out.

The reason given for the change is dentists do not use this skill to actually perform the treatment but supervise it. SERTA and NERB are now using the ADEX exam. Consequently, anyone taking the exam in their areas will have the periodontal section offered but optional starting in November 2013, encompassing approximately 30 states. While the periodontal exercise will be optional, it would not preclude some states from requiring this section. In Oregon, the law requires the Board of Dentistry to accept all exams. A statutory change would be needed to allow the Board to require this additional piece.

Additionally, candidates who opted out initially will have to pay a fee if they chose to take the periodontal clinical portion at a later date due to state licensure requirements where they may wish to practice.

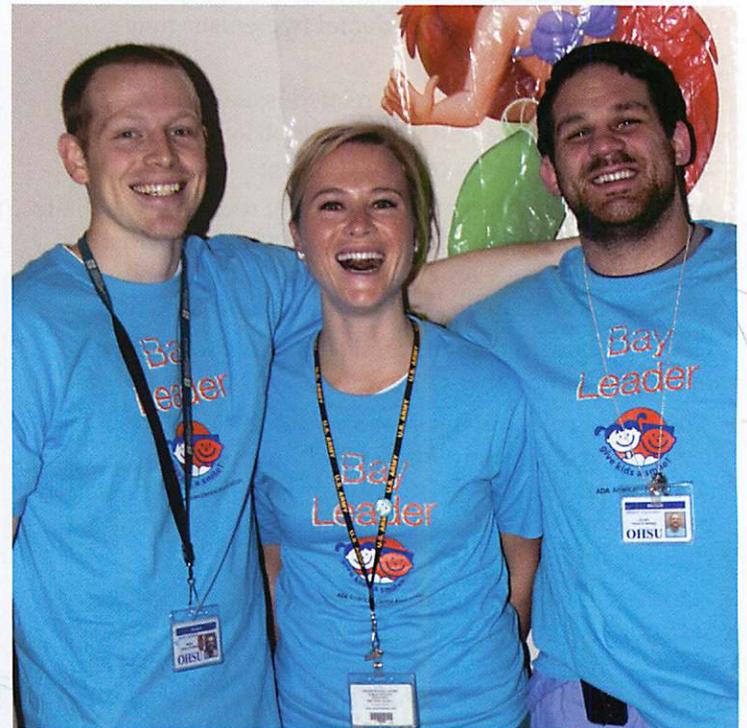
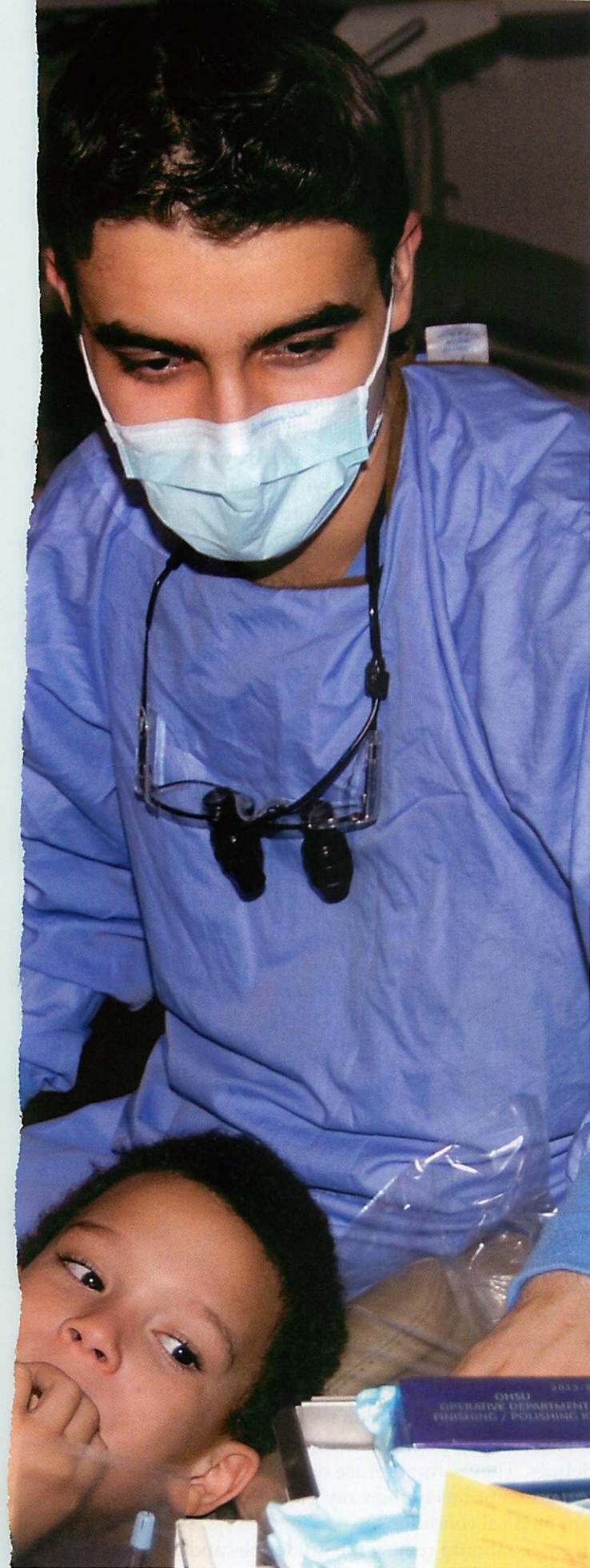
### Rule hearing to be scheduled for this spring will include the following issues in proposed rules:

- Posterior composite placement by hygienists and assistants.
- Proposal to allow dental hygienists to supervise EFDA's when applying dental sealants under indirect supervision.
- 818-03500020 - Removing references in wording of current dental hygiene rules regarding diagnosing and treatment planning for dental hygiene services since hygienists are allowed to do this. The patient would still need to have an exam scheduled with the dentist within 15 days of the hygiene services being performed.

### Board clarifies "Professional Standard of Care" for patient x-rays. Dentists should review new 2012 version.

Dental offices and patients continue to call inquiring about frequency and necessity for dental x-rays. Many dental offices are telling their patients that they must have x-rays every six months or every year. The professional standard of care for dental x-rays is set in the ADA/FDA dental x-ray guidelines. Standing orders for every patient to receive the same number of x-rays at the same frequency is not acceptable. This is not a rule change, and there is no "law," but rather a "professional standard of care." Patients must have x-rays by dentists within the FDA/ADA x-ray guidelines. They cannot refuse or sign a waiver. (There are some exceptions in the x-ray guidelines for those with certain medical conditions.)

Licensees should review the guidelines and adjust any patient x-ray orders accordingly.



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~~April Love, DDS~~

APRIL 10, 2013

DEAR MEMBERS OF THE BOARD OF DENTISTRY,

IT WAS SAD NEWS THAT THE TOPIC OF SILVER NITRATE  
COULD NOT BE ON THE AGENDA FOR THE PUBLIC HEARING  
APRIL 18 TH.

THIS IS A FORMAL REQUEST FOR THE BOARD TO  
RECONSIDER THE PROPOSAL THAT WOULD ALLOW A DENTAL  
HYGIENIST OR DENTAL ASSISTANT TO APPLY SILVER NITRATE  
TO TOOTH SURFACES UNDER THE GENERAL SUPERVISION OF  
A DENTIST.

THANK YOU FOR YOUR CONSIDERATION,

April Love DDS

RECEIVED

APR 10 2013

Oregon Board  
of Dentistry

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March 22, 2013

Oregon Board of Dentistry  
1600 SW 4th Avenue  
Suite 770  
Portland OR 97201

To Whom It May Concern:

The Raven Maria Blanco Foundation (RMBF) is a 501(c) 3 charity dedicated to raising awareness in the dental profession and the public regarding the importance of emergency medical preparedness in dental offices. Our organization is named in memory of 8-year-old, Raven, who died in 2007 during a routine dental check-up.

For our 2013 project to recognize National Children's Dental Health month, RMBF conducted a national survey to determine patient expectations and knowledge regarding medical emergency preparedness by their dentist. We surveyed 591 people from across the nation.

Attached, you will find a copy of the raw data. Several key points are noteworthy:

- 1) Dental patients overwhelmingly expect their dentist to be prepared to manage a medical emergency occurring during dental treatment in all of six key areas:
  - ① Ongoing training of the dentist,
  - ② Regular training of the dental staff,
  - ③ Periodically holding mock emergency drills,
  - ④ Having a written medical emergency plan,
  - ⑤ Stocking routine emergency medications, and
  - ⑥ Maintaining appropriate emergency equipment such as oxygen and an automated external defibrillator.
- 2) Most dental patients believe their personal dentist already has all six of these preparations in place.
- 3) Nearly 80% of dental patients would take some type of action against their dentist if they learned there was a deficiency in any area of medical emergency preparation. Over one in three patients would confront their dentist on the matter. An additional 20% would quietly change dentists and nearly a quarter (24%) would report the matter to their state dental board with the expectation of punitive action.

**Based on our communication with numerous dental lecturers on medical emergency preparedness, it is RMBF's position the vast majority of dental offices, including those in your state, are seriously lacking in multiple areas. However, based on the results of our survey, patients have a skewed view of the actual emergency preparedness of their dentist.**

We believe medical emergencies occurring during dental treatment are increasing in frequency and severity.

- ① Demographically, dental patients are aging.
- ② Advances in healthcare mean patients with complex medical histories (e.g. elderly or homebound) now receive dental care.
- ③ Dental treatment is becoming more sophisticated and increasingly invasive (e.g. implants and grafts). Given these facts, the public expectations of medical emergency preparedness in the six key areas listed above are both reasonable and appropriate, and should be incorporated into training and emergency preparedness procedures.

As the governmental agency charged solely with protection of your state's population, you are urged to improve the quality of medical emergency preparedness provided by those you license.

Kindly, reply with your board's position on this matter.

Sincerely,



Nicole Cunha  
Executive Director, RMBF

RMBF 2013 SURVEY FINDINGS

# PATIENT EXPECTATION'S on **Medical Emergency Preparedness** in the **DENTAL OFFICE**

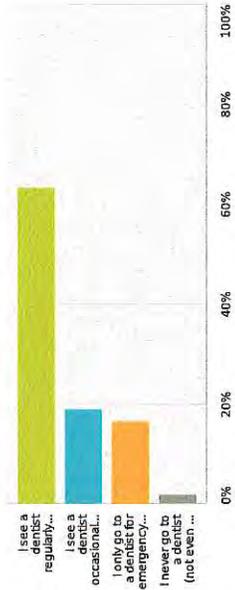
BY: DR. LARRY J. SANGRIK AND NICOLE CUNHA



Raven Maria Blanco Foundation, Inc.  
419 S. Lynnhaven Rd., Suite 111, Virginia Beach, VA 23452  
[www.rmbfinc.org](http://www.rmbfinc.org) | [info@rmbfinc.org](mailto:info@rmbfinc.org) | 757.502.8853

### Q1 Which best describes you?

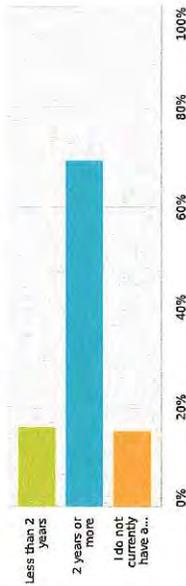
Answered: 591 Skipped: 0



Answer Choices	Responses
I see a dentist regularly (check-ups at least once a year)	373
I see a dentist occasionally (check-ups are usually less than once a year)	111
I only go to a dentist for emergency care (when in pain, or for an acute issue)	97
I never go to a dentist (not even in an emergency)	10
Total	591

### Q2 How long have you been a patient of your current general dentist?

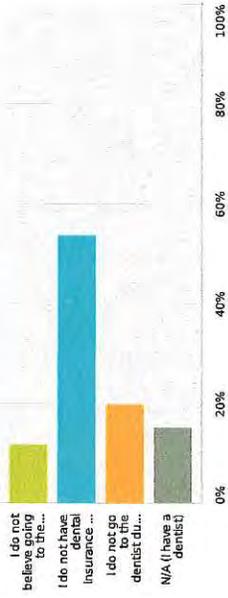
Answered: 580 Skipped: 11



Answer Choices	Responses
Less than 2 years	92
2 years or more	401
I do not currently have a general dentist	87
Total	580

**Q3 I currently do not have a dentist because?**

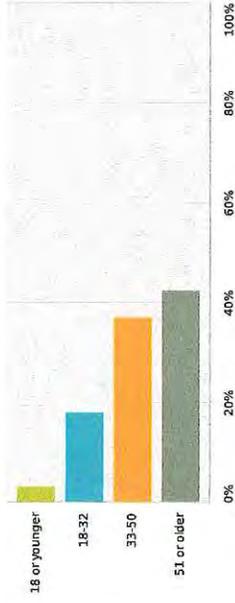
Answered: 66 Skipped: 505



Answer Choices	Responses
I do not believe going to the dentist regularly is important	11.63%
I do not have dental insurance and therefore cannot afford treatment	53.49%
I do not go to the dentist due to fear and/or anxiety	19.77%
N/A (I have a dentist)	15.12%
Total	66

**Q4 How old are you?**

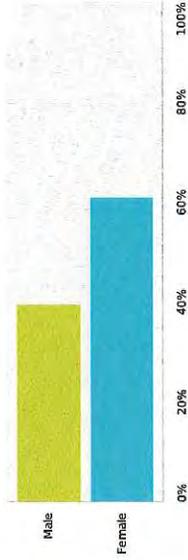
Answered: 504 Skipped: 87



Answer Choices	Responses
18 or younger	2.98%
18-32	17.86%
33-50	36.90%
51 or older	42.26%
Total	504

### Q5 Are you male or female?

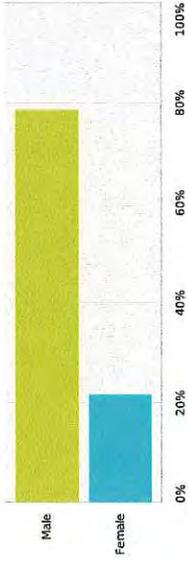
Answered: 504 Skipped: 87



Answer Choices	Responses
Male	198 39.29%
Female	306 60.71%
Total	504

### Q6 Is your dentist?

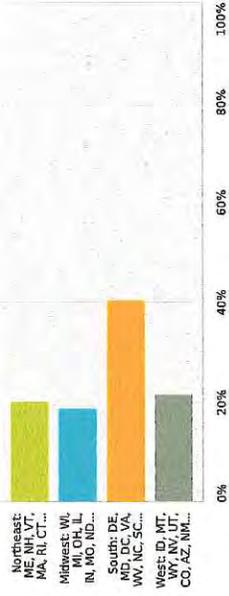
Answered: 497 Skipped: 94



Answer Choices	Responses
Male	390 78.47%
Female	107 21.53%
Total	497

**Q7 In what area of the country does your dentist practice?**

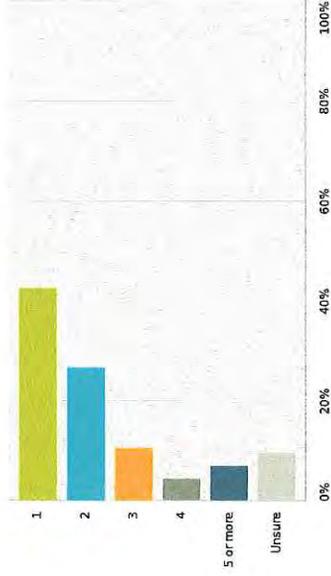
Answered: 497 Skipped: 94



Answer Choices	Responses
Northeast: ME, NH, VT, MA, RI, CT, NY, PA, NJ	99
Midwest: WI, MI, OH, IL, IN, MO, ND, SD, NE, KS, MN, IA	92
South: DE, VA, WV, NC, SC, GA, FL, TN, MS, AL, OK, KY, TX, AR, LA	200
West: ID, MT, WY, UT, CO, AZ, NM, AK, OR, CA, HI, WA	106
Total	497

**Q8 How many dentists practice in the dental office where you go for treatment?**

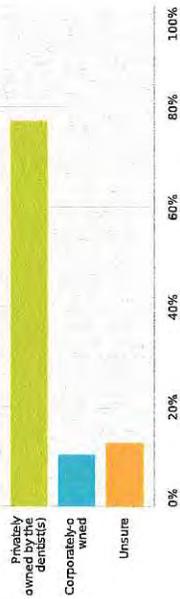
Answered: 497 Skipped: 94



Answer Choices	Responses
1	211
2	132
3	52
4	21
5 or more	34
Unsure	47
Total	497

**Q9 Is the dental practice where you go for treatment:**

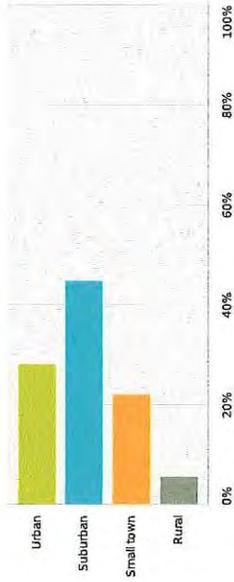
Answered: 497 Skipped: 94



Answer Choices	Responses
Privately owned by the dentist(s)	77.06%
Corporately-owned	10.26%
Unsure	12.68%
Total	497

**Q10 Where is the dental practice located?**

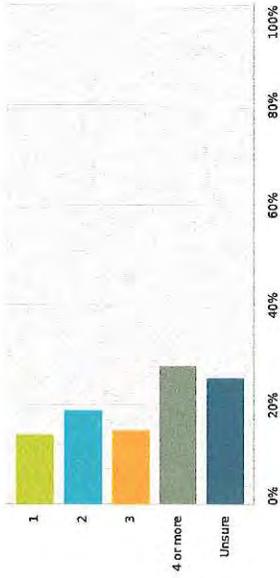
Answered: 497 Skipped: 94



Answer Choices	Responses
Urban	27.97%
Suburban	44.67%
Small town	21.93%
Rural	5.43%
Total	497

**Q11 How many dental hygienists practice in the dental office where you go for treatment?**

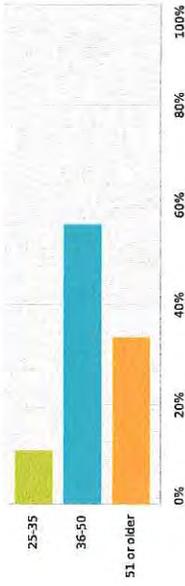
Answered: 497 Skipped: 94



Answer Choices	Responses
1	13.88%
2	18.71%
3	14.69%
4 or more	27.57%
Unsure	25.15%
Total	497

**Q12 In your estimation, how old is your general dentist?**

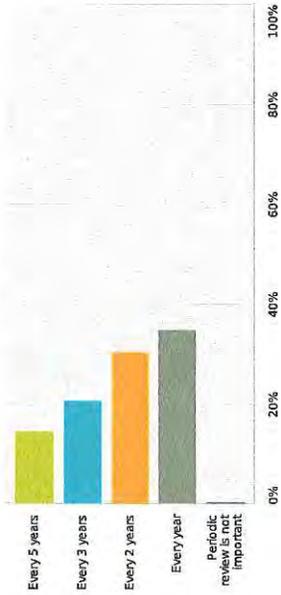
Answered: 497 Skipped: 94



Answer Choices	Responses
25-35	10.66%
36-50	55.94%
51 or older	33.40%
Total	497

**Q13** During dental school, all dentists are trained to deal with a wide range of medical emergencies which may occur during treatment. How often do you believe a dentist should review his/her training for a wide range of medical emergencies?

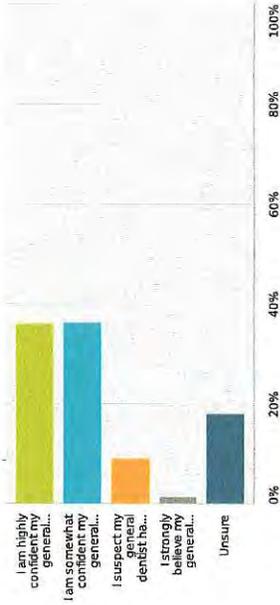
Answered: 493 Skipped: 99



Answer Choices	Responses
Every 5 years	71
Every 3 years	101
Every 2 years	149
Every year	171
Periodic review is not important	1
<b>Total</b>	<b>493</b>

**Q14** Based on your answer to the previous question, how confident do you feel your general dentist has received this training within the time period you expected?

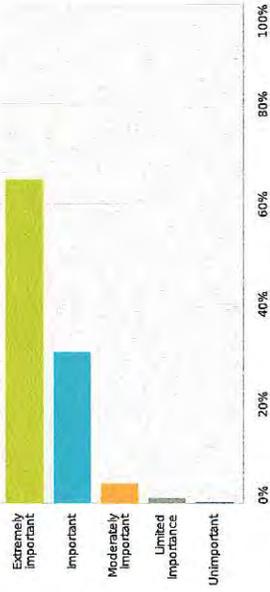
Answered: 493 Skipped: 96



Answer Choices	Responses
I am highly confident my general dentist has done this training	177
I am somewhat confident my general dentist has done this training	178
I suspect my general dentist has not done this training	44
I strongly believe my general dentist has not done this training	6
Unsure	88
<b>Total</b>	<b>493</b>

**Q15 How important do you believe it is for your dentist's entire staff to be formally trained to assist in responding to a medical emergency occurring during dental treatment?**

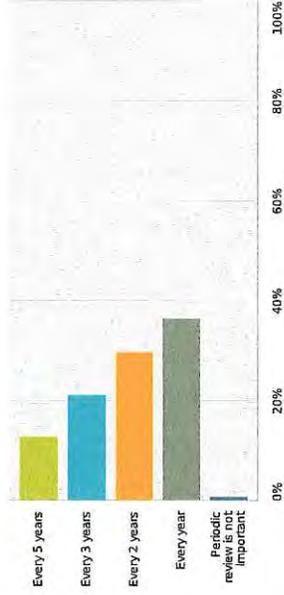
Answered: 491 Skipped: 100



Answer Choices	Responses
Extremely important	318
Important	148
Moderately important	19
Limited importance	5
Unimportant	1
Total	491

**Q16 How often do you believe your dentist's entire staff would need to be re-trained to a medical emergency?**

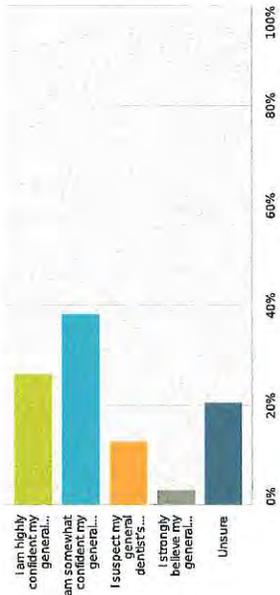
Answered: 491 Skipped: 100



Answer Choices	Responses
Every 5 years	62
Every 3 years	103
Every 2 years	145
Every year	178
Periodic review is not important	3
Total	491

**Q17** Based on your answer to the previous question, how confident do you feel your dentist's staff is currently receiving this training within the time period you listed above?

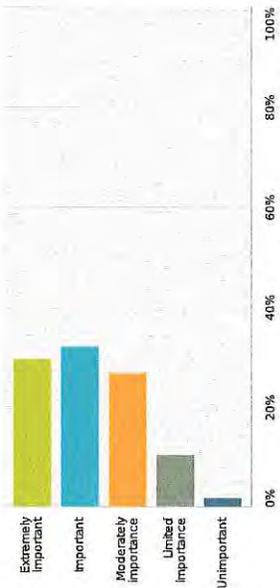
Answered: 491 Skipped: 100



Answer Choices	Responses
I am highly confident my general dentist's staff has done this training	128
I am somewhat confident my general dentist's staff has done this training	187
I suspect my general dentist's staff has not done this training	62
I strongly believe my general dentist's staff has not done this training	14
Unsure	100
Total	491

**Q18** Hospitals routinely hold mock drills to prepare for various medical emergencies. How important it is for your dentist to hold mock drills to prepare for a medical emergency occurring during dental treatment?

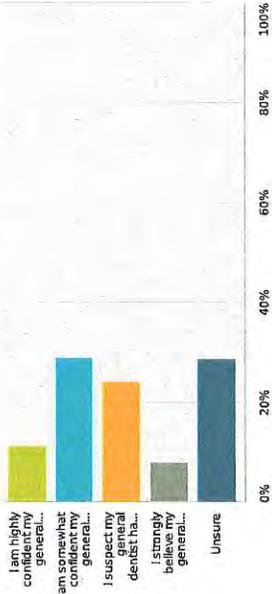
Answered: 488 Skipped: 103



Answer Choices	Responses
Extremely important	144
Important	156
Moderately importance	130
Limited importance	50
Unimportant	8
Total	488

**Q19 How confident are you that your dentist is currently holding mock drills with his/her staff to prepare for a medical emergency occurring during dental treatment?**

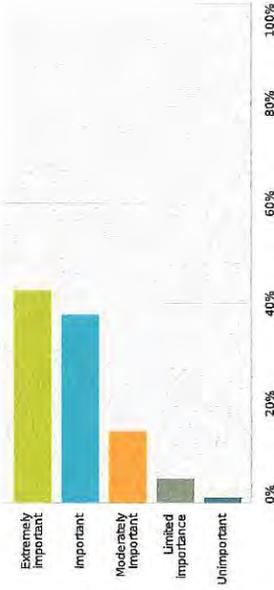
Answered: 488 Skipped: 103



Answer Choices	Responses
I am highly confident my general dentist has done this training	54
I am somewhat confident my general dentist has done this training	140
I suspect my general dentist has not done this training	117
I strongly believe my general dentist has not done this training	38
Unsure	139
Total	488

**Q20 Hospitals, schools and other entities that deal with the public have written emergency plans to help dictate a specific response and mitigate confusion. How important it is for your dentist to have a written plan specific for his/her office to address a medical emergency occurring during dental treatment?**

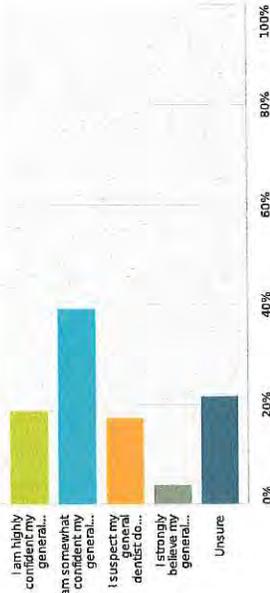
Answered: 484 Skipped: 107



Answer Choices	Responses
Extremely important	205
Important	182
Moderately important	69
Limited importance	23
Unimportant	5
Total	484

**Q21. How confident are you that your dentist currently has a written plan?**

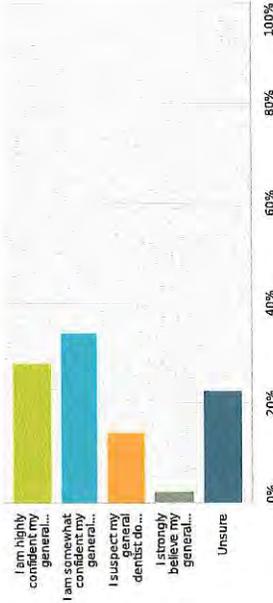
Answered: 484 Skipped: 107



Answer Choices	Responses
I am highly confident my general dentist has a written plan	18.60%
I am somewhat confident my general dentist has a written plan	39.05%
I suspect my general dentist does not have a written plan	17.15%
I strongly believe my general dentist does not have a written plan	3.72%
Unsure	21.49%
Total	484

**Q22. The American Dental Association recommends dentists stock seven specific medications for use during medical emergencies. However, no state requires a dentist to have them available. How confident do you feel your dentist currently has all seven medications available? 1. Aspirin (blood thinner for heart attacks) 2. An asthma inhaler (Ventolin / Albuterol) 3. Nitroglycerin (used in heart attacks to open coronary arteries) 4. Diphenhydramine (trade name Benedryl, used for minor allergic reactions) 5. Epinephrine (used in asthma, cardiac arrest and anaphylactic shock) 6. Ammonia inhalants (fainting) 7. Glucose (low blood sugar)**

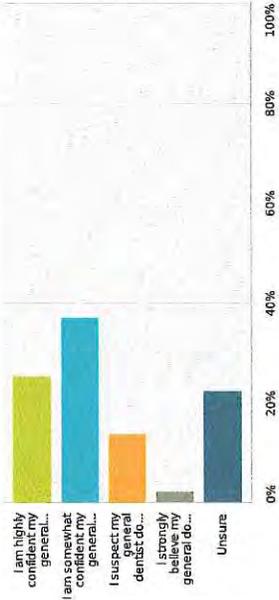
Answered: 481 Skipped: 110



Answer Choices	Responses
I am highly confident my general dentist has all seven medications	27.86%
I am somewhat confident my general dentist has all seven medications	33.89%
I suspect my general dentist does not have all seven medications	13.93%
I strongly believe my general dentist does not have all seven medications	2.08%
Unsure	22.25%
Total	481

**Q23 At least three sizes of blood pressure cuffs to accommodate all sizes of patients**

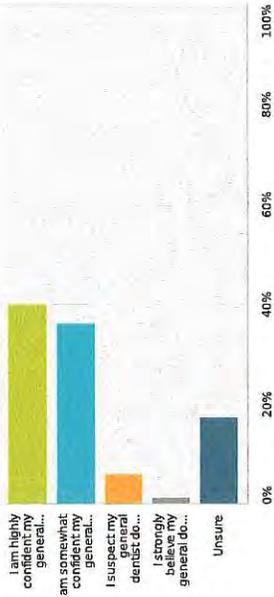
Answered: 477 Skipped: 114



Answer Choices	Responses
I am highly confident my general dentist has these devices	176
I am somewhat confident my general dentist has these devices	120
I suspect my general dentist does not have these devices	65
I strongly believe my general dentist does not have these devices	10
Unsure	106
Total	477

**Q24 A method of providing extra oxygen for breathing patients**

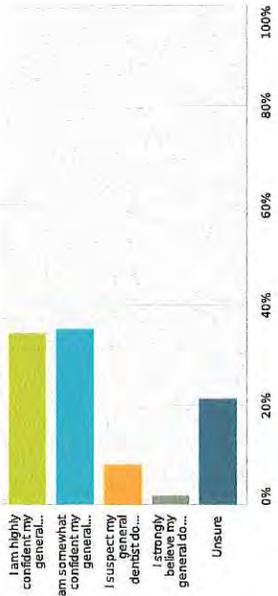
Answered: 477 Skipped: 114



Answer Choices	Responses
I am highly confident my general dentist has this device	190
I am somewhat confident my general dentist has this device	172
I suspect my general dentist does not have this device	28
I strongly believe my general dentist does not have this device	5
Unsure	82
Total	477

**Q25 A method of providing extra oxygen for a patient that has stopped breathing**

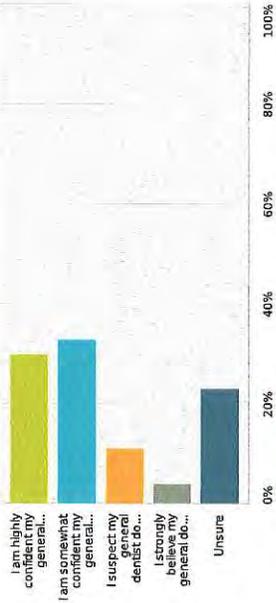
Answered: 477 Skipped: 114



Answer Choices	Responses
I am highly confident my general dentist has this device	163
I am somewhat confident my general dentist has this device	167
I suspect my general dentist does not have this device	38
I strongly believe my general dentist does not have this device	8
Unsure	101
Total	477

**Q26 An automatic external defibrillator (AED), a device to electrically start a non-beating heart**

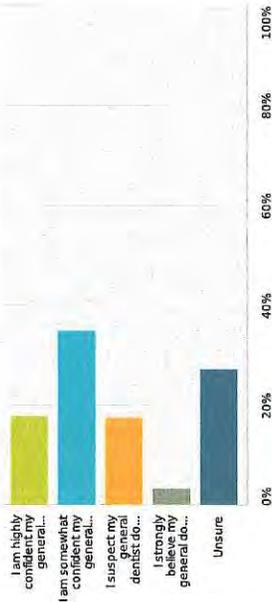
Answered: 477 Skipped: 114



Answer Choices	Responses
I am highly confident my general dentist has this device	142
I am somewhat confident my general dentist has this device	156
I suspect my general dentist does not have this device	52
I strongly believe my general dentist does not have this device	18
Unsure	109
Total	477

**Q27 A glucose monitor (a device to measure the level of sugar in the blood)**

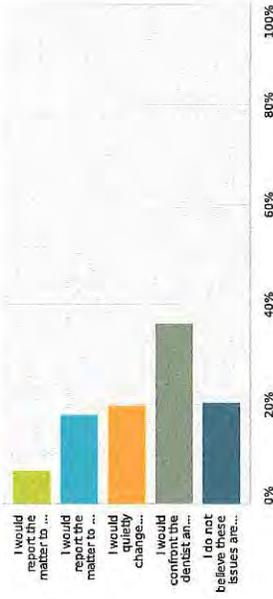
Answered: 477 Skipped: 114



Answer Choices	Responses
I am highly confident my general dentist has this device	84
I am somewhat confident my general dentist has this device	166
I suspect my general dentist does not have this device	83
I strongly believe my general does not have this device	15
Unsure	129
Total	477

**Q28 Based on your expectations, if you learned your dentist's office was deficient in any area, what would you likely do?**

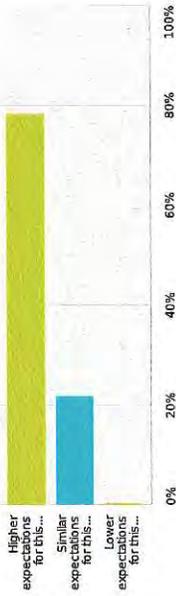
Answered: 475 Skipped: 116



Answer Choices	Responses
I would report the matter to the authorities (my state's dental board) and expect the dentist's license to be suspended for a specified period of time.	31
I would report the matter to the authorities (my state's dental board) and expect the dentist's license to be suspended until all areas are corrected.	84
I would quietly change dentists.	93
I would confront the dentist and not continue treatment at that office until I felt circumstances were changed.	171
I do not believe these issues are an important when choosing a dentist. I would continue to remain a patient.	96
Total	475

**Q29 Oral surgeons? Specialists in extractions, wisdom teeth, facial surgery and general anesthesia**

Answered: 467 Skipped: 124



Answer Choices	Responses
Higher expectations for this specialist than a general dentist	365
Similar expectations for this specialist and a general dentist	101
Lower expectations for this specialist than a general dentist	1
Total	467

**Q30 Endodontists? Specialists in root canal therapy**

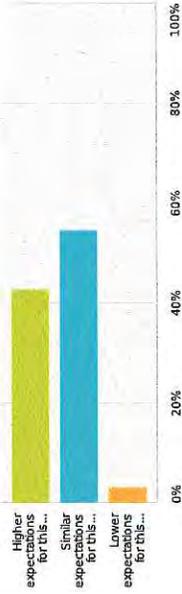
Answered: 467 Skipped: 124



Answer Choices	Responses
Higher expectations for this specialist than a general dentist	292
Similar expectations for this specialist and a general dentist	174
Lower expectations for this specialist than a general dentist	1
Total	467

### Q31 Periodontists? Specialists in treating gum diseases

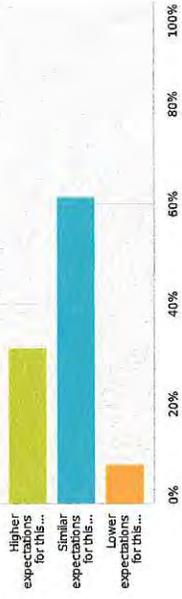
Answered: 467 Skipped: 124



ANSWER CHOICES	Responses	Total
Higher expectations for this specialist than a general dentist	199	467
Similar expectations for this specialist and a general dentist	254	467
Lower expectations for this specialist than a general dentist	14	467
<b>Total</b>	<b>467</b>	<b>467</b>

### Q32 Orthodontists? Specialists in moving teeth with braces

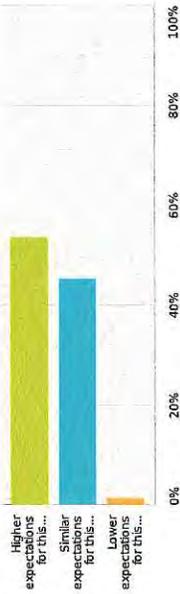
Answered: 467 Skipped: 124



ANSWER CHOICES	Responses	Total
Higher expectations for this specialist than a general dentist	145	467
Similar expectations for this specialist and a general dentist	286	467
Lower expectations for this specialist than a general dentist	36	467
<b>Total</b>	<b>467</b>	<b>467</b>

### Q33 Pediatric dentists? Specialists in dentistry for children

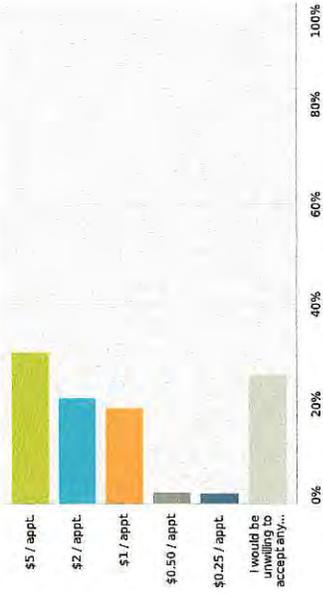
Answered: 467 Skipped: 124



Answer Choices	Responses
Higher expectations for this specialist than a general dentist	250
Similar expectations for this specialist and a general dentist	211
Lower expectations for this specialist than a general dentist	6
Total	467

### Q34 Currently, state dental boards have very few requirements for medical emergency preparedness. Eight states have no requirements. Preparing dental offices in all six areas of medical emergency preparedness will take time and money. How much would you be willing to pay out-of-pocket, per appointment, to cover the costs of increasing medical emergency preparedness in your dentist's office?

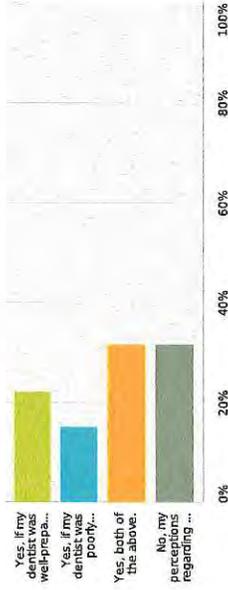
Answered: 467 Skipped: 124



Answer Choices	Responses
\$5 / appt.	141
\$2 / appt.	98
\$1 / appt.	89
\$0.50 / appt.	10
\$0.25 / appt.	9
I would be unwilling to accept any medical emergency preparedness in my dentist's office.	120
Total	467

**Q35 Would your positive or negative perceptions of your dentist's overall preparedness for a medical emergency occurring during your dental treatment influence your decision to speak to an attorney regarding possible litigation, if a medical event occurred?**

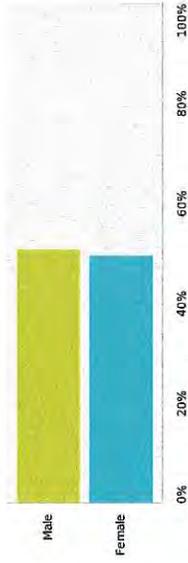
Answered: 467 Skipped: 124



ANSWER CHOICES	Responses
Yes, if my dentist was well-prepared, I would be less inclined to speak to an attorney.	103
Yes, if my dentist was poorly prepared, I would be more inclined to speak to an attorney.	70
Yes, both of the above.	147
No, my perceptions regarding my dentist's preparation for an emergency would not influence my decision to speak to an attorney.	147
<b>Total</b>	<b>467</b>

**Q36 Gender**

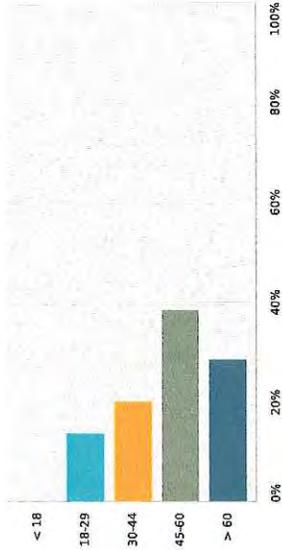
Answered: 356 Skipped: 235



ANSWER CHOICES	Responses
Male	180
Female	176
<b>Total</b>	<b>356</b>

**Q37 Age**

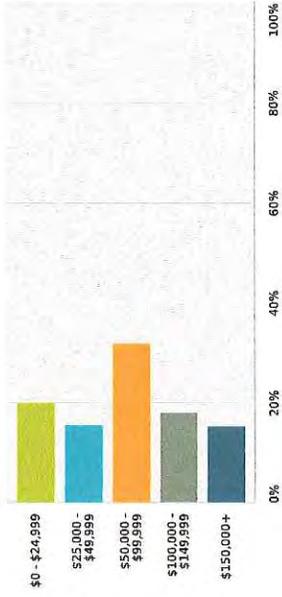
Answered: 356 Skipped: 235



Answer Choices	Responses
< 18	0
18-29	48
30-44	71
45-60	136
> 60	101
Total	356

**Q38 Household Income**

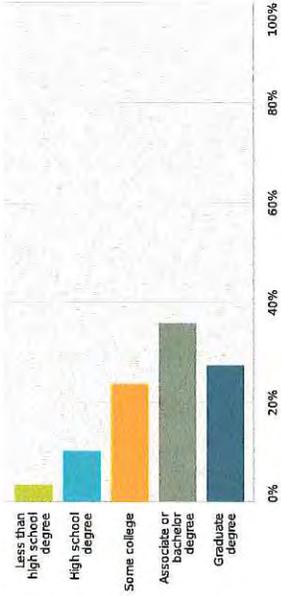
Answered: 337 Skipped: 254



Answer Choices	Responses
\$0 - \$24,999	67
\$25,000 - \$49,999	52
\$50,000 - \$99,999	107
\$100,000 - \$149,999	60
\$150,000+	51
Total	337

**Q39 Education**

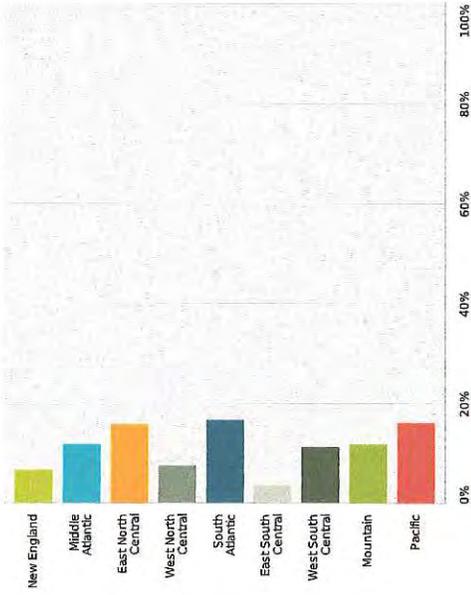
Answered: 356 Skipped: 235



Answer Choices	Responses
Less than high school degree	12
High school degree	36
Some college	84
Associate or bachelor degree	127
Graduate degree	97
Total	356

**Q40 Location (Census Region)**

Answered: 351 Skipped: 240



Answer Choices	Responses
New England	23
Middle Atlantic	41
East North Central	55
West North Central	26
South Atlantic	58
East South Central	12
West South Central	39
Mountain	41
Pacific	56
Total	351

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Steven Duffin, D.D.S.

11631 Lausanne St.

Wilsonville, OR 97070

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APR 10 2013

Oregon Board  
of Dentistry

April, 4, 2013

Oregon Board of Dentistry

1600 SW 4<sup>th</sup> Ave.

STE 770

Portland, OR 97201

Ladies and Gentlemen:

I approach you once again on the subject of the application of the antimicrobial agent silver nitrate under general supervision by a licensed dentist. There exists now an opportunity to reverse the decision made by this board last fall to disallow this simple, safe and effective therapy applied by dental hygienists.

I understand that this decision was made in the absence of adequate information on the subject and under the influence of detractors, whose self-interests are aligned with making no changes to the status quo. I have made great efforts to avoid this confrontation by presenting the historical scientific literature on the use of silver nitrate to Dr. Kleinstub almost two years ago. I also submitted to the full board my paper "Caries is Making a Come-Back", and asked for the opportunity to present my information and answer any questions. These early inquiries suggested that the application of silver nitrate by a dental hygienist fell under existing rules as it is a topical antimicrobial agent. During the ensuing time period hundreds of practitioners have adopted the silver nitrate protocol as described in my paper published in the California Dental Association, November 2012. My presentation on the subject at the 2012 annual OHSU Practice Based Research in Oral Health conference was well received by the profession.

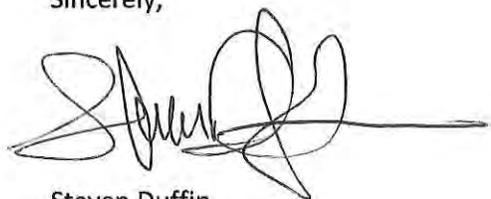
Tens of thousands of patients have been treated in Oregon with this safe, effective and affordable therapy. By making the choice to prevent dental hygienists from applying silver nitrate, the board has raised a very large barrier to care for those most at risk for caries. Should the board choose to continue to support this misguided

wellness for Oregon's citizens may step in to fill the gap. This would be an unfortunate outcome and cause the dental profession to be further fractured.

I am enclosing Text from G.V. Black's classic text The Pathologies Of The Hard Tissues Of The Teeth , Volume one, pages 249 to 254. This is where I learned about the use of silver nitrate to arrest caries, from the father of the modern dental profession. Being ignorant of this fact is unacceptable in today's dental profession.

Therefore, I urge the dental board to take the correct action by reversing its prior decision banning dental hygienists from applying silver nitrate.

Sincerely,

A handwritten signature in black ink, appearing to read 'Steven Duffin', with a long horizontal line extending to the right.

Steven Duffin

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# Back to the Future: The Medical Management of Caries Introduction

STEVEN DUFFIN, DDS

**ABSTRACT** Based on the literature, a protocol was developed involving the application of 25 percent silver nitrate directly to cavitated caries lesions, immediately followed by 5 percent sodium fluoride varnish. This protocol results in arrest of active caries lesions. This minimally invasive treatment is well-accepted by patients and reduces anxieties related to dental office visits.



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## AUTHOR

**Steve Duffin, DDS**, owner of Shoreview Dental LLC, practiced general dentistry for 30 years. He obtained a microbiology degree from the University of California, Los Angeles, in 1979 and his DDS degree from Emory School of Dentistry in 1983.  
*Conflict of Interest Disclosure:* Steven Duffin, DDS, is owner of Shoreview Dental, LLC.

In the late 1970s, it looked like the dental profession might be close to finding the cure for caries—the world's most prevalent disease.

Initiation of community water system fluoridation programs in the 1950s plus the introduction of fluoridated toothpaste substantially cut caries rates across many demographics in America. And there was talk of a caries vaccine that would be available in 10 years or so that would essentially eliminate the disease.<sup>1</sup>

Thirty-something years later, in many ways, things have not changed that much. Even today, there is still talk about a possible caries vaccine that would be available in 10 years. In more affluent populations within the United States, caries is a relatively minor health concern. Multiple studies show that 20 percent of

the population have 80 percent of dental caries. Those high caries rate populations are characterized by lower socioeconomic status. Contributing factors for high disease rates may be increased exposure to dietary sugars, lower dental IQ, and ineffective oral hygiene practices.<sup>2</sup>

What has changed is that we now have a much greater awareness that despite good oral health for a large proportion of Americans, there are great disparities among different populations within the United States; some continue to have a high prevalence of caries, and a correspondingly high morbidity from the disease. This is especially true for the children of some racial and ethnic minority populations, as was pointed out in the Surgeon General's report on Oral Health in America in the years 2000 and



**FIGURE 1.** Initial setup for subsequent application of silver nitrate and fluoride varnish.



**FIGURE 2A.**



**FIGURE 2B.**

**FIGURE 2.** Transfer of 25 percent silver nitrate from bottle to dappen dish for subsequent application using a microbrush.

2012 and in a recent front-page article in the *New York Times*.<sup>35</sup>

To try to eliminate these racial and ethnic oral health disparities, the response of the dental public health community has been logical: Do more of what has worked well for the more affluent populations. This has included increased emphasis on community water system fluoridation and use of fluoride-containing toothpaste, plus adding school-based fluoride varnish and sealant programs. Despite these laudable efforts, there is an increasing awareness that these methods are simply inadequate to provide protection for the children at highest risk—many of whom have such severe caries in the primary dentition (CIPD) that they require full-mouth restoration under general anesthesia.<sup>6</sup> The belief that doing more of the same preventive measures will be successful in high-risk populations has not proven to be effective. Despite all of these public health efforts at prevention, disease rates continue to rise in these high-risk populations.<sup>7</sup>

In 2005, the author's clinic began treating 2,500 Medicaid patients in a locale where there had been very limited access to dental care. This location was overwhelmed with cases of children with advanced caries, many of whom needed to be scheduled right away for in-hospital restorations. Emergency calls from parents with children in dental pain seemed to be a nightly occurrence.

This frustration led to the search for a better approach to preventing and managing caries—especially for the young children—than the methodologies available at that time.

This comprehensive search was comprised of all of the literature on the microbiological etiology of caries and how it had been approached by some of the founding fathers of the modern dental profession, including W.D. Miller, G.V. Black, and Percy Howe. It was impressive that, beginning with Miller, all three had utilized the known antimicrobial compound, silver nitrate, in solution to arrest active caries.<sup>8</sup> Black developed a protocol using multiple applications of silver nitrate directly to the lesion until it became hard and totally arrested.<sup>9</sup> Percy Howe, first research director of the Forsyth Institute in Boston, spent much of his time treating the poor working class children of Boston in addition to conducting research projects and training dentists from all over the world. Howe was so well-known for his successful treatment of caries with silver nitrate that beginning in the 1920s many dental professionals referred to silver nitrate solution simply as “Howe’s solution.”<sup>10,11</sup> In addition to these reports from the founders of modern dentistry at beginning of the 20th century, an extensive review of the more recent literature was formative in developing the silver nitrate solution followed by fluoride varnish protocol.<sup>1,2,12-21</sup>

And then, sometime around the middle of the 20th century, the dental profession seemed to forget this history of successful management of caries using silver nitrate. Perhaps it was the increasing affluence of the country, increasing access to dental care, or decreasing acceptability of the black appearance caries develops once arrested by silver nitrate. Regardless, by the 1960s, silver nitrate was no longer being routinely used in the United States for control of caries, nor was any other antimicrobial product adopted to replace it.

### Methods: Back to the Future — Adopting G.V. Black's Protocol in 2005

After a thorough review of the literature, Black's protocol of multiple applications of silver nitrate to control caries was implemented at the clinic. His experience and observations suggested that silver nitrate would be a safe and effective alternative to surgical restorations for the extensive lesions seen on a daily basis at this location.<sup>9</sup> The question of possible silver nitrate toxicity has been well-addressed in four publications.<sup>10,22-24</sup> In the quantities recommended by this protocol, toxicity from silver nitrate is not considered to be a concern. However, the possibility of an allergy to silver nitrate or silver ion compounds is a known contraindication and should be a consideration during the informed consent process.

After acquiring a bottle of 25 percent silver nitrate (25 percent silver nitrate and 75 percent purified water) from Henry Schein, Inc., (Gordon Laboratories) informed consent was obtained and a tiny amount was carefully applied directly on the child's caries lesions with a microbrush. When the child returned the following week, the lesions were dark and hard, and on subsequent visits it appeared that the active caries had been fully arrested.

Encouraged by this first success, use of this procedure was continued on other patients with active cavitated caries. Over time, this protocol was refined

to be more effective. Empirically, it appeared that applying fluoride varnish over the area treated with silver nitrate would have the multiple benefits of (a) preventing any contact of the silver nitrate with the soft tissue; (b) providing a protective layer to keep the silver nitrate from being washed away by saliva; plus (c) adding the benefits of fluoride.

The setup (FIGURE 1) and execution of this protocol could hardly be simpler. Before implementing this protocol, a tooth-by-tooth evaluation should be conducted to determine whether a sufficient layer of dentin remains between the carious cavitation and the pulp. Tools to assist in this

assessment include radiographs, presence or absence of symptoms in the tooth, color or surface texture of the lesion, and dimensions of the lesion. There should be a minimum of 1 mm of healthy dentin between the advancing front of the lesion and the pulp, which can be observed via radiographs. Do not apply if there are any signs of pulpitis or draining fistula, visual signs of pulp in the lesion (pink color), or if the cavitations are large enough that they likely border the pulp. Doing so prevents the silver nitrate from reaching tooth pulp in sufficient quantity to be painful and theoretically induce pulpitis. Following of this protocol has never resulted in pulpitis at the clinic.

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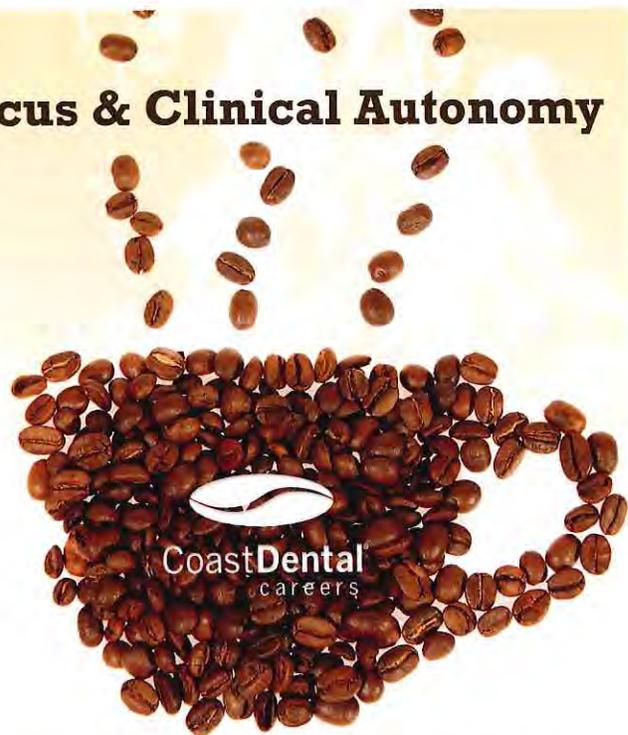
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**FIGURE 3.** Silver nitrate application, using a microbrush, to cavitated lesion.



**FIGURE 4.** Application of 5 percent sodium fluoride varnish over silver nitrate in cavitated lesion



**FIGURE 5.** "Little black scar" as a result of silver nitrate application to cavitated lesion.



**FIGURE 6.** Appearance of tooth after addition of tooth colored filling.



**FIGURE 7.** Radiograph demonstrating presence of secondary dentin after silver nitrate followed by fluoride varnish protocol.



**FIGURE 8.** Root cavity after silver nitrate/fluoride varnish treatment.

Once it has been established that the patient is a viable candidate for the protocol, begin by transferring the silver nitrate from the bottle, via micro pipette (Henry Schein item No. 2013051), to a small dappen dish (Henry Schein item No. 294487) (FIGURE 2). After drying the lesion, apply a single drop of approximately 17 µl of 25 percent silver nitrate solution using a microbrush (Henry Schein item No. 1078831) to upward of eight caries lesions (FIGURE 3). Immediately cover with a 5 percent sodium fluoride varnish preparation; fluoride varnish used by the clinic was manufactured by Centrix (FIGURE 4). After all the caries lesions have been treated in this way, apply 5 percent sodium fluoride varnish to the rest of the child's teeth. Repeat silver nitrate solution and 5 percent sodium fluoride varnish application to all carious lesions at two, four, eight, and 12 weeks. Evaluate the state of caries arrest at each time interval. Discussion about restorative options with patient and/or parents is done at week 12.

Great success was observed in arresting active caries from this combination therapy. However, the dark appearance of the arrested lesions (FIGURE 5) was of concern to some the parents because the unfavorable cosmetic appearance. It was explained to parents that the silver nitrate kills all cavity causing bacteria, but in doing so it leaves a "little black scar" on the tooth, and that after four to six weeks, it is possible to place a tooth-colored filling without the need for local anesthesia (FIGURE 6). This explanation has been readily accepted by patients and parents, and the cosmetic concern is much less of an issue now.

### Results

By the end of 2011, the clinic had treated more than 5,000 children with the silver nitrate followed by fluoride varnish protocol over the previous five years. Overall, these findings suggest that this protocol has achieved complete arrest of active caries in almost all the teeth for which it was used. This

clinical impression has been reinforced in situations where radiographs were taken of the treated teeth after completion of the protocol. There is clear evidence of new secondary dentin formation at the base of the lesion (FIGURE 7). The formation of secondary dentin following arrest of the lesion may explain why restorations can be subsequently placed without the need for local anesthesia. When a restoration is chosen, a full discussion about the advantages and disadvantages of the restorative materials glass ionomer, composite, and amalgam is held with the patient. Currently, the clinic has an assignment of approximately 2,500 Medicaid patients, of whom 80 percent are children. The first three years were spent working through the backlog of children with extensive, deep cavitations. At that time, the practice experienced an annual average of 20 full-mouth restorations under general anesthesia.

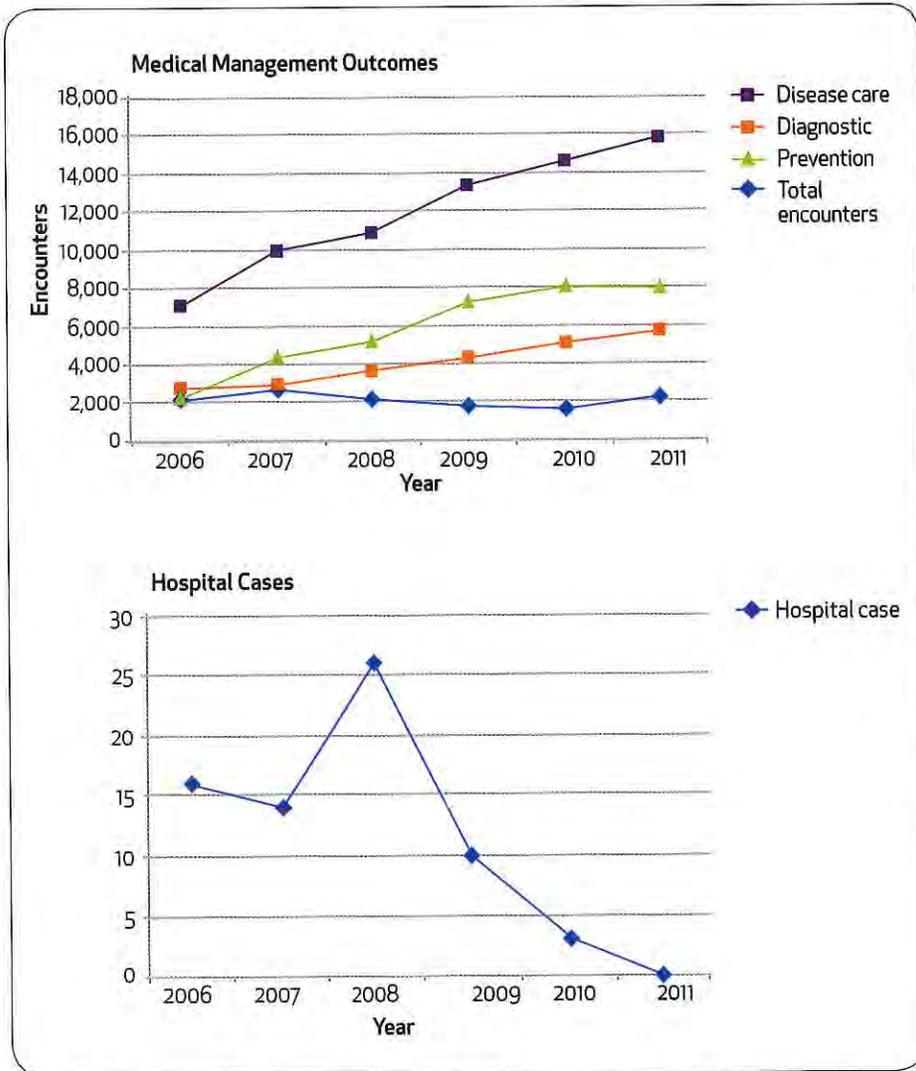


FIGURE 9. Medical management outcomes and hospital cases.

Since then, with increasing use of the silver nitrate followed by fluoride varnish protocol, each year fewer children have required operating room treatment. By 2011, zero children required in-hospital restorations. No significant adverse effects were observed while using this protocol. To try to confirm the apparent effectiveness of this treatment protocol, an outcome analysis of children in the caries management program was conducted. This analysis was difficult to perform because the protocol was implemented as clinical practice rather than research. In addition, the clinic's

dental software was not designed to keep track of lesions that become arrested and do not need a restoration.

To maintain randomization, this analysis involved selecting every 10th chart from the clinic's patient records, from A to Z, and selecting children who had received the caries arrest protocol. This resulted in a sample of 106 children between 2-12 years of age; they had a minimum of 1 and mean of 5.2 follow-up visits within 30 months after the initial treatment. In these children, 578 caries lesions were identified at the date of initial examination. Upon review,

only seven of the 578 treated teeth subsequently required extraction due to continuing pathology. The clinic had continued to follow the status of the treated teeth in these children and found that for this random sample, 98 percent of the lesions remained arrested for up to four years after treatment.

Even though no outcome data has been obtained for the adults and senior citizens in this practice, it is the dentist's clinical impression that they are getting the same magnitude of benefit as the children. This is particularly important because these patients frequently use multiple medications leading to a high prevalence of xerostomia and increased rates of root caries. When older patients are assessed, many of whom are in long-term care facilities, and they are told that their root cavities can be treated with medicine that removes the need for immediate restorations, they are very agreeable to this plan (FIGURE 8).

## Discussion

The clinic offers a comprehensive, family-based caries prevention program that is focused on primary prevention through good diet and hygiene and regular dental checkups.<sup>25</sup> However, when a patient presents with cavitated lesions, whether child or adult, after explaining the procedure and obtaining written consent, the silver nitrate followed by fluoride varnish protocol is used to prevent extension of the disease. The patient response has been extremely gratifying. There is a dramatic decrease of apprehension many of the patients feel due to their previous experiences of having restorations done while they were in pain from active lesions. It is often observed that other family members, including young children, watch the treatment so they too will be less apprehensive about future dental clinic visits.

The overall effect of using this medical management approach, when the primary prevention measures have not been successful, has substantially affected the nature of the practice. Although the clinic still has the same number of patients enrolled for services, there are now far more visits for prevention and diagnostic purposes than for restorations. **FIGURE 9** shows the breakdown by purpose of visit for adults and children between 2006 and 2011 and the number of hospital cases.

**Summary**

When primary prevention measures have not been successful, use of 25 percent silver nitrate followed by 5 percent sodium fluoride varnish results in arrest of advancing caries lesions. The elimination of active disease creates an improved environment for the placement of restorations. Since this protocol involves multiple patient visits, it provides the opportunity to more effectively treat the primary infection and better convey prevention messaging such as oral hygiene instruction and dietary counseling. These atraumatic patient encounters reduce their overall anxieties associated with dental care visits.

A tooth-by-tooth evaluation would be conducted to determine whether a sufficient layer of dentin remains between the carious cavitation and the pulp. There should be a minimum of 1 mm of healthy dentin between the advancing front of the lesion and the pulp, which can be observed via radiographs. Do not apply if there are any signs of pulpitis or draining fistula, visual signs of pulp in the lesion (pink color), or if the cavitations are large enough that they likely border the pulp. Doing so prevents the silver nitrate from reaching tooth pulp in sufficient quantity to be painful and theoretically induce pulpitis.

This protocol introduces a new technology to reduce the incidence of disease burden in children and adults with the highest need. Implementation of this protocol into the public health infrastructure could drastically reduce the need for treatment of extensive dental restorations under general anesthesia. While findings utilizing this protocol have been very positive, there exists research opportunities to better understand the mechanisms behind this highly effective treatment. ■■■■■

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a time on different days. Leave the decayed material in the dentin where it is. Do not disturb it or attempt to remove it. The removal of this is particularly painful to the child. Cut away the angle of the tooth and follow straight toward the gingival, leaving the surface flat, being careful to incline the file so as to cut most from the lingual surface, making a V-shaped opening as shown in Figures 181, 182. In making these cuts, it is best to note carefully the position of the gum septum, and, if possible, avoid cutting so far that the gum tissue will overlap the cut surface; for this will often make a little pocket in which it will be difficult to prevent decay starting afresh. The little fellows, unless there is something that hurls to prevent them, are good feeders and will bite through foodstuffs enough to keep these spaces pretty well cleaned and it is now easy to supplement the natural by artificial cleaning. When these have been cut in this way and polished with polishing tape or the disk, if some decay is left or some dentin is exposed, it should be treated with silver nitrate. To do this, first lay a crystal of silver nitrate on a glass slab and crush it. Have some water and an orangewood stick cut to a point ready (an ordinary wooden toothpick with a flat end may be used). Put a single small drop of water on the crushed crystal and make as nearly a saturated solution as possible. Slip the rubber dam over the teeth, hold it with the fingers of the left hand, dry the cut surfaces and apply this solution to the cut surface and the decay in the dentin until it is well saturated. Now, if it is possible to place the cut surfaces directly in the sunlight for ten minutes, do so. The mirror can be used to reflect the sun's rays directly onto the cut surface. If the direct rays of the sun can not be had, use the brightest light available, and, if possible, continue it longer. If time enough can not be given at a first trial to obtain a full black color of the carious dentin, try again at another sitting and another until it is obtained. Generally, after one or two sittings, the child will learn just what is wanted and plenty of time can be given. Each carious area, such as shown in the illustrations, should be treated in the same way.

The object in this treatment is to fill the part of the dentin softened by decay with the insoluble salt of silver that has been precipitated by light, and incidentally to destroy the organisms in it. That portion of silver nitrate, which has not been precipitated by light, dissolves out within a short time and is gone; it is of no value. It is useless to endeavor to treat such

o/o<sup>2</sup><sub>c</sub>

decays with silver nitrate without this exposure to light. But when the full black color is obtained, decay is generally effectively stopped. To do this requires such control of the child as will enable one to use the file a little at a time and proceed in shaping the surfaces and in polishing them. This may be done with a thin stone in the engine and finished with disks. In this work the child need not be troubled with the rubber dam or any close confinement. But in applying silver nitrate, the rubber dam should be used. Applications made without it will generally be useless. One should make no attempt to go on the rubber dam. Indeed, nothing should be done that is likely to cause pain. When this has been held in position for ten minutes, or longer, if the child is not too restless, throw a stream of water on it to wash away superfluous silver nitrate and end the sitting for the day. When it is apparent that the first application is ineffective, make another after one or two days. Repeat this as often as may be necessary. All exposed dentin and the decay should assume a full black color. Enamel will not be stained. Any silver nitrate precipitated on the surface of the enamel will disappear within a few days.

Generally decay is effectually stopped by this treatment if the tooth and cut surfaces are kept fairly well cleaned. The cleaning may be done by the mother or the nurse after proper instruction. The dentist, however, should see these cases frequently to know that the cleaning is well done. He may find it necessary to repeat the treatment with silver nitrate occasionally. Sometimes we find caries of the enamel beginning in the gingival thirds of the labial surfaces. If these can be discovered before the enamel rods have fallen out, they may be cleaned, using caution not to break away the frail enamel, and treated with silver nitrate without further preparation. Then the cleaning with the brush should be effective.

Either this incipient decay of the enamel or the deeper decays of the proximal surfaces will be stopped, provided the surface is such that it can be kept fairly clean. In this treatment one will escape most of the painful part of the operation in the treatment of these cases, for the little filing that is to be done will generally not be very painful. This is applicable to the proximal surfaces of incisors and cuspids and to labial caries. The labial cavities, from which enamel rods have fallen, can not be cut away very completely, but we can break away the enamel and trim it carefully so as to make these depressions as smooth as possible and then treat them in the same

way, and, by proper instructions to parents, they may be kept clean by brushing, and the teeth, although mutilated and out of shape, will be useful to the time of their shedding. All cases of the recurrence of decay is noted, the silver nitrate should again be applied.

A word of caution should be said about the use of silver nitrate, and it is an important one. It must not be used if the decay has approached near the pulp of the tooth. There is nothing else that will cause so severe a toothache as silver nitrate used over a pulp that is nearly exposed by decay. Personally, I have had a few very memorable experiences with it. The pain was so severe and so uncontrollable that I felt compelled to sacrifice important teeth. One may use silver nitrate with perfect freedom wherever there is a good coating of sound dentin over the pulp, but we must not risk affecting the pulp. Of course, up to a certain age we have the recourse of destroying the pulp and removing it, but after the beginning of the absorption of the roots that recourse is lost to us. Treatment with silver nitrate should be confined strictly to shallow cavities. It is not well suited to deep cavities in which there will be accumulation. Its success depends much upon strict cleanliness and free washings by the fluids of the mouth and by foodstuffs after the treatment. Other plans of treatment must be employed for deeper cavities. The application of the silver nitrate seems to be of much benefit also in beginning caries of enamel. When it has been precipitated freely among the loosened ends of the enamel rods, decay does not rebegin so readily and such vigorous cleaning is not necessary to hold it in check.

A word as to the handling of children in this class of cases. A dental school clinic is not a suitable place to handle little children. We are practically debarred by the conditions from teaching this clinically in schools. If I am to handle children, I want to know the parents; I want to know that they are depending on me to manage the teeth of their children and that I will have their assistance and sympathy in this management. I will not undertake, further than for present relief, the handling of children of strangers, and I would not advise anyone to try to do it. Remember that in undertaking to treat decays of these teeth, it is a thing that one must begin to-day and follow it up from week to week and from year to year, until the shedding time of these teeth, and one should have that particularly in view and have the parents particularly impressed with the necessity.

Of course, we can not expect much assistance from the child, as the rule. Yet, many of them become enthusiastic and do their part most bravely. Furthermore, the prophylactic work with the tooth brush must be done by the parent or the nurse, and this should be insisted upon, and when we have made a silver nitrate treatment we must expect to have the child brought to us and examine these teeth from time to time and see that decay has not again started and is making inroads. We may, if decay is again starting up in some part of a surface that has been treated in this way, treat it again and stop it again, and again, if necessary.

There are some objections to this method of treatment. The first objection is that it makes the cut surfaces of the teeth very black, and often the line will show through the enamel and give it a very bad appearance. This adds to the disfigurement caused by the necessary cutting. For this reason, it is a very objectionable practice from the esthetic standpoint, and yet, with all of its objections, it is often the best we can do. Parents will object to the discoloration of the teeth in many cases. Yet, if the child is very sensitive, we can scarcely do better than to use this method. The teeth can be made to look very much better by other methods of treatment, however, methods that will be more painful to the child.

WE MAY ENCAVATE THE CAVITIES AND FILL WITH CEMENT, HALL'S STRENGTH, OR WAX PLATE ORTHO-PASTE. Where we can succeed in making the necessary excavation, this should be preferred, but to fill with these materials at all successfully, we must excavate the cavities quite thoroughly. In filling these little teeth with cement, I should not insist upon extensions of the cavity — extensions for prevention — but should simply remove the decay, cutting away the overhanging margins of enamel and making the filling without any considerable effort at extension. Unfortunately, the cements are not reliable and in many cases they will wash out from these little teeth very quickly; in some other cases again, they seem to stand quite well. Sometimes cement fillings, put in early, stand until the teeth are shed. But whenever fillings of this class are used, the child should be seen frequently and the fillings repaired if they wash away, or are found to be very loose from shrinkage. Extensions of decay beside the filling will also require treatment. We need to watch these teeth much closer than we watch the teeth of older persons, for changes occur rapidly; the predisposition to decay is often very severe, so that the

teeth decay very quickly indeed, and, unless we keep a very close watch of them, we will find that they have decayed badly in the interim. In this connection, it is especially unfortunate that our cements are so unreliable. A cement that we may use this week and find afterward that it is doing good service, may not be good next month. These changes that occur in the cements are very vexatious. No means has yet been devised by which they can be prevented, but very earnest search is being made. Of course, wherever we can, a gold filling is the right thing to make, but the cases where we can make gold fillings successfully in the teeth of little children are very few. It should be undertaken only when we have the most positive assurance that a really good filling can be made. Also, we must be especially careful to preserve the courage of the children.

GIC

THE TREATMENT OF DECAY IN THE OCCLUSAL SURFACES OF INCISORS AND Molars

In these we should not care particularly for the color, and we may use any of the filling materials without the color objection that pertains in the incisors. If we obtain control of the child before the decay is large, we may break near the enamel from about the cavity, open it as widely as possible, and then use silver nitrate, not, in this case, entirely for the purpose of stopping decay, but for the purpose of relieving the sensitive pain. For this purpose it should be used in almost precisely the same manner that we would for the stopping of the carious process in shallow cavities. After the action of the silver nitrate for a week or ten days, having applied it two or three times, we will generally find that the sensitiveness has been relieved, and then we may cut out the decay and make a filling. In the meantime, especial care should be taken in washing the cavities clean after eating and keeping them so that they will be washed freely with the fluids of the mouth. The difficulty with these decays in the occlusal surfaces is that, unless we can open them very wide, they will fill up with food, which will ferment and the decay will again progress, notwithstanding the treatment with silver nitrate. Therefore, this treatment should be mainly for the purpose of obviating the sensitiveness in order that we may excavate and make a filling. In this, we are running the risk of considerable discoloration of the dentin that will show through the enamel. We will not always succeed well with this process; sometimes the sensitiveness will remain and hinder us from making a sufficient excavation, but the case will be the

AG  
CJ

W.C.

better for the use of the silver nitrate in the limiting of the decay that will occur, even if we do not entirely succeed. We may repeat this again and again, if the cavity is not so large as to encroach too near the pulp of the tooth. When these have been excavated, they may be filled readily with amalgam, or with gold in some cases. When a case can be handled sufficiently well to fill with gold, one should not use silver nitrate and have the tooth blackened about the margins of the filling, but should excavate and fill the cavity just the same as for an adult. There is no difference whatever in the operation except that we have the child to deal with. Taking it all in all, amalgam seems to be the best material for filling this class of cavities, though oxyphosphate of copper cement is often doing excellent service.

#### TREATMENT OF DECAYS IN THE PROXIMAL SURFACES OF DECIDUOUS MOLAR TEETH.

These are difficult in the extreme to handle. The deciduous molars are larger than the incisors which come in their place, and they are in many cases considerably crowded when the permanent incisor teeth come through. The deciduous cuspid tooth is also smaller than the tooth which will replace it. If we cut the proximal surfaces of the deciduous molars, they usually fall together very quickly, consequently we are, in a measure, deterred from that method of handling proximal cavities in them; and yet not entirely, for, if we can treat these cavities when they are small, we may, by a different method, cut them out without separating the teeth so far as to be in trouble from their dropping together. Generally we will find these decays beginning pretty close to the occlusal portion of the surface, or near the marginal ridge, and the form of the crown is such that if we slope the cut well to the linguo-gingival, i. e., slope our cutting toward the gingival on the lingual, we may cut away considerably without entirely destroying the contact of these teeth, or, if we destroy the contact, leave enough of enamel upon the proximal surface toward the buccal so that it will come against the enamel of the next tooth, making a new contact that will be good and sufficient. The occlusal surfaces of the deciduous teeth are represented somewhat enlarged in Figure 183. In Figure 184 they are represented as the proximal surfaces should be cut in the treatment. Generally decay has occurred in the mesio-buccal corner of the occlusal third of the mesial surface. We may make a cut in this way, sloping linguo-gingivally, and leave a portion near the buccal angle of the surface to make a new contact. 183

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# OTHER ISSUES

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**7. Request for Approval to become a Board Approved Provider for Expanded Practice Permit.**

ORS 680.200 (1)(ii) Expanded Practice permit; requirements.

(1) Upon application accompanied by the fee established by the Oregon Board of Dentistry, the board shall grant a permit to practice as an expanded practice dental hygienist to an applicant who:

- (a) Holds a valid, unrestricted Oregon dental hygiene license;
- (b) Presents proof of current professional liability insurance coverage;
- (c) Presents documentation satisfactory to the board of successful completion of an emergency life support course for health professionals, including cardiopulmonary resuscitation, from an agency or educational institution approved by the board; and
- (d) Presents documentation satisfactory to the board that the applicant has:
  - (A)(i) Completed 2,500 hours of supervised dental hygiene practice; and
  - (ii) After licensure as a dental hygienist, completed 40 hours of courses, chosen by the applicant, in clinical dental hygiene or public health sponsored by continuing education providers approved by the board.**

Oregon Oral Health Coalition has submitted an Expanded Practice Dental Hygiene Continuing Education (CE) Provider Application (Attachment 1). Oregon Oral Health Coalition is requesting that the Board approve them as an EPP Provider.

Board Approved:

RECEIVED

FEB 27 2013

Oregon Board  
of Dentistry

Oregon Board of Dentistry  
1600 SW 4<sup>th</sup> Avenue, Suite 770  
Portland, OR 97201  
www.oregon.gov/dentistry  
(971) 673-3200

Expanded Practice Dental Hygiene  
Continuing Education (CE) Provider Application

Provider Name (name of individual or facility):

Oregon Oral Health Coalition

Business Phone No.:

971-224-1038

Mailing Address (street address, city, state, zip):

PO Box 3132, Wilsonville, OR 97070

Email or Web site (optional):

Philip.Giles@OCDC.net

Taxpayer ID Number:

30-0449673

Will Offer On-line Courses:

No  Yes

Organization Type (select one):

- Association  2 or 4 yr Institution of Higher Learning  Non-Profit Corporation  
 Licensed Health Facility  Other education organization Individual  Government Agency  
 Corporation  Other (please specify):

CE Coordinator Name:

Philip Giles

CE Coordinator Phone No.:

971-224-1038

Instructor's Education/Training (attach Instructor(s) resume or curriculum vitae (CV)):

Karen Hall, RDH, EPDH resume attached

CE Coordinator's Signature:

*Philip Giles*

Date:

2/26/13

***Karen M. Hall, RDH, EPDH***

1929 Westlake Loop  
Newberg, OR 97132

***Objectives-***

My goals and objectives are to continue to utilize my education and experiences to provide preventative and periodontal services to those with limited access to oral health care, to teach continuing education courses on increasing access to dental services and improving patient health outcomes, and to expand the role of mid-level dental providers to reduce access barriers.

***Education-***

BS in dental hygiene, OHSU 1985

***Licensure-***

Registered dental hygienist with Expanded Practice permit for the state of Oregon since 2007

***Experiences-***

I am currently employed by Virginia Garcia Memorial Health Center as an EPDH providing periodontal care to pregnant patients and preventative and periodontal care to students in Tigard and Forest Grove school-based health centers.

In addition, I am contracted by the Oregon Oral Health Coalition to present First Tooth training to medical and dental professionals throughout the state.

I am a regular volunteer, locally and abroad, for Medical Teams International, where I also served on the Mobile Dental Advisory board for several years.

Previous to my current employment, I worked for four years at OHSU in the hospital treating medically compromised adults. The first fifteen years of my dental hygiene career were in family practice dental offices in Oregon.

***References-*** available upon request



Preventing early childhood caries through medical and dental provider education and collaboration

# Module 1: The prevalence and impact of oral disease

## "FIRST TOOTH"

**Project goals:**

- Expand the oral health workforce in Oregon by utilizing medical and dental providers to deliver early childhood caries prevention services to at-risk children ages birth to three years.
- Train local oral health champions to be First Tooth trainers within communities, health care organizations and CCO's for sustainability beyond the grant funding.
- Facilitate collaborative referral relationships between dentists and primary medical care providers so that all Oregon children have a dental home.



## 1 Early childhood caries can lead to...

- Extreme pain
- Spread of infection and possible cellulitis
- Crooked bite (malocclusion)
- Extensive and costly dental treatment
- Inability to concentrate
- Impaired language development
- High risk of developing tooth decay in permanent teeth – chronic condition



Adapted from The American Academy of Pediatrics Oral Health Initiative Oral Health Risk Assessment Training for Pediatricians and Other Child Health Professionals

# 1 Current status of children's oral health

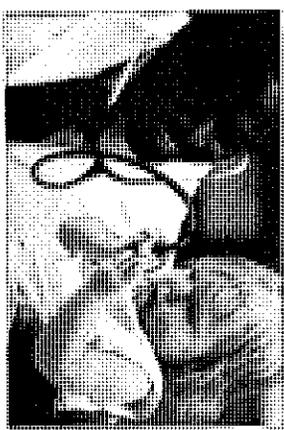
- According to the 2007 Oregon Smile Survey<sup>1</sup>...
  - 59.3% of 1<sup>st</sup> graders have or had a cavity
  - 35.3% of 1<sup>st</sup> graders have untreated tooth decay
  - Compared with neighboring states, Oregon has a higher rate (35%) of untreated decay among school children and is above the national average (29%)
- The Dental Care Health Professional Shortage Area (HPSA) is 55.6% in Oregon compared to 26.9% nationally<sup>2</sup>
- Children on the Oregon Health Plan have few options for accessing dental care in many counties.

Source<sup>1</sup> www.oregon.gov/OSDH/OralHealth/SmileSurvey\_2007.pdf  
 2 Downloaded from <http://www.dhs.gov>



# 1 Why providers of pediatric patients?

- They have frequent contact with infants and children.
- They can help prevent or reduce the risk of tooth decay.
- They can provide appropriate referrals to a dentist for early intervention and/or treatment.



# 1 AAP dental home policy statement

- Every child should begin to receive oral health risk assessments by 6 months of age from a pediatrician or qualified pediatric health care professional.
- Infants identified as having significant risk of caries should be entered into an aggressive anticipatory guidance and intervention program provided by a dentist between 6 and 12 months of age.
- Pediatricians should support the establishment of a dental home for all children between 6 and 12 months of age.

See Resource binder: AAP Dental Home Policy Statement

Source: Heik, K, Wada, P, Carrapata, C, Keech, M, Jure, T & Wicks, M. (2003). American Academy of Pediatrics Policy Statement: Oral Health Risk Assessment, Timing and Establishment of the Dental Home. Pediatrics; 111(5):1419 to 1421



# 1 Medical providers/dental providers

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li>• Medical providers</li> <li>• Assess</li> <li>• Screen</li> <li>• Educate</li> <li>• Intervene</li> <li>• Refer</li> </ul> | <ul style="list-style-type: none"> <li>• Dental providers</li> <li>• Assess</li> <li>• Screen/Examine</li> <li>• Educate</li> <li>• Intervene</li> <li>• Refer</li> </ul> |
|--|---|



# Module 2: Risk assessment

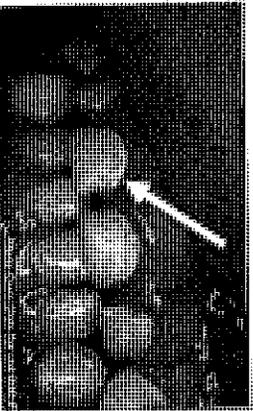
## 2 First clinical signs of caries

First clinical signs of caries

- White spots
- Acids have demineralized enamel
- First appear at gumline of upper front teeth
- High risk for developing cavities

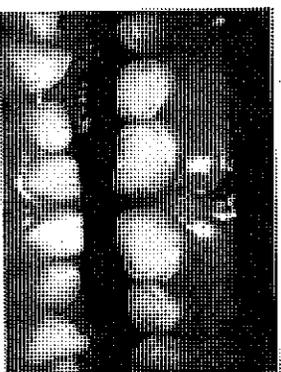
White spots can be remineralized with early intervention

- Fluoride
- Behavior modification: improved brushing & dietary habits
- Indication for dental referral

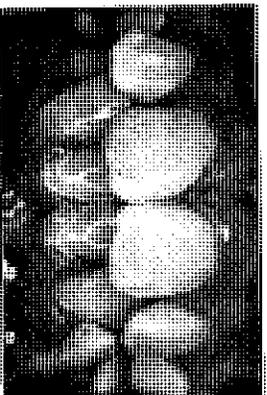


## 2 Defining early childhood caries

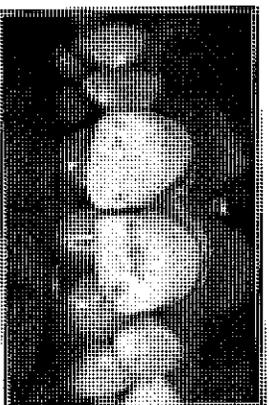
- Process of demineralization to cavities in primary dentition
- Lesions can progress rapidly
- Affects teeth least protected by saliva
- Often associated with bottle or sippy cup use throughout the day or at night



## Example of fluorosis



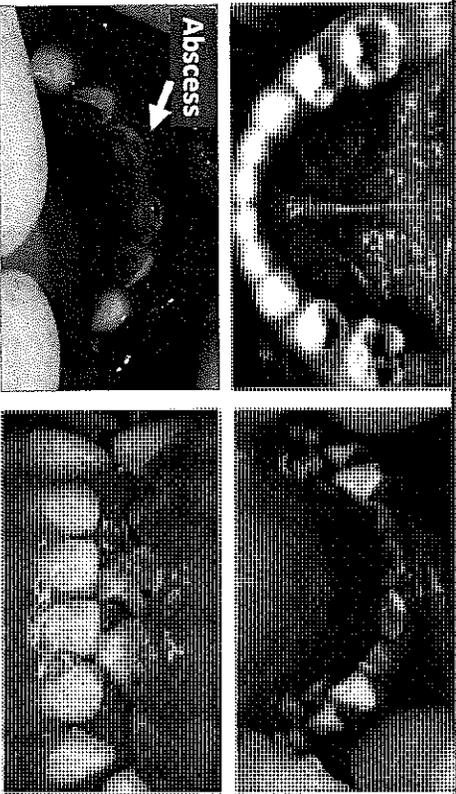
Mild Fluorosis



Severe Fluorosis



## 2 Severe caries



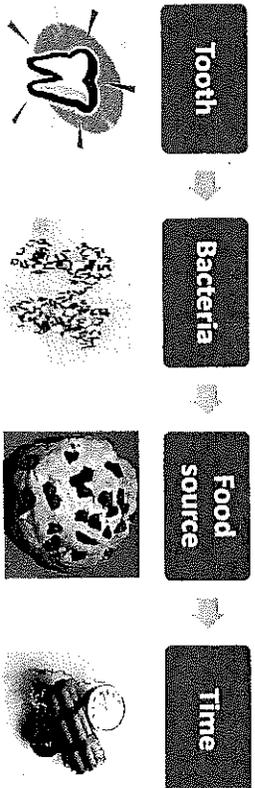
See AAP Flip Chart and Office Pocket Guide

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## 2 Caries process

Requires 4 factors



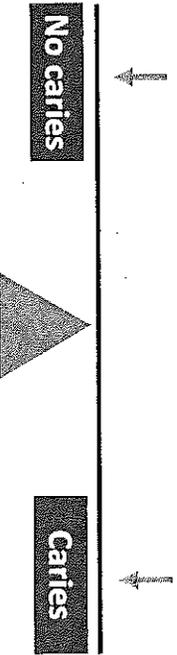
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## 2 Caries process: ongoing balance

**Protective Factors**  
Strength of enamel  
-Fluoride  
Adequate salivary flow

**Pathologic Factors**  
Strep mutans  
Carbohydrates  
Reduced salivary flow

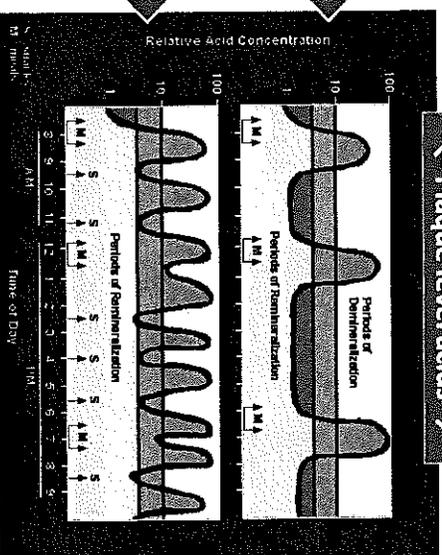


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## 2 Caries process and diet

← Plaque level acids →

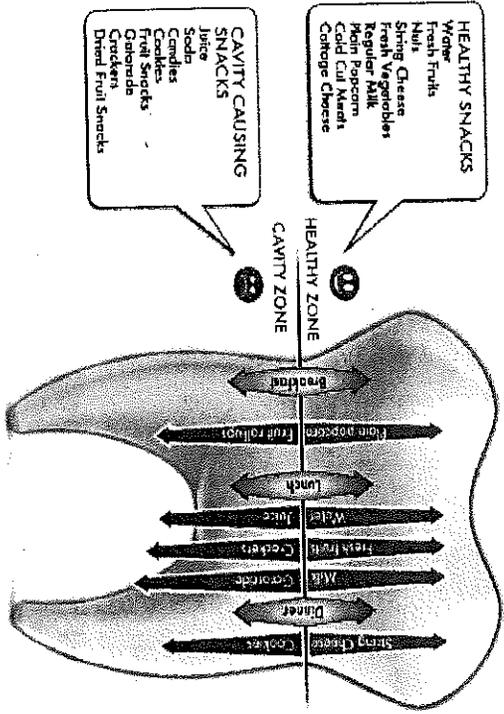


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# GIVE YOUR TEETH A CHANCE

Snack Smart



UNIVERSITY of WASHINGTON

## 2 Why is risk assessment important?

- Risk status determines:
  - Age of first dental visit – as early as when the first tooth erupts
  - Use of fluoride – fluoride varnish is not indicated in children at low risk of caries under the age of 3
  - Extent of nutritional and hygiene counseling

## 2 Caries process and transmission



- Bacteria established by age 2
- Natural process occurs through normal activities
- Encourage regular dental care for pregnant women and mothers of infants

See Handout : Oral Health During Pregnancy



## 2 Who is most at risk?

### Children at high risk for early childhood caries

- Caries Risk Indicators**
- Children on Medicaid (low socioeconomic group)
  - Children who have visible plaque, white spot lesions or previous caries
  - Children whose mother/primary caregiver has caries or has siblings who have caries
  - Premature or low birth weight children
  - Children with special health care needs
  - Children with poor dietary and feeding habits

See AAP Flip Chart



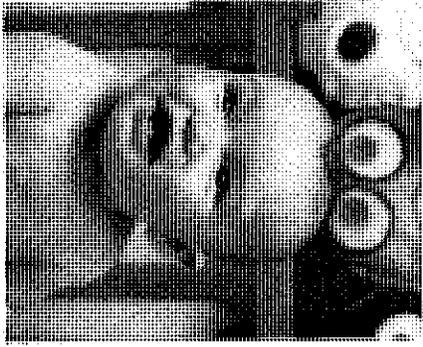
## 2 Be conscientious of cultural diversity

- Increased rate of dental caries in certain ethnic groups.
- Beliefs about health, disease, diet and hygiene in different cultures may impact practices and child-rearing habits.



## 3 Healthy primary teeth are important

- For normal development
- For space maintainers
- For cavity-free permanent teeth
- For keeping treatment costs low



First Dental Visit	Ave. 5 Year Cost
Before age 1	\$263
After age 1	\$447

Early preventive dental visits: effect on subsequent utilization and costs. Pediatrics 2004;114:418-423

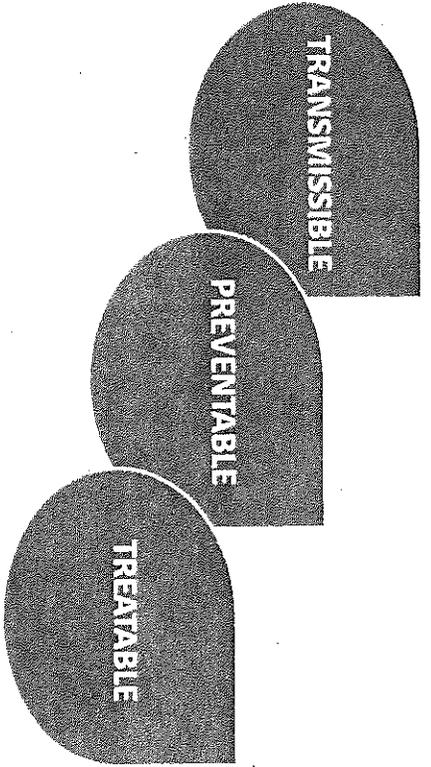


### Module 3:

Oral health education and anticipatory guidance for parents/caregivers

## 3 Anticipatory guidance

Early childhood caries is:



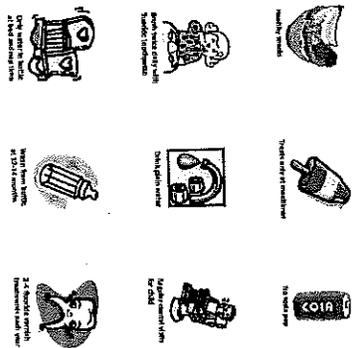
### 3 Motivational Interviewing (MI)

- Goal of MI is to establish rapport with the parent/caregivers and then discuss a “menu of options” for infant oral health and carries preventive behavior.
- MI focuses on techniques such as:
  - Open-ended questioning
  - Affirmations
  - Reinforcement of self-efficacy
  - Reflective listening
  - Summarizing

See Explore-Offer-Explore



### 3 MI menu of options



On a scale of 1-10, how confident are you that you can accomplish this goal?  
1 2 3 4 5 6 7 8 9 10

See Motivational Interviewing Tool



### 3 Anticipatory Guidance/education

**Toddlers**  
2-3 years old

**Babies**  
A beautiful, strong, healthy, smiling baby is the goal. But a beautiful, strong, healthy, smiling baby is also a baby who is happy, healthy, and safe. This is the goal for every parent. The AAP recommends that you start brushing your baby's teeth as soon as they have their first tooth. Use a soft-bristled toothbrush and a smear of fluoride toothpaste.

**Pregnancy**  
During pregnancy, your body goes through many changes. Your teeth are no exception. Hormonal changes can make your gums more sensitive and prone to bleeding. This is called gingivitis. To keep your gums healthy, brush and floss regularly, and see your dentist for a checkup.

**Toothpaste tips**  
How much should my family use?

Smear  
1/2 pea size  
age 2

Half  
1 pea size  
age 3

Pea  
1 pea size  
age 6

**Toothbrush tips**  
Choose the right size tool for the job!

Toothbrushes come designed and sized for every age.

- Choose the right toothbrush for your child's age.
- Choose a soft bristled toothbrush.
- Replace a toothbrush when the bristles are worn or every 2-3 months.

Time for a new toothbrush!

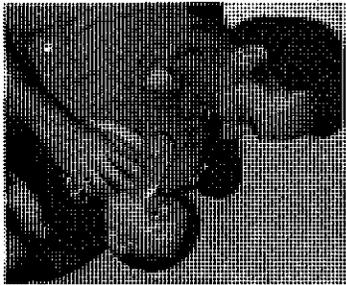
### 3 Use diverse formats for delivering oral health education

- DVDs
- AAP flip chart
- Pocket guide
- Posters
- Handouts
- Puppets or plastic models



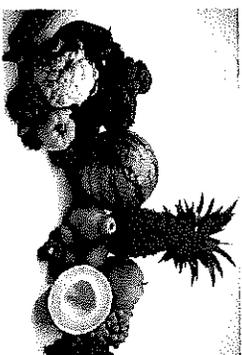
### 3 Diet and feeding: 0-12 months

- Breastfeeding does not increase the risk for caries
- Hold infant for bottle and breastfeedings
- No bottles at bedtime/nap (or use water only)
- Introduce cup at 6 months, wean bottle at 12-18 months
- Avoid constant use of sippy cup, pacifier
- Introduce appropriate snacks
- Encourage rinsing the mouth out with water



### 3 Diet and feeding: toddlers

- 1-2 years
- Discontinue bottle feeding at 12-18 months
- Avoid excess juice
- Avoid sweet, sticky snacks – dried fruit, crackers, candy
- Reserve soda, candy and sweets for “special occasion” treats
- 2 and older
- Choose fresh fruits, vegetables, or whole grain snacks



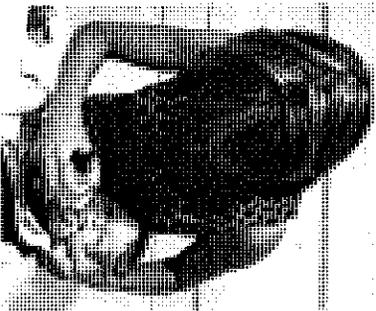
Good preventive medicine for obesity too!



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### 3 Oral hygiene

- < 1 year
  - Clean mouth with cloth or soft toothbrush
  - As teeth erupt, use smear of toothpaste 2x/day\*
- 1-6 years
  - Brush 2X/day using half-pea-sized amount of fluoridated toothpaste
  - Parent/caregiver performs and supervises
- > Age 6 years
  - Brush 2X/day with pea-sized amount of fluoridated toothpaste



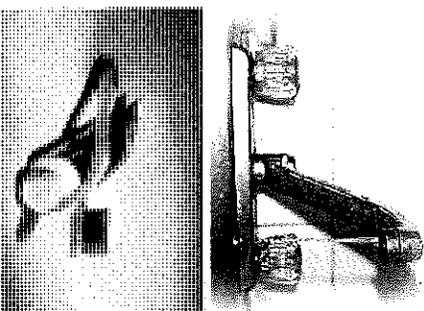
\*It is recommended by ASTDD, AAPD and AAP that children at high risk for caries use fluoridated toothpaste when the first tooth erupts.



See Recommendations for Fluoride Usage

### 3 Sources of fluoride

- Systemic
  - Water fluoridation
  - Fluoride supplements
  - Fluoridated bottled water
- Topical
  - Fluoride toothpastes
  - Fluoride varnish
  - Water fluoridation
  - Fluoridated bottled water
  - Fluoride supplements
  - Fluoride rinses
  - Gels, foams



Adapted from the Washington Dental Service Foundation



### 3 Fluoridated water

How much fluoride is in my patient's drinking water?

- To learn how much fluoride is in a community water system, link to the Centers for Disease Control's "My Water's Fluoride" at: <http://apps.nccdc.cdc.gov/MWF/Index.asp>



### 3 Fluoride supplementation

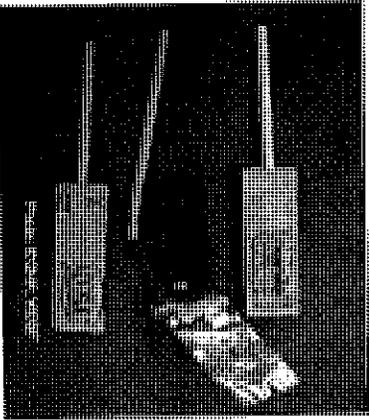
ADA, AAPD, AAP and CDC recommendations

Age	<0.3 ppm	0.3-0.6 ppm	>0.6 ppm
0-6 mo	None	None	None
6 mo-3 y	0.25 mg/d	None	None
3-6 y	0.50 mg/d	0.25 mg/d	None
6-16 y	1.0 mg/d	0.50 mg/d	None

<http://apps.nccdc.cdc.gov/MWF/Index.asp>



### 3 Fluoride varnish



- Effective**
  - 30% - 69% decrease in caries
- Safe**
  - No preservatives, BPA, dyes
  - No evidence-based contraindications
- Easy**
  - Takes 30 seconds to apply

Use of fluoride varnish for caries prevention has been endorsed by the ADA, but reminds on "off-label" use of the product, because it is not cleared for marketing by FDA for this purpose.



### 3 Treatable

- Success in treating caries is dependent upon parents/caregivers taking an active role in their child's oral health.
- Intervention with fluoride varnish can reverse early stages of caries.
- Early access to a dental home with regular maintenance schedule is important.



## Module 4: Implementation and workflow

### 4 What to look for

- Lift the lip to inspect soft tissue and teeth
- Eruption sequence
  - Summarized in the AAP flip chart
- Assess oral hygiene
  - Presence of plaque
  - Presence of white spots or dental decay
  - Signs of abscesses in the gums
- Provide education on brushing and diet during examination
- Apply fluoride varnish

See AAP Flip Chart and Office Pocket Guide

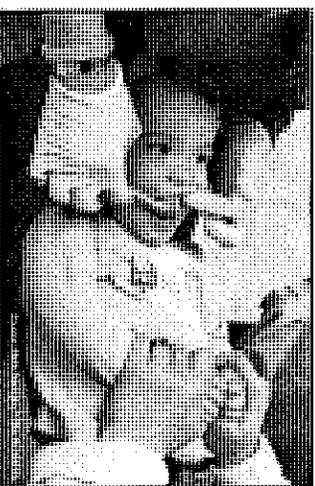
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### 4 The early oral screening

Your oral exam of the child may take no more than 1 minute: Knee-to-Knee, Lift the Lip

Start ← 1 minute → Finish



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4

## Fluoride Varnish

### Video



4

## Fluoride varnish application

1. Have supplies ready
2. Position the child
  - Knee-to-knee
  - Table top exam
  - Toothbrush often prompts opening!
  - Lift the lip
  - Quick visual inspection



See Handout: Fluoride Varnish Application

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4

## Fluoride varnish application

Dry teeth with cotton gauze



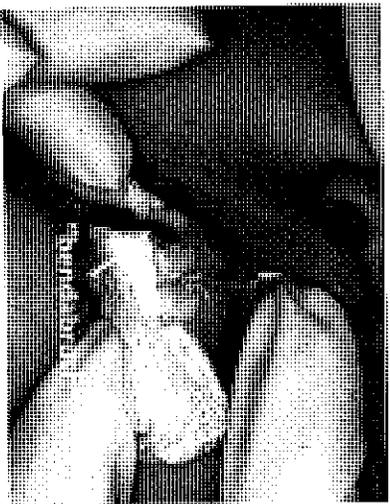
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4

## Fluoride varnish application

Apply fluoride to all surfaces with applicator



See AAP Flip Chart

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4

## Post varnish instructions

- Child may take a drink of water immediately
- No brushing until the next day
- Can skip fluoride supplement for the day
- Ok to drink as usual
- Avoid hard, crunchy and sticky foods the rest of the day
- Advise caregiver teeth *may* be yellow for a day (based on varnish)
- Repeat every 3 months for children at high risk for caries

See Parent Handout: What you need to know about fluoride varnish

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## 4 ITR- Interim Therapeutic Restorations

### Interim Therapeutic Restoration Policy Statement

- ITR is a beneficial technique in contemporary pediatric dentistry.
- ITR may be used to restore and prevent caries in young patients, uncooperative patients, patients with special needs, and in situations in which traditional cavity preparations and restorations are not feasible.
- ITR is often effective in helping children be less fearful because it can defer definitive treatment until the child matures or primary teeth are exfoliated.

See Resource binder: AAPD Policy on ITR



## 4 ITR- Interim Therapeutic Restorations

- No anesthetic needed!
- Bonds with the tooth to seal margins and releases fluoride into adjacent tooth structure.
- Monitor patient closely with 3-6 month exams and fluoride varnish.
- Explain temporary nature of material to parent.
- D2940 is proper code for ITR, unless it is limited to the enamel, which would be coded as D1351.

See Resource binder: Triage placement



## 4 Behavior Management

### Tips for managing child behavior – in office

- Utilize your staff who have good rapport with 0-3 year olds.
- Engage the parent during the exam.
- Recognize that the child will most likely cry the first few appointments.
- Utilize knee-to-knee technique or have child in parent's lap or chest while reclined in the dental chair.
- Explain to the parent what you are looking for in the mouth.
- Positive reinforcement – for child and parent.

See Resource binder: Guideline on Behavior Guidance



## 4 Documenting oral health services and findings

- Exam forms
- Electronic medical records
- Chart labels/stickers
- Smartphrases

Oral Health Assessment—Birth to 3 Years of Age	
Maternal/giver's oral health	Existing dental home? Yes No
<input type="checkbox"/> Caries	<input type="checkbox"/> Shining
<input type="checkbox"/> Plaque	<input type="checkbox"/> Demineralization
<input type="checkbox"/> Night feeding	<input type="checkbox"/> Frequent snacking/juice intake (except cup)
<input type="checkbox"/> Special needs	<input type="checkbox"/> SSS
Does mother have a dentist?	
Yes	No
Outcome	Education
	Fluoride
	Referral
	Completed

© 2009 AAP Oral Health Initiative

See Resource binder: chart label template



RCHORAL ORAL HEALTH ASSESSMENT RCHFL

Caregiver

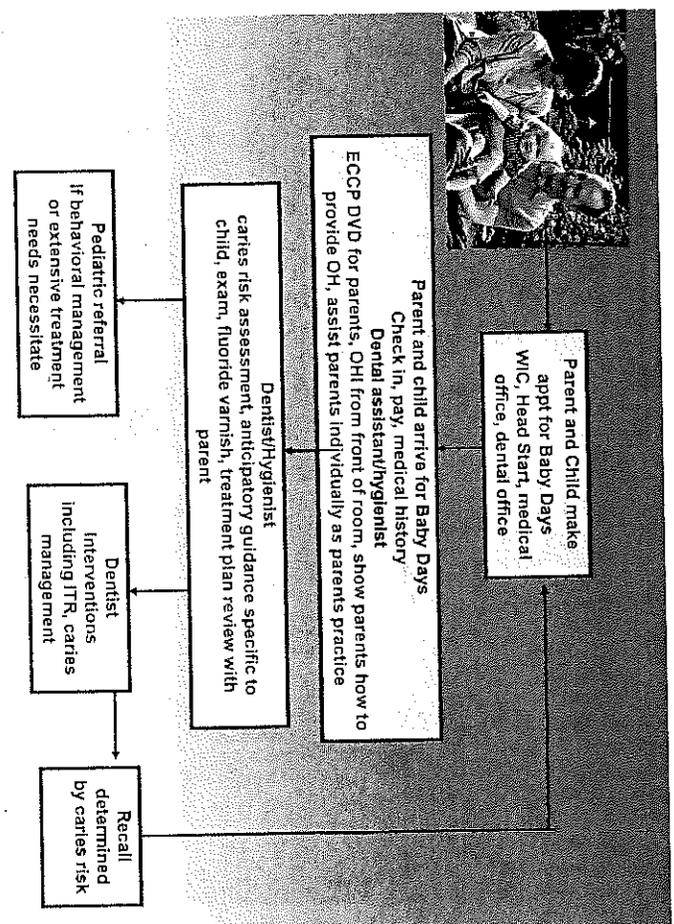
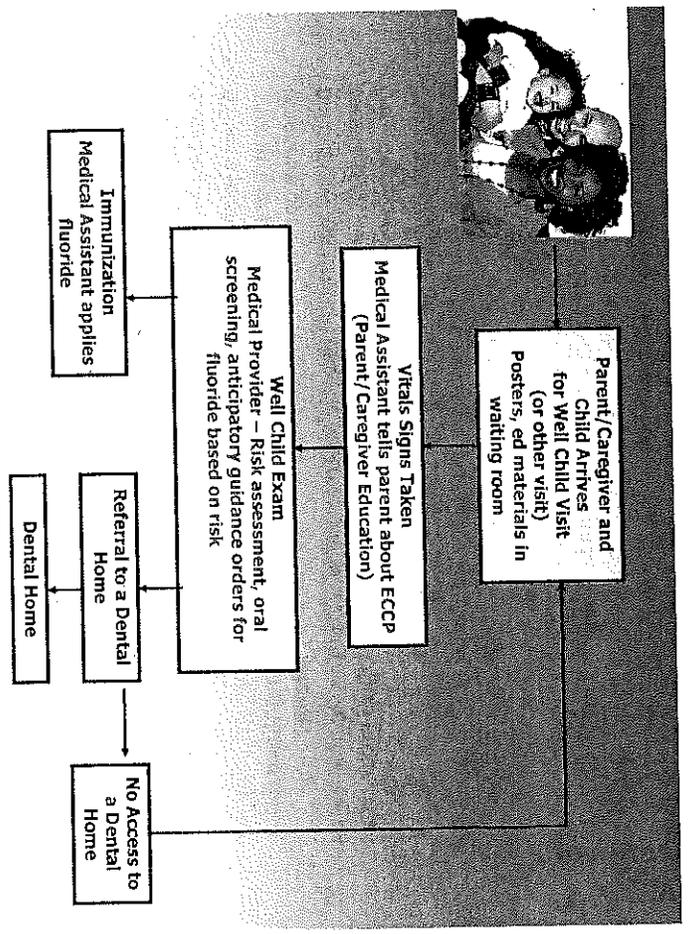
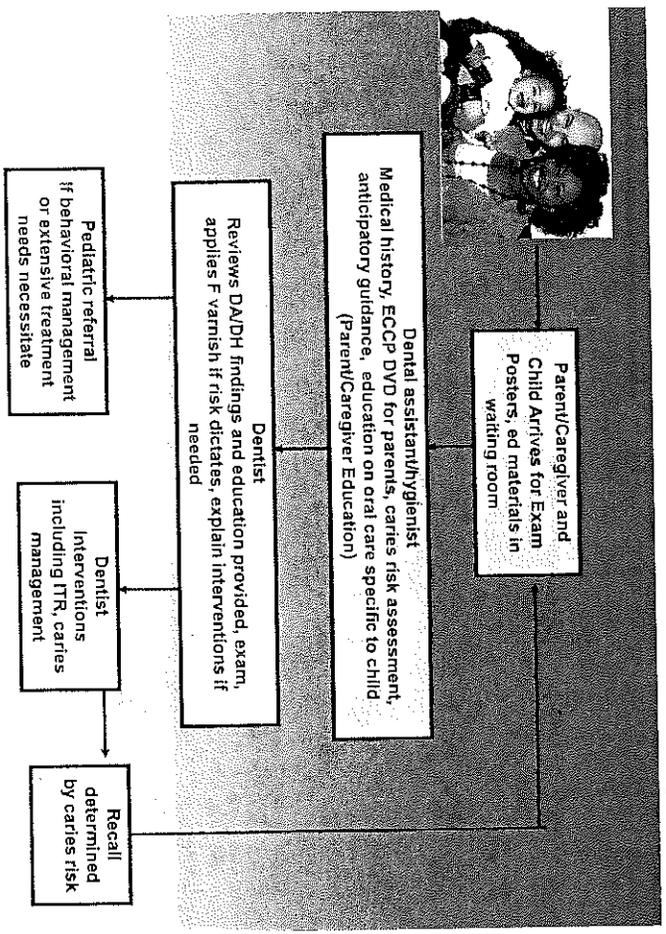
- Does mother/caregiver have a history of caries? {YES/NO:63}
- Does mother/caregiver have a dentist? {YES/NO:63}

Child

- Existing dental home? {YES/NO:63}
- Frequent snacking/juice intake? {YES/NO:63}
- SES? {LOW/MED/HIGH:10045}

Fluoride

- Supplement? {YES/NO:63}
- Varnish indicated? {YES/NO:63}
- Applied? {YES/NO:63}



## 4 Baby Days



Used with permission by the Virginia Garcia Memorial Health Center



## 4 Baby Days



Used with permission by the Virginia Garcia Memorial Health Center



## 4 Fluoride varnish reimbursement

- Oregon Health Plan (OHP)-enrolled children (under 19 years of age) may have fluoride applied twice every 12 months:
  - Additional topical fluoride treatments may be available, up to a total of 4 treatments per child within a 12-month period, when high-risk conditions or oral health factors are clearly documented in chart notes.
- Private third party payers have their own rules about reimbursing for fluoride varnish. Their current general practice is not to reimburse medical providers for applying fluoride varnish. Please check with your provider representative for specific policy information.

See Resource binder: Topical Fluoride Varnish OHP Reimbursement



## 4 OHP reimbursement for medical providers

- Children under 7 years of age, may have topical fluoride varnish applied by a medical provider during a medical visit.
- Bill on a professional claim (CMS-1500 or electronic equivalent) using the appropriate procedure code (D1206 – Topical fluoride varnish) and ICD-9 Diagnosis code V07.31 (Prophylactic fluoride administration).
- Bill the Division (DMAP) directly regardless of whether the client is fee-for-service (FFS,) enrolled in a Fully Capitated Health Plan (FCHP) or Physician Care Organization (PCO).
- Topical Fluoride Varnish applied in a medical setting of a Federally Qualified Health Center/Rural Health Center/Indian Health Center is inclusive of the office visit or well-child check and is not reimbursable as a stand-alone service.
- In Oregon, an oral screening by a medical provider is not a separate billable service and is included in the office visit. The Oral Health Program is currently discussing reimbursement to medical providers by the commercial payers and self-insured organizations.



# 4

## Billing and reimbursement - dental

ECC Billing Codes for most insurance companies

- D0145 Exam (under age 3) - Up to 2X/ Yr
- D1206 Fluoride Varnish - 2X/Yr, with up to 4X/Yr with documentation of high risk for caries
- D1330 OHI - bundled with Exam Code
- D1310 Nutritional Counseling - bundled with Exam Code



# 4

## OHP eligibility

- Providers can check OHP client eligibility and managed care enrollment by using the following methods:
  - Provider Web Portal located on the Web at <https://www.or-medicaid.gov/ProdPortal/default.aspx>;
  - Automated Voice Response (AVR) at 866-692-3864 (toll-free); or 270/271 Electronic Data Interchange Batch Transactions

Additional information on eligibility verification can be found at:  
[http://www.oregon.gov/DHS/healthplan/tools\\_prov/electronverify.shtml](http://www.oregon.gov/DHS/healthplan/tools_prov/electronverify.shtml)



# 4

## Billing and reimbursement

Billable Procedures: Oregon Health Plan (OHP)

Code	Diagnostic Code	Description	Maximum Allowable Fee	Limitations
D1206	V07.31	Topical Fluoride Varnish (Prophylactic fluoride administration)	\$13.65*	Up to 2 times in a 12-month period. Additional treatments are available, up to 4 times for high-risk children.

\*Topical Fluoride Varnish applied in a medical setting of a Federally Qualified Health Center/Rural Health Center/Indian Health Center is not reimbursable as a stand-alone service



# 4

## Local resources and collaboration

- Assign a dental referral coordinator to streamline referrals.
- Keep in contact with referral sources to establish good working relationships and to maintain an accurate referral list.
- <http://www.oregon.gov/oha/healthplan/pages/managed-care/plans.aspx#choose>
- Utilize the DCO 101 document to help the patient access the resources available.

See Resource binder: DCO-OHP 101 and OHP Client Brochure



## 4 Ready, Set, Implement!!!

- Determine who will deliver the services.
- Decide when the services will be delivered.
- Identify an oral health champion.
- Create a plan for fluoride varnish and materials.
- Decide who will coordinate dental referrals.
- Establish process for chart documentation.
- Create process for eligibility and billing.

 See Resource binder: Ready, Set, Implement

Adapted from the Washington Dental Service Foundation



## 4 It can be done!

- ECC prevention services can be incorporated into the medical well-child visit, immunization schedule or when the child comes in for treatment of illness.
- Integrating the young patient into the dental office is important to increase access to ECC prevention and treatment.
- Utilize staff creatively to provide ECC prevention services.
- DVDs, posters and brochures can increase awareness of oral health and decrease the amount of time ECC prevention services occupy during the visit.



## "First Tooth" Training and Technical Assistance Contacts

**Karen Hall, RDH EPPH**

First Tooth trainer/technical assistance

khall@vghmc.org

or

**Philip Giles**

First Tooth Coordinator

Philip.Giles@OCDC.net

971-224-3018

You can also access our website for materials and online training

**First Tooth Website**

[www.healthoregon.org/firsttooth](http://www.healthoregon.org/firsttooth)



## Questions?



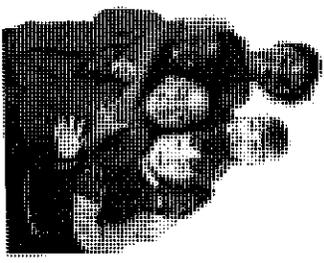
 Please fill out the training feedback form





# Thank you!

- Oregon Oral Health Coalition's Early Childhood Caries Prevention Committee
- "First Tooth" Advisory Group
- Virginia Garcia Memorial Health Center
- Washington Dental Service Foundation
- American Academy of Pediatrics



www.kidsofcolorado.org  
www.kidsofcolorado.org



**7. Request for Approval to become a Board Approved Provider for Expanded Practice Permit.**

ORS 680.200 (1)(ii) Expanded Practice permit; requirements.

(1) Upon application accompanied by the fee established by the Oregon Board of Dentistry, the board shall grant a permit to practice as an expanded practice dental hygienist to an applicant who:

- (a) Holds a valid, unrestricted Oregon dental hygiene license;
- (b) Presents proof of current professional liability insurance coverage;
- (c) Presents documentation satisfactory to the board of successful completion of an emergency life support course for health professionals, including cardiopulmonary resuscitation, from an agency or educational institution approved by the board; and
- (d) Presents documentation satisfactory to the board that the applicant has:
  - (A)(i) Completed 2,500 hours of supervised dental hygiene practice; and
  - (ii) After licensure as a dental hygienist, completed 40 hours of courses, chosen by the applicant, in clinical dental hygiene or public health sponsored by continuing education providers approved by the board.**

Pacific University Continuing Education Department has submitted an Expanded Practice Dental Hygiene Continuing Education (CE) Provider Application (Attachment 1). Pacific University Continuing Education Department is requesting that the Board approve them as an EPP Provider.

Board Approved:

RECEIVED

FEB 25 2013

Oregon Board  
of Dentistry

Oregon Board of Dentistry  
1600 SW 4<sup>th</sup> Avenue, Suite 770  
Portland, OR 97201  
www.oregon.gov/dentistry  
(971) 673-3200

Expanded Practice Dental Hygiene  
Continuing Education (CE) Provider Application

Provider Name (name of individual or facility):

Pacific University

Business Phone No.:

503-352-2663

Mailing Address (street address, city, state, zip):

222 SE 8<sup>th</sup> Avenue #513  
Hillsboro OR 97123

Email or Web site (optional):

www.pacificu.edu/chp/continuingeducation/index.cfm  
lisa.downing@pacificu.edu

Taxpayer ID Number:

93-0386892

Will Offer On-line Courses:

No  Yes

Organization Type (select one):

Association

2 or 4 yr Institution of Higher Learning

Non-Profit Corporation

Licensed Health Facility

Other education organization Individual

Government Agency

Corporation

Other (please specify):

CE Coordinator Name:

Lisa Downing

CE Coordinator Phone No.:

503-352-2663

Instructor's Education/Training (attach Instructor(s) resume or curriculum vitae (CV)):

All continuing education courses past, present and future.  
Course offerings and instructor information available upon  
request.

Please see attached single flyer.

CE Coordinator's Signature:

Lisa Downing

Date:

2/21/13

**COURSE | ADVANCED ULTRASONIC SCALING**

June 14, 2013 – 9:00am to 4:00pm 6 hours CE (3 lecture, 3 lab)

**Shawna Rohner, RDH, MS** will explain the latest evidence-based research on the use of ultrasonics in the management of nonsurgical periodontal therapy and give clinicians guidelines, tips and hands-on practice in the use of ultrasonic instrumentation. Review of instrumentation techniques using several types of tips will be covered extensively. Information regarding ultrasonic technology, safety issues, clinical practice and maintenance of ultrasonic units included.

Session Fee: \$300, includes lunch. Course limited to 32 attendees.

**COURSE | REVIEW OF NITROUS OXIDE/OXYGEN (N<sub>2</sub>O/O<sub>2</sub>) SEDATION: TECHNIQUES FOR SAFE AND EFFECTIVE ADMINISTRATION**

June 28, 2013 – 9:00am to 4:00pm, 6 hours CE (3 lecture, 3 lab)

**Gail Aarnodt, RDH, MS & Kathryn Bell, RDH, MS** designed this course as a review of administration techniques for N<sub>2</sub>O/O<sub>2</sub> sedation. Course topics will include mechanism of action, contraindications for use, and administration techniques for achieving safe and effective sedation. Recovery from sedation and appropriate documentation will also be reviewed. The morning will be presented in a lecture format and the afternoon will provide an opportunity to practice administration of N<sub>2</sub>O/O<sub>2</sub> sedation in a supervised clinical setting.

Session Fee: \$ 300, includes lunch.

**COURSE | LOCAL ANESTHESIA DELIVERY TECHNIQUES: COMMON ERRORS & BEST USE PROTOCOLS**

July 12, 2013 9:00am to 4:00pm, 6 hours CE (3 lecture, 3 lab)

**Gail Aarnodt, RDH, MS & Kathryn Bell, RDH, MS** will lead this review of local anesthetic injection techniques for dental and dental hygiene professionals. Common errors and best use protocols will be covered for each of the most common injections. In addition, advanced injection alternatives will be presented. The morning will be presented in a lecture format and the afternoon will provide an opportunity to practice the techniques in the clinical setting.

Session Fee: \$300, includes lunch.

**Questions:** [lisa.downing@pacificu.edu](mailto:lisa.downing@pacificu.edu)

**COURSE | DIGITAL RADIOGRAPHY**

July 26, 2013 9:00am to 12:00noon, 3 hours CE (1 lecture, 2 lab)

**Amy Coplen, RDH, MS** leads this session during which participants will learn how digital imaging works, as well as practical tips on placing digital sensors on patients. In addition, participants will have an opportunity to place digital images on manikins and partners trying several different XCP holders.

Session Fee: \$150. Course limited to 20 attendees.

**COURSE | REVIEW OF RADIOLOGY TECHNIQUES AND PATHOLOGY**

July 26, 2013 1:00pm to 4:00pm, 3 hours lecture CE

**Amy Coplen, RDH, MS** guides this session during which participants will learn ways to eliminate common radiographic errors. They will also review radiographic pathology including caries, bone loss, and cysts affecting the jaw. Participants will be given an opportunity to practice interpretation of radiographs through case studies.

Session Fee: \$150. Fee for Both sessions: \$300, includes lunch.

**REGISTRATION | Pay per course or series**

**For Credit Card payment: REGISTER ONLINE**

**To pay by check:**

Circle Session(s): Scaling Nitrous Local Digital Radiography Review of Radiology

Email: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone number: \_\_\_\_\_ Pacific Graduate? year: \_\_\_\_\_

Total Cost: \_\_\_\_\_

- Pacific Alumni – Pay \$275 for each full day course (discount of \$25)
- Make check payable to: Pacific University CHP CE
- Mail check and completed registration to:

Pacific University College of Health Professions  
Continuing Education  
222 SE 8th Ave, #573  
Hillsboro, OR 97123



**DENTAL HEALTH SCIENCES | 2013 SUMMER CE SERIES**

June 14 — Advanced Ultrasonic Scaling

June 28 — Nitrous Oxide/Oxygen Sedation

July 12 — Local Anesthesia

July 26 Morning Session — Digital Radiography

July 26 Afternoon Session — Review of Radiology Techniques and Pathology

**SPONSORS/EXHIBITORS:**

**BECOME AN SPONSOR OR EXHIBITOR**

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March 31, 2013

Oregon Board of Dentistry  
1600 SW 4<sup>th</sup> Ave. Suite 770  
Portland, OR 97201

Board Members:

I am submitting the attached course documentation for your consideration.

According to Administrative Rule 818-035-0040:

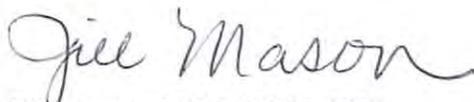
**Expanded Functions of Dental Hygienists**

(1) Upon completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association or other course of instruction approved by the Board, a dental hygienist who completes a Board approved application shall be issued an endorsement to administer local anesthetic agents under the general supervision of a licensed dentist.

For the past 25+ years, the attached course has been provided by the OHSU Continuing Education Department and has been approved based on its affiliation with OHSU, a CODA accredited institution. OHSU no longer wishes to include this course in its CE offerings, and as a result, has left no current alternatives for post-graduate dental hygienists to obtain this education locally.

I am requesting approval of this course, in order to provide an avenue for dental hygienists in Oregon to obtain their local anesthesia endorsement.

Sincerely,

A handwritten signature in cursive script that reads "Jill Mason".

Jill Mason, MPH, RDH, EPP  
Associate Professor  
OHSU School of Dentistry

**LOCAL ANESTHESIA CERTIFICATION COURSE**  
**COURSE DIRECTOR: Jill Mason, MPH, RDH, EPP**

**Recommended Texts:**

Malamed, SF. Handbook of Local Anesthesia, 6<sup>th</sup> Ed. 2013. Elsevier-Mosby:St. Louis, MO. ISBN:978-0-323-07413-1

Bassett, KB, DiMarco, AC, Naughton, DK. Local Anesthesia for Dental Professionals. 2010. Pearson:Upper Saddle River, NJ. ISBN-13:978-0-13-158930

**COURSE OBJECTIVE:**

Provide integrated basic science and clinical training in atraumatic local anesthesia techniques for dentistry.

**COURSE CONTENT:**

**SECTION I:**

- A. Review of Trigeminal Nerve Branches and Pathways:**
  - V<sub>2</sub> Division
  - V<sub>3</sub> Division
  
- B. Anatomical Considerations:**
  - Review of anatomical landmarks used for injection placement
  - Use of radiographs, palpation, and visual cues to identify landmarks

**SECTION II:**

- A. Armamentarium:**
  - Armamentarium required for the safe delivery of local anesthetics
  - Proper handling and sterilization of armamentarium
  
- B. Medico-legal Considerations and Risk Management:**
  - Malpractice Insurance
  - Documentation requirements
  - Appropriate chart entries
  - Dental Practice Act

### **SECTION III:**

#### **A. Local Anesthetics:**

- Actions and concentrations of commonly used anesthetics
- Biotransformation
- Factors that influence effectiveness of local anesthetic
- Maximum Recommended Dosage
- Proper dosage calculation
- Criteria for anesthetic selection (age, length of procedure, duration, potential for Post-op discomfort or self-mutilation)

#### **B. Vasoconstrictors:**

- Actions and concentrations of commonly used vasoconstrictors
- Maximum Recommended Dosage
- Proper dosage calculation

### **SECTION IV:**

#### **A. Pre-Anesthetic Patient Evaluation:**

- Medical history indications and absolute and relative contraindications to local anesthetics and vasoconstrictors
- Age
- Emotional state
- Blood pressure
- Systemic disease status (ASA)
- Physician consults
- Current medications
- Past history of reactions

#### **B. Systemic Reactions:**

- Managing and avoiding systemic reactions
- Relative overdose
- Allergy
- Syncope
- Drug interaction
- Cardiovascular effects
- Hyperventilation

#### **C. Local Reactions:**

- Managing and avoiding local reactions
- Trismus
- Hematoma

- Tissue sloughing
- Paresthesia
- Broken needle
- Post-op self mutilation

## **SECTION V:**

### **A. Clinical Technique and Practice:**

*Maxillary Injection Techniques for the following injections:  
PSA, MSA, ASA, IO, GP, NP*

- Nerve pathways
- Injection site and facial/oral landmarks
- Pathway of injections including anatomical structures in the area
- Depth of injections and type of needle
- Amount/type of solution and vasoconstrictor
- Nerves, soft and hard tissues anesthetized
- Percent positive aspiration
- Indications/contraindications

*Mandibular Injection Techniques for the following injections:  
IA, LB, G-G, Akinosi, M/I*

- Nerve pathways
- Injection site and facial/oral landmarks
- Pathway of injections including anatomical structures in the area
- Depth of injections and type of needle
- Amount/type of solution and vasoconstrictor
- Nerves, soft and hard tissues anesthetized
- Percent positive aspiration
- Indications/contraindications

*Supplemental Injection Techniques for the following injections:  
Papillary, Intraligamentary (PDL), AMSA*

- Nerve pathways
- Injection site and facial/oral landmarks
- Pathway of injections including anatomical structures in the area
- Depth of injections and type of needle
- Amount/type of solution and vasoconstrictor
- Nerves, soft and hard tissues anesthetized
- Percent positive aspiration

- Indications/contraindications

**B. Local Anesthesia for Specialties:**

*Pediatric Considerations:*

- Dosage
- Anatomy
- Behavioral management
- Post-op mutilation

*Endodontic Considerations:*

- Inflammation
- Surgery
- Hemostasis
- Duration

*Periodontic Considerations:*

- Duration
- Surgery
- Hemostasis
- Rebound bleeding

*Oral Surgery Considerations:*

- Duration
- Post-op comfort

*Prosthodontic Considerations:*

- Duration
- AMSA

**SECTION VI:**

***EXAMINATION***

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**NEWSLETTERS**  
**&**  
**ARTICLES OF**  
**INTEREST**

**Nothing to report under this tab**

# LICENSE RATIFICATION

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## **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**

H6432	KATIE K ARNESTAD, R.D.H.	2/13/2013
H6433	JOEL A RAY, R.D.H.	2/14/2013
H6434	ANDREA N WEBB, R.D.H.	2/14/2013
H6435	CECILIA F DONALDE, R.D.H.	2/14/2013
H6436	CHRISTINE N SCOTT, R.D.H.	2/14/2013
H6437	JENNIFER M MAIN, R.D.H.	3/1/2013
H6438	ASHLEY N FOSTER, R.D.H.	3/21/2013
H6439	JAMASA C GRAHAM, R.D.H.	3/21/2013
H6440	VERONIKA V SMOUS, R.D.H.	3/21/2013
H6441	LISA M ELLIOTT, R.D.H.	3/21/2013
H6442	NAKISA ASADIZIARI, R.D.H.	3/21/2013
H6443	SHELLEY C GILBERT, R.D.H.	3/21/2013
H6444	SYLVIE M WROBEL, R.D.H.	3/21/2013
H6445	CHRISTINE A KARNITZ, R.D.H.	4/1/2013
H6446	HEIDI N. CRONE, R.D.H.	4/1/2013
H6447	REBECCA L. BELLO, R.D.H.	4/1/2013
H6448	VICTORIA NGUYEN, R.D.H.	4/1/2013
H6449	ALLISON R. MENASHE, R.D.H.	4/1/2013
H6450	LINDSAY C. PURKEYPYLE, R.D.H.	4/1/2013
H6451	AUGUSTA C. WILSON, R.D.H.	4/1/2013
H6452	BETHANY K. HOLMES, R.D.H.	4/1/2013
H6453	KIM N. PHAN, R.D.H.	4/1/2013

### **Dentists**

D9838	ANA E CASTILLA, D.D.S.	2/14/2013
D9839	MICHAEL T CHRISTENSEN, D.D.S.	2/14/2013
D9840	PASCAL V NGUYEN, D.M.D.	2/14/2013
D9841	TIN M LE, D.M.D.	3/1/2013
D9842	KALE T GRAY, D.M.D.	3/1/2013
D9843	BO G CROFOOT, D.D.S.	3/1/2013
D9844	KENNETH D MC GOWAN, D.M.D.	3/1/2013
D9845	DONNA J QUINBY, D.M.D.	3/21/2013
D9846	KYLE E CRAWSHAW, D.M.D.	3/21/2013
D9847	LEWIS C JONES, D.M.D.	3/21/2013
D9848	JEFFREY S VAN KIRK, D.M.D.	3/21/2013
D9849	ERIN E TAO, D.D.S.	3/21/2013
D9850	LAURA A SNYDER, D.D.S.	3/21/2013
D9851	SIRISHA BHAMIDIPATY, D.D.S.	4/1/2013
D9852	TRAVIS L. CHAPMAN, D.M.D.	4/1/2013
D9853	SUSAN A NORDSTROM, D.M.D.	4/1/2013

### **Dental Faculty**

DF0027	JAY R ANDERSON, D.M.D.	3/1/2013
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