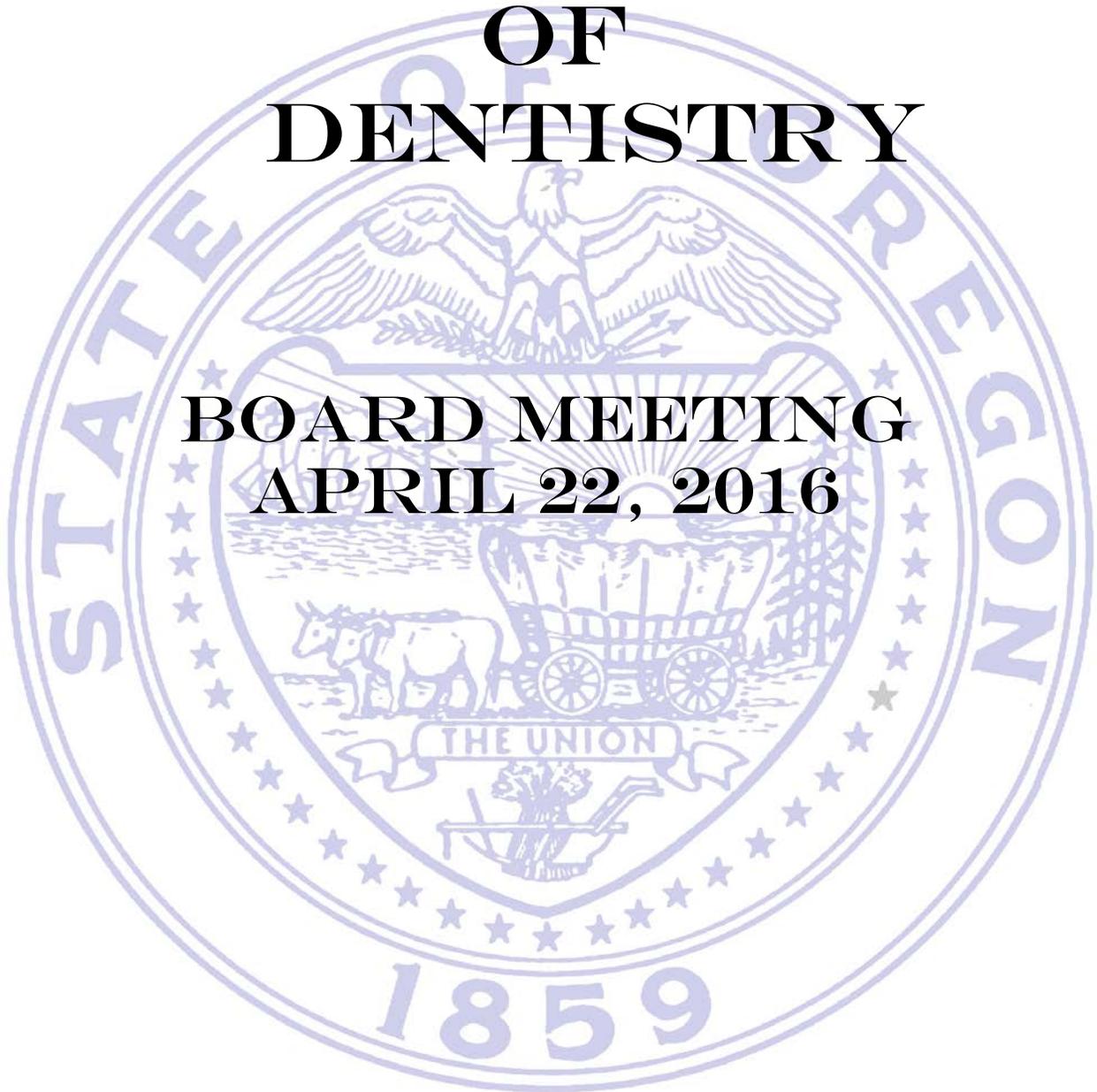


PUBLIC PACKET

**OREGON BOARD
OF
DENTISTRY**

**BOARD MEETING
APRIL 22, 2016**



STANDARD PROTOCOLS FOR GENERAL CONSENT ORDERS

CIVIL PENALTIES

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

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

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

RESTITUTION PAYMENTS

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

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

REIMBURSEMENT PAYMENTS

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

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

CONTINUING EDUCATION – BOARD ORDERED

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

COMMUNITY SERVICE

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

FALSE CERTIFICATION OF CONTINUING EDUCATION

Licensee shall be reprimanded, pay a \$___ (\$2,000 for dentists OR \$1,000 for dental hygienists) civil penalty, complete ten hours of community service within 60 days and complete the balance of the ___ (40 OR 24) hours of continuing education for the licensure period (4/1/-- to 3/31/-- OR 10/1/-- to 9/30/--), within 60 days of the effective date of this Order. As soon as possible following completion of the continuing education the Licensee shall provide the Board with documentation certifying the completion.

WORKING WITHOUT A CURRENT LICENSE

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

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

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

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

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

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

FAILURE TO CONDUCT WEEKLY BIOLOGICAL TESTING OF STERILIZATION DEVICES

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

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

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

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

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

STANDARD PROTOCOLS FOR CONSENT ORDERS SPECIFICALLY RELATED TO ALCOHOL ABUSE

ALCOHOL

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

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

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

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

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

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

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

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

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

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

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

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

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

STANDARD PROTOCOLS FOR CONSENT ORDERS SPECIFICALLY RELATED TO SUBSTANCE ABUSE

DRUGS

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

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

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

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

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

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

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

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

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

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

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

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

IF APPROPRIATE –

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

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

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

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

STANDARD PROTOCOLS FOR CONSENT ORDERS SPECIFICALLY RELATED TO SEXUAL VIOLATIONS

SEX RELATED VIOLATIONS

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

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

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

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

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

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

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

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

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

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

IF APPROPRIATE –

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

STANDARD PROTOCOLS FOR CONSENT ORDERS REQUIRING CLOSE SUPERVISION

CLOSE SUPERVISION

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

STANDARD PROTOCOLS – DEFINITIONS

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

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

STANDARD PROTOCOLS – PARAGRAPHS

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

APPROVAL OF MINUTES

**OREGON BOARD OF DENTISTRY
MINUTES
February 19, 2016**

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

STAFF PRESENT: Stephen Prisby, Executive Director
Paul Kleinstub, D.D.S., M.S., Dental Director/Chief Investigator
Daryll Ross, Investigator (portion of meeting)
Harvey Wayson, Investigator (portion of meeting)
Teresa Haynes, Exam and Licensing Manager (portion of meeting)
Michelle Lawrence, D.M.D., Consultant (portion of meeting)
Daniel Blickenstaff, D.D.S., Investigator (portion of meeting)
Jessica Conway, Office Manager (portion of meeting)
Ingrid Nye, Office Specialist (portion of meeting)

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

VISITORS PRESENT: Christina Swartz Bodamer, ODA; Pamela Lynch, R.D.H.; Caroline Maier, R.D.H.; Brad Fuller, D.M.D.; Lynn Ironside, R.D.H.; Cassie Button, R.D.H.

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

NEW BUSINESS

MINUTES

Dr. Beck moved and Dr. Hongo seconded that the minutes of the December 18, 2015 Board meeting be approved as amended. The motion passed with Dr. Beck, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith, Dr. Schwindt, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye.

ASSOCIATION REPORTS

Oregon Dental Association

Christina Swartz Bodamer reported that the Oregon Dental Conference is scheduled for April 7th-9th and that registrations can be made at oregondentalconference.org.

Oregon Dental Hygienists' Association

Lynn Ironside introduced the new President of the ODHA, Cassie Button, R.D.H.

Oregon Dental Assistants Association

Nothing to report at this time.

COMMITTEE AND LIAISON REPORTS

WREB Liaison Report

Dr. Jonna Hongo reported on the Buffalo Model/Patient Centered CIF stating that other state Boards were contacting WREB with concerns that the Buffalo Model/Patient Centered CIF is labeled as a pilot project. The Boards also asked questions regarding the use of the Buffalo Model/Patient Centered CIF as an official licensing exam.

AADB Liaison Report

Dr. Amy Fine was not able to attend the AADB meeting in Washington DC, and Ms. Yadira Martinez reported on behalf of the Board members who attended the conference, as previously discussed in the December 2015 Board meeting. Dr. Fine asked if the Board had any questions regarding the letter included in the board book materials.

ADEX Liaison Report

Dr. Jonna Hongo reported that ADEX passed new bylaws banning liaisons from simultaneously serving competing agencies. As a result, Dr. Hongo was forced to resign her committee appointment and step down as Bylaws Chairman. Dr. Hongo asked her fellow Board members if they would like to replace her position as ADEX dental liaison. The Board members could follow up with Mr. Prisy for more information if interested.

CDCA Liaison Report

Dr. Amy Fine reported that the CDCA annual meeting was held January 14-16, 2016 in Orlando, Florida. Dr. Fine reported that the main focus of the meeting was the Buffalo Model/Patient Centered CIF and its status as a pilot program.

Board Committee Report

Yadira Martinez, RDH reported that the Dental Hygiene Committee met on January 21, 2016. The Committee recommended two motions be brought to the Board.

OAR 818-042-0020 – Dentist and Dental Hygienist Responsibility

The Board reviewed and discussed how many dental assistants an Expanded Practice Dental Hygienist can hire and supervise at any given time. Dr. Fine moved and Dr. Smith seconded that the Board move the discussion to the Rules Oversight Committee. The motion passed with Dr. Beck, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith, Dr. Schwindt, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye.

OAR 818-042-0050 Taking of X-Rays – Exposing Radiographs

The Board reviewed and discussed. Dr. Hongo moved and Dr. Beck seconded that the Board

move the discussion to The Rules Oversight Committee. The motion passed with Dr. Beck, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith, Dr. Schwindt, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye.

EXECUTIVE DIRECTOR'S REPORT

Board Member & Staff Updates

Mr. Prisby announced that Dr. Daniel Blickenstaff was hired as the OBD's new full-time dental investigator on January 4, 2016. Congratulations were given to current Board members, Dr. Julie Ann Smith and Dr. Todd Beck, as well as past Board President, Dr. Norm Magnuson for their induction into the American College of Dentists and the International College of Dentists as New Fellows.

Legislation & Executive Order Updates

Mr. Prisby stated that the short legislative session started February 1st and ends March 6th. Mr. Prisby stated that he attached proposed legislation that will have a direct impact on the Board, and other legislation that the Board may find important, as well as Governor Brown's Executive Order #16-06 and subsequent audit report.

Budget Status Report

Mr. Prisby reviewed the latest budget report for the 2015 - 2017 Biennium. The report, which is from July 1, 2015 through December 31, 2015, shows revenue of \$696,191.02 and expenditures of \$559,370.68. Mr. Prisby said he would be happy to answer questions that the Board members have regarding the report.

Customer Service Survey Report

Mr. Prisby stated that he attached the legislatively mandated survey results from July 1, 2015 - January 31, 2016, including comments received. The results of the survey show that the OBD continues to receive positive ratings from the majority of those that submit a survey.

Board and Staff Speaking Engagements

Mr. Prisby stated that he and Teresa Haynes gave a License Application Presentation to the graduating Dental Hygiene students at OIT in Klamath Falls on Monday, January 25, 2016.

He also reported that he and Teresa Haynes gave a License Application Presentation to the graduating Dental Hygiene students at OIT-Chemeketa in Salem on Wednesday, February 17, 2016.

2016 Dental License Renewal

Mr. Prisby stated that 1955 postcard notices were mailed to Oregon licensed dentists for the March 31, 2016 Renewal Cycle. As of Feb. 18th, 885 had already renewed, leaving 1061 left to renew. This data is consistent with previous renewal periods.

AADA & AADB Midyear Meetings

Mr. Prisby stated that the midyear meetings are scheduled for April 10-12 in Chicago. The Joint Commission on National Dental Examinations conducts an annual forum for representatives of state boards of dentistry for the purpose of exchanging information about National Board Dental and Dental Hygiene Examinations. The meeting will take place directly following the conclusion of the AADB meeting. Dr. Todd Beck agreed to attend and participate on behalf of the Board.

Mr. Prisby requested the Board approve his attendance at the AADA & AADB Midyear meetings. Dr. Fine moved and Dr. Hongo seconded that his travel be approved. The motion passed with Dr. Beck, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith, Dr. Schwindt, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye.

Board Social

Mr. Prisby announced that Board members, staff and any interested parties were invited to attend a social gathering at Big Al's in Beaverton which was to occur after the Board meeting on February 19. A quorum of the Board may be present.

Newsletter

Mr. Prisby stated that the last newsletter was published in December. The next edition should be going out in the summer to incorporate the Board's Strategic Plan along with other important news and updates relevant to our Licensees.

CORRESPONDENCE

AAFE Letter and Request

Dr. Beck moved and Dr. Underhill seconded that the issue of using dermal fillers by Oregon dentists be reviewed and discussed by the Licensing, Standards and Competency Committee and directed staff to gather more information from Dr. Malcmacher regarding his class on dermal fillers. The motion passed with Dr. Beck, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith, Dr. Schwindt, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye.

Approval Letter – Dental Pilot Project

Minimal Sedation Emails from Bobbie Marshall

OSOMS Letter regarding ambiguity in the rule

Dr. Smith moved and Dr. Beck seconded that the Anesthesia Committee review the rules regarding utilizing certified anesthesia assistants, and clarify the language in appropriate rules. The motion passed with Dr. Beck, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith, Dr. Schwindt, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye.

OTHER BUSINESS

The Board Received a Request for permission to be an examiner for the Western Regional Dental Restorative Exam – Sara Hill, R.D.H. Dr. Hongo moved and Dr. Fine seconded that the Board grant permission to be an examiner. The motion passed with Dr. Beck, Dr. Fine, Dr. Hongo, Mr. Morris, Dr. Smith, Dr. Schwindt, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye.

ARTICLES AND NEWS OF INTEREST (no action necessary)

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.

OPEN SESSION: The Board returned to Open Session.

Sue Dicile spoke with regards to her plans as facilitator for the upcoming, April 22-23rd Strategic Planning Session. Ms. Dicile shared feedback from meetings with Board members and Board staff. She was very pleased with the Board members for following up with her quickly, and for their candor. She anticipated working with Mr. Prisby on a draft agenda over the next few weeks and the Board reviewing prior to the April Board meeting and Strategic Planning Session on April 23.

CONSENT AGENDA

2016-0122, 2016-0118 and 2016-0097 Dr. Smith moved and Dr. Hongo seconded that the above referenced cases be closed with a finding of No Violation of the Dental Practice Act per the staff recommendations. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Dr. Hongo, Dr. Schwindt, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye.

COMPLETED CASES

2015-0140, 2016-0070, 2015-0179, 2015-0157, 2015-0125, 2015-0129 and 2015-0132 Dr. Smith moved and Dr. Fine seconded that the above referenced cases be closed with a finding of No Violation of the Dental Practice Act or No Further Action per the Board recommendations. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Dr. Hongo, Dr. Schwindt, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye. Dr. Schwindt recused himself on Case # 2015-0125. Ms. Riedman recused herself on Case # 2015-0179

2016-0095

Dr. Beck moved and Dr. Fine seconded that the Board regarding Respondent #1, close the case with a Letter of Concern addressing the issue of ensuring that prior to providing patient treatment, instruments are checked for confirmation of sterilization; for Respondent #2, close the case with a finding of No Violation; for Respondent #3, move to close the case with a Letter of Concern addressing the issue of ensuring that instruments have been sterilized when removing them from the autoclave and before placing them in an area designated for sterilized instruments. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Dr. Hongo, Dr. Schwindt, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye.

2015-0111

Dr. Underhill moved and Dr. Fine seconded that the Board close the case with a Letter of Concern reminding Licensee to ensure that he obtain approval of esthetics in writing prior to processing a removable denture. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Dr. Hongo, Dr. Schwindt, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye.

2015-0101 Carothers, David N., D.D.S.

Ms. Martinez moved and Ms. Riedman seconded that that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand and a civil penalty of \$6,000.00 to be paid within 90 days, 40 hours of Board approved community service, and monthly submission of spore testing results for a period of one year from the effective date of the order. Complete 3 hours of Board approved continuing education on record keeping and 6 hours of Board approved continuing education on maintaining periodontal health around implants within the next 9 months, and a refund to the patient of \$25,916.00 The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Dr. Hongo, Dr. Schwindt, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye.

2015-0133

Dr. Schwindt moved and Dr. Underhill seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that he has permission from the patient before discussing the patient's care with another provider, and to assure that his office tracks the date of spore testing, writes that date on the test package, and mails the sample promptly. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Dr. Hongo, Dr. Schwindt, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye.

2014-0223

Mr. Morris moved and Dr. Hongo seconded that the Board close the matter with a Letter of Concern addressing the issue of ensuring that treatment notes accurately document treatment that is provided, and that when treatment notes are written by a dental assistant the notes are thoroughly reviewed for accuracy. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Dr. Hongo, Dr. Schwindt, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye.

2015-0138 Goodman-Cherrier, Edward E., D.D.S.

Ms. Riedman moved and Dr. Hongo seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent order incorporating a reprimand, a \$6,000.00 civil penalty, 40 hours of Board approved community service and monthly submission of spore testing results for both of his sterilizers. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Dr. Hongo, Dr. Schwindt, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye.

2015-0151

Dr. Fine moved and Dr. Beck seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that the name of all medications recommended to patient is documented in the patient's chart, that all radiographs are dated, and to assure that the autoclaves are being spore tested on a weekly basis. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Dr. Hongo, Dr. Schwindt, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye.

2015-0080

Dr. Beck moved and Dr. Underhill seconded that the Board close the matter against all three Respondents with no further action. The motion passed with Dr. Beck, Dr. Fine, Dr. Schwindt, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye. Dr. Smith and Dr. Hongo recused themselves.

2015-0124

Dr. Underhill moved and Dr. Smith seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that his autoclaves are monitored using a biological

monitoring testing on a weekly basis, and to assure that it is ultimately his responsibility to know if he is abiding by the Oregon Dental Practice Act. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Dr. Schwindt, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye. Dr. Hongo recused herself.

2015-0227 Kim, Sean S., D.M.D.

Ms. Martinez moved and Dr. Beck seconded that the Board combine with case 2014-0087 and issue an Amended Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand, a civil penalty of \$5,000.00, a reimbursement of \$1,870.67 to Met Life for patient RS, a refund to patient RS of \$1,940.00, a refund to patient SB of \$2,712.00. Take a Board approved Dental Remediation Continuing Education course encompassing all phases of dentistry, especially diagnosis, radiograph interpretation, endodontics, nitrous oxide sedation and chart documentation within the next 6 months. Submit 10 completed cases to the Board in the first year after completion of the Board approved Dental Remediation Continuing Education course, and the next 2 cases where the patient's Vertical Dimension of Occlusion (VDO) has been altered. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Dr. Hongo, Dr. Schwindt, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye.

2015-0145

Mr. Morris moved and Dr. Hongo seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that his documentation is complete and accurate and that he is certain that the patient understands that a little metal will show when a metal collar margin is placed supragingival. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Dr. Hongo, Dr. Schwindt, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye.

2015-0057

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

2015-0067 Oliver, Bradley C., D.M.D.

Dr. Fine moved and Dr. Hongo seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand and a refund to the patient of \$4,942.00. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Dr. Hongo, Dr. Schwindt, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye.

2015-0061

Dr. Hongo moved and Dr. Smith seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that all treatment is completely documented and that all autoclaves are spore tested on a weekly basis. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Dr. Hongo, Dr. Schwindt, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye.

2015-0102 Olson, John L., D.M.D.

Dr. Beck moved and Dr. Underhill seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand, a refund to the patient of \$1,260.00, a \$3,000.00 civil penalty to be paid within 60 days, 20 hours of Board approved community service to be completed within six months, and monthly submission of spore testing results for a period of one year from the effective date of the order. The motion

passed with Dr. Smith, Dr. Beck, Dr. Fine, Dr. Hongo, Dr. Schwindt, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye.

2015-0156

Dr. Underhill moved and Dr. Hongo seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that PARQ is documented, that all documentation and billing is complete and accurate, and that he tests his autoclave with spore strips on a weekly basis. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Dr. Hongo, Dr. Schwindt, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye.

2015-0121

Dr. Smith moved and Dr. Beck seconded that the Board close the matter with a Strongly Worded Letter of Concern reminding Licensee to assure that his answering service contacts him whenever one of his patients calls. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Dr. Hongo, Dr. Schwindt, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye

2015-0104

Dr. Schwindt moved and Dr. Hongo seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that all patients that she treats are patients of record of the clinic before she provides hygiene services to them. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Dr. Hongo, Dr. Schwindt, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye.

2015-0123

Mr. Morris moved and Dr. Smith seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that his autoclaves are spore tested on a weekly basis. The motion passed with Dr. Smith, Dr. Fine, Dr. Hongo, Dr. Schwindt, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye. Dr. Beck recused himself.

2015-0051 Starr, Duane T., D.M.D.

Dr. Hongo moved and Dr. Underhill seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand and a payment to the patient of \$1,500.00 and be held obligated to reimburse the patient (upon receipt of expenses paid) up to \$25,000.00 for dental treatment to correct the patient's dental health in the area of teeth #'s 10 & 11. The motion passed with Dr. Smith, Dr. Fine, Dr. Hongo, Dr. Schwindt, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye. Dr. Beck recused himself.

2015-0155

Dr. Beck moved and Dr. Smith seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that the instruments she uses have been sterilized in an autoclave that has been tested on a weekly basis. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Dr. Hongo, Dr. Schwindt, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye.

2015-0103

Dr. Underhill moved and Dr. Hongo seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that all bonding material is removed after the bonding of a porcelain restoration, and that all sterilizers need to be tested every week that patients are seen, even if a given sterilizer has not been used. The motion passed with Dr. Beck, Dr. Fine,

Dr. Hongo, Dr. Schwindt, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye. Dr. Smith recused herself.

2016-0055 Thompson, Robert W., D.M.D.

Ms. Martinez moved and Dr. Smith seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand, three hours of Board approved continuing education in record keeping, two hours of Board approved continuing education in opioid prescribing practices and ten hours of Board approved community service to be completed within six months. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Dr. Hongo, Dr. Schwindt, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye.

2015-0158 Thompson, Dan E., D.M.D.

Dr. Schwindt moved and Dr. Hongo seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand and a payment to the patient's parents of \$2,478.85. The motion passed with Dr. Smith, Dr. Fine, Dr. Hongo, Dr. Schwindt, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye. Dr. Beck recused himself.

2016-0088

Mr. Morris moved and Dr. Hongo seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that the strengths of all local anesthetics and any vasoconstrictors administered are documented accurately. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye. Dr. Schwindt recused himself.

2015-0137 White, Harlan L., D.M.D.

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

2016-0031 Bailey, William, D.D.S.

Dr. Fine moved and Dr. Underhill seconded that the Board issue an Order of Reinstatement ratifying the re-instatement of Licensee's dental license effective 1/5/16. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Dr. Hongo, Dr. Schwindt, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye.

2014-0153

Dr. Hongo moved and Dr. Underhill seconded that the Board decline Licensee's proposed resolution and affirm the Board's action of 10/30/15. The motion passed with Dr. Beck, Dr. Fine, Dr. Hongo, Dr. Schwindt, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye. Dr. Smith recused herself.

2014-0071

Dr. Beck moved and Dr. Smith seconded that the Board close the matter with no further action. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Dr. Hongo, Dr. Schwindt, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye.

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

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

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

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

2014-0043 Leinassar, Jeffrey M., D.M.D.

Dr. Schwindt moved and Mr. Morris seconded that the Board reaffirm the Board's February 27, 2015 vote in case 2014-0043 and refer the matter to hearing. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Dr. Hongo, Dr. Schwindt, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye.

2004-0173

Mr. Morris moved and Dr. Beck seconded that the Board deny Licensee's request and affirm his Agreement, whereby he agreed to enter the Health Professionals' Services Program. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Dr. Hongo, Dr. Schwindt, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye.

2013-0195 & 2015-0114 Lynch, Theodore R., D.D.S.

Ms. Riedman moved and Dr. Hongo seconded that the Board accept Licensee's offer of the Interim Consent Order by which he agrees not to practice dentistry pending further order of the Board, and indefinitely suspend further action on the Notice of Proposed Disciplinary Action, dated 7/13/15, pending further action of the Board. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Dr. Hongo, Dr. Schwindt, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye.

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

Dr. Fine moved and Dr. Underhill seconded that the Board ratify the Interim Consent Order by which Licensee agreed not to practice dentistry pending further order of the Board, indefinitely postpone enforcement of Licensee's Amended Consent Order, dated 12/9/15, and deny Licensee's request for license reinstatement. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Dr. Hongo, Dr. Schwindt, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye.

2015-0022 Tripp, Matt T., R.D.H.

Dr. Beck moved and Dr. Underhill seconded that the Board offer Licensee a Consent Order incorporating a reprimand; a \$100.00 payment to the Board to reimburse for the cost of advice sought from the State's Attorney General; four hours of Board approved continuing education in professional ethics; a full waiver and release of all claims against the State, the Board, and the Board's Agents, Staff and Attorneys; relief from all of the Board's investigation and litigation costs; and the Order will be a public document. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Dr. Hongo, Dr. Schwindt, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye.

LICENSURE AND EXAMINATION

Request for C.E. Extension: Toivo T. Sepp, D.M.D.

Dr. Hongo moved and Dr. Underhill seconded that the Board deny the requested CE extension for Dr. Sepp. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye. Dr. Schwindt recused himself.

Case Summary 2015-0028

Ms. Martinez moved and Dr. Hongo seconded that the Board release summary of the investigation. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Dr. Hongo, Dr. Schwindt, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye.

Clarification on ORS 680.205(1)(l)(d)

Dr. Schwindt moved and Dr. Smith seconded that the Board clarify ORS 680.205(1)(l)(d)The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Dr. Hongo, Dr. Schwindt, Mr. Morris, Ms. Riedman, Ms. Martinez and Dr. Underhill voting aye.

Request for Approval Moderate Sedation Course: Gerald Papador, D.D.S.

Dr. Beck moved and Dr. Hongo seconded that the Board allow Dr. Papador to complete Dr. Ken Reed's course "Comprehensive Training in Parenteral Moderate Sedation" which is 60 hours and then complete 25 dental patients by intravenous route at Oregon Health and Science University (OHSU) under the direct supervision of the Periodontal Faculty who hold either a Parenteral Moderate or Deep Sedation Permit. The motion passed with Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye. Dr. Smith recused herself.

Request for Non-resident Permit: Adrian Rivas, D.M.D.

Dr. Underhill moved and Dr. Beck seconded that the Board grant the non-resident permit. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye.

Request for Non-resident Permit: Drew D. Richards, D.D.S.

Dr. Underhill moved and Dr. Beck seconded that the Board grant the non-resident permit. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye.

Request for Non-resident Permit: John B. Wayland, D.D.S.

Dr. Underhill moved and Dr. Beck seconded that the Board grant the non-resident permit. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye.

Request for Non-resident Permit: Robert Hessberger, D.D.S.

Dr. Underhill moved and Dr. Beck seconded that the Board grant the non-resident permit. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye.

Request for Non-resident Permit: Thomas Brown, D.D.S.

Dr. Underhill moved and Dr. Beck seconded that the Board grant the non-resident permit. The motion passed with Dr. Smith, Dr. Beck, Ms. Martinez, Dr. Fine, Dr. Hongo, Mr. Morris, Ms. Riedman, Dr. Underhill and Dr. Schwindt voting aye.

February 19, 2016

Board Meeting

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Ratification of Licenses Issued

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

DENTAL HYGIENISTS

H7130	SARAI MALUHIA FARR, R.D.H.	12/10/2015
H7131	JENNIFER R GRUZENSKY, R.D.H.	12/10/2015
H7132	HALEY MARIE BEVER, R.D.H.	12/17/2015
H7133	ANDRES GARCIA, R.D.H.	12/17/2015
H7134	MINDY S MEDINA, R.D.H.	12/24/2015
H7135	HEIDI CLAIRE LYNN DESMARAIS, R.D.H.	1/11/2016
H7136	BRANDI ROSE TARABOCHIA, R.D.H.	1/13/2016
H7137	SARAH MARIE SIELER, R.D.H.	1/13/2016
H7138	PATRICK S PORTER, R.D.H.	1/13/2016
H7139	TASHINA MARIE STOFFEL, R.D.H.	1/20/2016
H7140	AMANDA P KHAMPHILAVONG, R.D.H.	1/27/2016
H7141	DESIREE STARR FOWLER, R.D.H.	1/27/2016
H7142	OKSANA S SVIRZHEVSKIY, R.D.H.	1/27/2016
H7143	NICOLE M ULRICH, R.D.H.	2/3/2016

DENTISTS

D10384	SANDA M MOLDOVAN, D.D.S.	12/10/2015
D10385	STEPHEN ERIC STANLEY, D.M.D.	12/10/2015
D10386	JEFFREY ALLEN PACE, D.M.D.	12/10/2015
D10387	MICHAEL W YOUNG, D.D.S.	12/10/2015
D10388	RACHEL ELIZABETH WHITE, D.D.S.	12/24/2015
D10389	BRETT MUNRO STRONG, D.D.S.	1/20/2016
D10390	YUCHEN HU, D.M.D.	1/20/2016
D10391	VANESSA R AXELSEN, D.D.S.	1/21/2016
D10392	GLENN THOMAS ASHWORTH, D.D.S.	1/27/2016
D10393	BRIAN NGUYEN, D.M.D.	1/29/2016
D10394	DANIEL J LUNDQUIST, D.D.S.	2/3/2016
D10395	PATTON M MINKIN, D.D.S.	2/3/2016

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

Announcement

No announcements

ADJOURNMENT

The meeting was adjourned at 2:40 pm. President Harvey stated that the next Board meeting would take place April 22, 2016.

Alton Harvey Sr.
President

DRAFT

ASSOCIATION REPORTS

Nothing to report under this tab

COMMITTEE REPORTS

WREB
Hygiene Exam Review Board Meeting
March 11, 2016
Phoenix, AZ
Summary

HERB members in attendance:

Ermelinda Baca, RDH	Nancy Maus, RDH
Josette Beach, RDH	Marilyn McClain, RDH
Sally Berg, RDH	Jennifer Porter, RDH
Beth Cole	Sharon Osborn Popp, PhD
Catherine Cornell, RDH	Kelly Reich, RDH
Mary Davidson, RDH	Melinda Reich, RDH
Kathy Heiar, RDH	Karen Sehorn, RDH
Janet Ingrao, RDH	Marianne Timmerman, RDH
Jackie Leakey, RDH	Nathaniel Tippit, DDS
Meg Long, RDH	Gail Walden, RDH
Maria Sharon Mangoba, RDH	Robin Yeager
Yadira Martinez, RDH	

Welcome

Mary Davidson, HERB Chair, commenced the meeting at 8:05 am. She welcomed all attendees, asked members to introduce themselves and thanked them for their service to WREB. In addition, she asked all HERB members to sign the WREB nondisclosure agreement.

Consent Agenda

Mary presented the consent agenda which consisted of the summary of the July, 2015 HERB meeting.

Motion/Second

Approve the consent agenda.

Motion Passed

WREB Overview

Beth Cole, CEO, updated the board on WREB's income and expense history as well as hygiene's exam growth. She touched on external factors, other testing agencies and the political environment that affect WREB. She also discussed changes to our internal environment, which includes new examination sites, accomplishments and the WREB Information Network (WIN). A practice analysis will be completed the last quarter of 2016.

Review of Committee Reports

Kelly Reich and Janet Ingrao, Co-Directors of Dental Hygiene Exam Development and Administration, presented the committee reports summarized below.

Local Anesthesia

Committee members, a number of WREB Examiners and students from four Dental Hygiene programs field tested the new patient-based component of the local anesthesia written examination. Sharon Osborn Popp, Ph.D. is in the process of completing her analysis of performance data and examination feedback. The goal is to implement to new component for the 2017 exam season. Upon implementation, a Candidate tutorial will be posted to the WREB website to familiarize students and faculty with the navigation of the computerized exam.

The committee is exploring other methods to better calibrate examiners as well as considering additional examiner exercises for the All Examiner Workshop. They continue to develop new test items for the written exam including items for the next set of patient-based cases. Members are also reviewing the textbook, "Local Anesthesia for the Dental Hygienist", second edition, to decide whether to add the textbook to the current list of Local Anesthesia examination reference materials.

The committee has no recommendations for the 2017 exam season.

Motion/Second

Approve the Local Anesthesia committee report, as presented.

Motion Passed

Restorative

Committee members reviewed performance results and a statistical summary of the four field tests administered. Most notable differences so far are a trend toward more comparability in level of challenge between amalgam and composite and a trend toward more comparability in level of challenge between MO and DO.

Educator forums were held in Washington and Oregon to discuss the 2016 restorative examination and field test results. WREB showed the restored field test preparations. Educators worked one-on-one with WREB representatives to better understand the grading criteria and how the restorations are evaluated by examiners.

The committee also finalized the scoring changes and Candidate retake eligibility for the 2017 examination.

Restorative committee recommendations for the 2017 exam season:

- Utilize electronic scoring for the typodont calibration exercises during the AEW; modeling how calibration is conducted at the dental workshop
- Allow candidates to retake onsite within specific parameters

Motion/Second

Approve the Restorative committee report, as presented.

Motion Passed

Dental Hygiene

Committee members reviewed candidate statistics, which included candidate performance in regards to onsite retakes. The members learned that there is no statistically significant difference between retake passing percentages in 2014 and 2015 regardless of schedule of the exam. This consistency includes

- retake attempts at different sites versus onsite retakes
- retake times of next day versus same day retakes.

The committee increased the time and scope of the New Examiner Orientation the day prior to their first WREB examination and implemented changes to the AEW.

Dental Hygiene Committee recommendations for the 2017 exam season:

- Utilize electronic scoring for the typodont calibration exercises during the AEW
- Diagnostic Radiographs will include only the following criteria and result in a maximum (-4) point penalty if not criteria not met:
 - Exposure dates within WREB guidelines

- Density, contrast and print quality are such that anatomical structures and oral conditions can be evaluated
- A portion of each tooth in the treatment submission is visible in the series
- Apex and bone circumscribing the entire root visible
- Alveolar crestal bone visible
- Periodontal Assessment Changes:
 - Reduce Periodontal Probing to 12 sites.
 - Revise and field-test to include questions on furcation involvement, mobility, clinical attachment loss, radiographic bone loss and classification of disease.
- Assess a point value to the EIE rather than evaluate
 - Revise and field-test the Extraoral/ Intraoral Examination responses to NSF, Follow up or monitor (in office), and Immediate referral.

The above revisions will necessitate the committee revising the scoring and distribution of points.

- Examiners may exclude tooth surfaces on the CAF that are compromised to the extent that instrumentation would be unethical (decay, mobility, etc).

Motion/Second

Approve the Dental Hygiene committee report, as presented.

Motion Passed

Psychometric Update

WREB's testing specialist, Sharon Osborn Popp, PhD, presented year end candidate pass rates and examiner performance. She did extensive studies on the onsite retakes for dental hygiene and found no significant difference between onsite and conventional retake passing percentage for dental hygiene. She discussed the recent pass rates as well as candidate performance over time. Sharon also presented statistics in regards to examiner performance. Sharon evaluated examiner agreement using both a site-based analysis and a pool-based analysis. Pool-based statistics help compare an examiner's performance to all examiners in the pool to estimate degree of severity. This serves as an additional check on examiner performance via site based statistics and helps identify examiners in most need of guidance regarding adherence to WREB criteria. Sharon also concluded that exam sites have an extremely high level of comparability with respect to examiner grading and is evidence of high quality and consistency among examiners.

HERB Member Updates

Each member delivered a brief report on behalf of their respective boards. Josette Beach, the educator member, reported that the WA restorative educator feedback regarding the standardized WREB preparations were addressed by Kelly Reich at the Educator forum. Josette thanked WREB for a smooth open enrollment process this year. She also encouraged the continued open communication between WREB and the educator community.

Miscellaneous

The next HERB meeting will be held in Austin, TX on Thursday, June 23, 2016.

Having no further business, the meeting adjourned at 12:00 pm.

Respectfully submitted,

Robin Yeager
 Director of Dental Hygiene Operations

From: bverner@cdcaexams.org [<mailto:bverner@cdcaexams.org>]

Sent: Thursday, March 31, 2016 12:20 PM

To: Stephen Prisby

Subject: CDCA Quarterly Newsletter - March 2016



2016 Annual Meeting Recap and Feedback

CDCA members from across the U.S. attended our 47th Annual Meeting allowing for great dialogue in important sessions like the town hall and committee meetings. Our agenda offered many great opportunities for learning highlighted by the new and innovative Patient Centered CIF ADEX Dental Exam ("buffalo model") and CDCA's Zegarelli speaker Dr. Juan Yepes's well received presentation on Radiation Safety. We hope you enjoyed the meeting experience. We also want to thank attendees for filling out the post event survey and actively using the new CDCA events app. We look forward to next year's meeting and are already looking for ways to make it more valuable for attendees while helping CDCA better meet its mission.

To read more about the annual meeting, please read [Chairman Perkin's recent letter to CDCA membership here](#). Also on our member resources section is [Dr. Yepes's presentation on Radiation Safety](#).



2016 New Member Orientation



CDCA Board of Directors welcoming the 2016 Annual Meeting attendees

Below are just a handful of comments we received in the annual meeting post-event survey.

"The 2016 Annual Session was excellent. There was opportunity to network with colleagues while attending informative, educational sessions. It was one of the most enjoyable sessions that I have attended. Keep up the good work."

"I also value taking the Annual session notes back to share with [my] State Board of Dentistry. I found the Buffalo Model presentation very interesting and visionary for CDCA to be involved in now and in the future."

"Meeting is valuable to network and find out what the organization is doing and where we are going."

"Need more time and training!"

"I was just impressed by the helpfulness of the entire CDCA staff and as a new member I felt welcomed by all the persons I came in

contact with from varying jurisdictions."

"The meeting was a lot of fun with the pedometers, the competitions and especially the app. THAT was an outstanding contribution for communicating the meeting schedules, having the Zegarelli slides and so much more!"

"The townhall meeting did not provide sufficient time to allow the participants the opportunity to informally discuss or present issues that were of concern to them."

"The CDCA app was a great addition -- I liked the exchanges taking place with examiners and I like the photos on there."

CDCA To Test First Graduating Class of the University of New England College of Dental Medicine

The CDCA has been invited to test dental candidates at the University of New England College of Dental Medicine in Portland, Maine, beginning with the class of 2017. The CDCA currently administers the ADEX dental hygiene exam at the university. Please look for an opportunity to examine there as early as fall of 2016.

2016 CDEL Licensure Task Force

The CDCA is excited to be invited to participate in this year's ADA Licensure Task Force on June 8-9 and August 2-3. Chairman Dave Perkins will represent CDCA again this year. Last year's meeting brought excellent discussion and exchange and we look forward to more productive meetings with the task force about the future of licensure assessments.

ADEX Annual Meeting Date Change

The ADEX Annual Meeting will be held earlier this year on August 5-7, 2016. We anticipate this move from its traditional early November date to be permanent in order to give more time to agencies administering the ADEX exams to adjust to content, criteria and scoring changes.

Guy Shampaine Award Winner Selected: Dr. Henry Levin

The CDCA would like to congratulate Dr. Henry Levin, the first awardee of the Guy Shampaine Award. Dr. Levin, a CDCA member since 1996, was selected by a panel of five CDCA members based on the nominations received last fall. He was recognized and presented the Guy Shampaine Award during the general assembly at the 2016 annual



Dr. Henry Levin accepts the Guy Shampaine Award alongside his family and Drs. Shampaine, Perkins, and Barrette.

meeting. Besides the individual award received during the annual meeting, his name will also be added to our new Guy Shampaine Award winner plaque, which hangs prominently at CDCA central office.

Nominations for the 2017 award will reopen this fall. The Guy Shampaine Award is awarded to a CDCA member whose outstanding efforts on behalf of the CDCA embody our values of service, dedication, and integrity. All CDCA active and consultant members are eligible to receive the award.



Michael Zeder, Director of Testing Operations and Technical Services, wearing the new CDCA Oxford shirt

CDCA Shirts Available for Purchase

For those interested in purchasing CDCA oxford shirts, you can [find them here](#). Men, women and plus sizes are available as well as a selection of three colors. Prices range from \$35-\$45 and are available directly from the manufacturer.

All Exams Posted

Chairman Dave Perkins announced at the 2016 Annual Meeting that all CDCA examinations will now be presented as options when the call for examiners goes out. This will include exams in Hawaii and Jamaica as well as additional examination opportunities at our Patient Centered CIF (Buffalo Model) exam sites. Due to an exam calendar that includes exams in all 12 months, the assignment committee will be meeting more frequently and sending out open calls five times a year. Please check your email frequently to make sure you do not miss any exam opportunities.

ADEX Patient Centered CIF Exam Featured in Today's FDA

An informative article on the CDCA administered ADEX Patient Centered CIF exam, written by Drs. Dave Perkins and Ellis Hall, was recently featured in the Florida Dental Association's magazine Today's FDA. To read the article, please visit our [Member News page](#).



Dr. Dave Perkins and Ms. Brittany Verner at the 2016 ASDA Annual Session

Outreach Efforts

The CDCA has been increasing its public affairs outreach efforts by participating in key conferences including the 61st Southern Dental Deans and Examiners Conference and ASDA Annual Session as exhibitors. These conferences allowed us to talk with educators and candidates outside of the exam process. If you are aware of any specific regional conferences you believe may be of value to the CDCA, please reach out to our Public Affairs and Special Projects Leader, Brittany Verner, bverner@cdcaexams.org.

Recent Dental Faculty Feedback

The 2016 Patient Centered CIF exams are now in full swing. With all exams sites having now completed at least two exams, we are starting to receive feedback from dental faculty. Read what two school faculty coordinators are saying below:

"What an incredibly positive experience we just completed with the buffalo model! Our students were relaxed and better able to demonstrate their abilities. Our patients were treated fairly and ethically. The mutually cooperative spirit was palpable. Any issues were resolved quickly, fairly and transparently.

I really don't know what more I can say beyond thanking you for introducing this approach and allowing us to apply it at our school. From my vantage point this is a sea change. Your team did everything possible to make the application of the PCCIF work within the constraints of our school."

"The exam was a smashing success! Not only was the level of anxiety markedly reduced, but I felt our patients were well cared for.

For the second time, no patient left in a temporary or without a chart note signed by faculty. The new format is a winner! It has removed many of the vexing issues out of the candidates' control..."

2016 Steering Committee Meeting & Educators' Conference

The CDCA will be holding its 2016 Steering Committee Meeting & Educator's Conference on June 16-17, 2016, at the Westin BWI Airport Hotel in Linthicum, MD. The 2015 Educator's Conference experienced record attendance and we hope for another engaging event this year.

Meet the CDCA Staff– Dr. Stuart Blumenthal

Please join us in welcoming Dr. Stuart Blumenthal for the position of Assistant Director of Examinations. Dr. Blumenthal is a graduate of the University of Maryland with a DDS, has received his certificate in pediatric dentistry and was granted diplomate status in 2010. Dr. Blumenthal's family has been practicing Pediatric dentistry in the Baltimore, Maryland area for generations and recently sold his well respected practice.

He has been involved with the Maryland Academy of Pediatric Dentistry at all levels currently serving as its Public Policy



Advocate and as a member of its Council on Government Affairs. He has been active on the legislative Committees for the Maryland State Dental Association and Maryland Dental Action Coalition. In addition, he is a member of the ADA, Maryland State Dental Association, American Association of Hospital Dentists and Johns Hopkins Medical and Surgical Association.

"Dentistry has always been my passion and I am excited for the opportunity to work in this new capacity," stated Blumenthal. "I look forward to helping the CDCA further its mission and goals."

Dr. Blumenthal will bring new expertise and perspective to the Director of Examinations office under Dr. Ellis Hall. He will help manage the growing list and types of examinations being offered by the CDCA and be able to look at our current protocols with new eyes. As a boarded specialist, he is also well qualified to manage the development of our continuing specialty exam series. Dr. Blumenthal will play an important part in maintaining and advancing our current quality and be meaningfully involved in any new ventures.

_CDCA By the Numbers: Dental and Dental Hygiene Clinical 2016 Year-to-Date Stats

2,513 Dental Candidates Tested

649 Dental Hygiene Candidates Tested

1 Dental Auxiliary Candidates Tested

1 New Exam Sites Added

31 Different Dental and Dental Hygiene Exam Sites Visited

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This email was sent to stephen.prisby@state.or.us by:
The Commission on Dental Competency Assessments
1304 Concourse Dr, Suite 100
Linthicum, Maryland 21090



THE COMMISSION ON DENTAL COMPETENCY ASSESSMENTS
1304 CONCOURSE DRIVE, SUITE 300 | LINTHICUM, MD 21090
TEL: 301-563-3300 | FAX: 301-563-3307
cdcaexam.org

Dear James:

I am pleased to inform you that Dr. David Perkins, Chair of the CDCA, has appointed you to serve as a member of the Public Advocacy Committee. This appointment was approved by the Board of Directors.

I am attaching the following documents for reference: Constitution & Bylaws, Committee Operating Manual and Committee Operating Guidelines.

Committee members were selected to provide a broad representation of the membership and to furnish the talent and expertise to achieve the goals of the committee.

The members of the 2016 Public Advocacy Committee are:

Ms. Ailish Wilkie, Public Member, Chair-Massachusetts

Ms. Terry Brisbin-New Jersey

Dr. Robert Caldwell-DC

Mr. Rodney Ching, Public Member-Hawaii

Ms. Mimi Kevan, Public Member-Vermont

Mr. James Morris, Public Member-Oregon

Dr. James Jansen, Board Liaison-Indiana

I sincerely hope that you are interested and will accept this appointment. I would appreciate receiving your response before March 18, 2016 by “replying” to this email.

Thanks for your consideration. I look forward to hearing from you.

Best regards,

A handwritten signature in black ink that reads 'Patricia M. Connolly-Atkins'.

Patricia M. Connolly-Atkins, RDH, MS
Secretary



Oregon

Kate Brown, Governor

Board of Dentistry
1500 SW 1st Ave. Ste 770
Portland, OR 97201-5837
(971) 673-3200
Fax: (971) 673-3202

Oregon Board of Dentistry Committee Meetings Dates

All Committee meetings will take place at the Oregon Board of Dentistry Offices located at 1500 SW 1st Ave., Suite 770, Portland Oregon.

**Oregon Board of Dentistry
Enforcement and Discipline Committee Meeting
Tuesday, May 17, 2016
6:00 p.m.**

**Oregon Board of Dentistry
Licensing, Standards and Competency Committee Meeting
Thursday, May 19, 2016
6:30 p.m.**

**Oregon Board of Dentistry
Anesthesia Committee Meeting
Tuesday, July 26, 2016
6:30 p.m.**

**Oregon Board of Dentistry
Rules Oversight Committee Meeting
TBD**

Please mark your calendar for these dates. Agendas will be sent at a later date.

If you have any questions, please contact Executive Director, Stephen Prisby at 971-673-3200 or Stephen.Prisby@state.or.us

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

STANDING COMMITTEES

Communications

Purpose: To enhance communications to all constituencies

Committee:

Todd Beck, D.M.D., Chair
Yadira Martinez, R.D.H., E.P.P.
Alton Harvey, Sr.

Barry Taylor, D.M.D., ODA Rep.
Gail Aamodt, R.D.H., M.S., ODHA Rep.
Linda Kihs, CDA, EFDA, OMSA, MADAA, ODA Rep.

Subcommittees:

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

Dental Hygiene

Purpose: To review issues related to Dental Hygiene

Committee:

Yadira Martinez, R.D.H., E.P.P., Chair
Amy B. Fine, D.M.D.
Alicia Riedman, R.D.H., E.P.P.

David J. Dowsett, D.M.D., ODA Rep.
Wilber Ramirez-Rodriguez, R.D.H., ODHA Rep.
Mary Harrison, CDA, EFDA, EFODA, FADAA, ODA Rep.

Enforcement and Discipline

Purpose: To improve the discipline process

Committee:

Julie Ann Smith, D.D.S., M.D., Chair
Alicia Riedman, R.D.H., E.P.P.
Todd Beck, D.M.D.
James Morris

Jason Bajuscak, D.M.D., ODA Rep.
Jill Mason, R.D.H., ODHA Rep.
Mary Harrison, CDA, EFDA, EFODA, FADAA, ODA Rep.

Subcommittees:

Evaluators

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

Licensing, Standards and Competency

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

Committee:

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

Daren L. Goin, D.M.D., ODA Rep.
Susan Kramer, R.D.H., ODHA Rep.
Mary Harrison, CDA, EFDA, EFODA, FADAA, ODA Rep.

Rules Oversight

Purpose: To review and refine OBD rules

Committee:

Brandon Schwindt, D.M.D., Chair
Jonna Hongo D.M.D.
Alicia Riedman, R.D.H., E.P.P.

Bruce Burton, D.M.D., ODA Rep.
Lynn Ironside, R.D.H., ODHA Rep.
Bonnie Marshall, CDA, EFDA, EFODA, MADAA, ODA Rep.

LIAISONS

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

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

American Board of Dental Examiners (ADEX)

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

Commission on Dental Competency Steering Committee (CDCA)

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

Oregon Dental Association – Alton Harvey, Sr.

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

E.P.P. Oregon Dental Assistants Association – Alton Harvey, Sr.

Western Regional Exam Board (WREB)

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

OTHER

Administrative Workgroup

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

Committee:

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

Subcommittee:

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

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

Anesthesia

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

Committee:

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

*Not Selected by the OBD

**EXECUTIVE
DIRECTOR'S
REPORT**

EXECUTIVE DIRECTOR'S REPORT

April 22, 2016

Board Member & Staff Updates

I have been receiving interest forms from the governor's office for our upcoming Board vacancy with Dr. Jonna Hongo's term expiring in April. I believe we will have a new Board member onboard by the June Board meeting. The Office Manager position is posted on the state's employment website as I unfortunately had to dismiss our former Office Manager. We have hired a temporary office support person to assist while we fill the position.

OBD Budget Status Report

Attached is the latest budget report for the 2015 - 2017 Biennium. This report, which is from July 1, 2015 through February 29, 2016, shows revenue of \$1,233,679.42 and expenditures of \$801,888.28. If Board members have questions on this budget report format, please feel free to ask me. **Attachment #1**

2017-19 Budget Planning Kickoff

I attended a statewide budget planning meeting in Salem on March 15th. I attached information showing the time line for completing the process and instructions. **Attachment #2**

Update on 2016 Short Legislative Session

The 2016 short legislative session ended on March 25th. HB 4016 and HB 4095 are the two pieces of legislation that have the most direct impact on the OBD. **Attachment #3**

Customer Service Survey

Attached are the legislatively mandated survey results from July 1, 2015 – March 31, 2016, and comments received. The results of the survey show that the OBD continues to receive positive ratings from the majority of those that submit a survey. **Attachment #4**

Board and Staff Speaking Engagements

Dr. Paul Kleinstub and I made a presentation to the second year Dental Students at the OHSU School of Dentistry in Portland on Wednesday, February 24, 2016.

Teresa Haynes and I made a License Application Presentation the Dental Hygiene students at ODS/OIT in La Grande on Monday, February 29, 2016. We were also joined by Dr. Gary Underhill who shared some words of wisdom from a Board member's perspective.

The Oregon Dental Conference was held at the Oregon Convention Center in Portland, April 7-9, 2016. We had a table outside the Exhibit Hall with staff available to answer questions. Dr. Paul Kleinstub and I made presentations on Thursday, April 7th covering an overview of the Board, the complaint process and a review of the "must knows." As part of the DBIC Risk Management Seminar on Thursday, we presented on the investigative process as well.

2016 Dental License Renewal

The following are the final numbers on the March 2016 Dental Renewal:
1966 – Renewed as of April 4, 2016; 1788– Expired (84 Out of State, 58 in Oregon); 35 – Retired; 1 – Resigned

AADA/AADB/NDAEF Mid-Year Meeting

I will have an update for the Board regarding the American Association of Dental Administrators (AADA) and the American Association of Dental Boards (AADB) Meetings. Dr. Beck attended the National Dental Examiners Advisory Forum (NDAEF), all were held between April 10-11, 2016, in Chicago, IL.

Proposed DANB Meeting

Teresa Haynes and I have been working with DANB to facilitate the July 1, 2016 change over, regarding DANB issuing all dental assisting certifications on behalf of the OBD, as voted on by the Board at the December 18, 2015 Board meeting. I propose a visit to DANB headquarters in Chicago to review the final documents, meet with their leadership and work out the final details of this arrangement. I ask that the Board approve my travel to Chicago, IL in June, and I will approve Ms. Haynes' travel. **ACTION REQUESTED**

CAFR Gold Star Certificate 2015

The State Controller's Office has once again issued the OBD a FY 2015 Gold Star Certificate signifying that the OBD has provided accurate and complete fiscal year end information in a timely manner. **Attachment #5**

2017 OBD Meeting Dates

Attached is a draft of the proposed meeting dates for 2017. The Board needs to adopt dates for next year's meetings. **Attachment #6 ACTION REQUESTED**

Oregon Employees Charitable Fund Drive Results

The annual report for the Charitable Fund Drive is provided. **Attachment #7**

Citizen Advocacy Center

There is an opportunity to support the Citizen Advocacy Center (CAC) in September when their annual meeting is held in Portland. The Oregon Medical Board's Executive Director, Kathleen Haley is helping coordinate with the CAC and asked the other health regulatory boards for support as well. Sponsorship for a coffee break runs \$500.00. CAC is the only organization that represents public members on health boards. It has low membership fees and an excellent newsletter with information relevant to the OBD. I ask that the Board consider sponsoring a coffee break which would give the OBD mention in their meeting materials and discounts on attending the meeting. **Attachment #8 ACTION REQUESTED**

Strategic Planning Session

Tab 18 in the Board book and has been disseminated as a separate public document with information for our session. We will discuss the agenda items and have an overview with Sue Dicile toward the end of our board meeting today. I will have some remarks, and so will Lori Lindley as we set the stage for our session tomorrow.

Newsletter

The last newsletter was published in December. I anticipate the next edition going out later in the year will incorporate the Board's Strategic Plan along with other important news and updates relevant to our Licensees.

Appn Year 2017
BOARD OF DENTISTRY
Fund 3400 BOARD OF DENTISTRY
For the Month of FEBRUARY 2016

REVENUES

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
0975	OTHER REVENUE	9,728.61	990.48	10,719.09	55,001.00	44,281.91
0505	FINES AND FORFEITS	53,500.00	6,000.00	59,500.00	75,000.00	15,500.00
0205	OTHER BUSINESS LICENSES	800,542.00	348,060.00	1,148,602.00	3,141,259.00	1,992,657.00
0605	INTEREST AND INVESTMENTS	2,358.74	470.59	2,829.33	8,000.00	5,170.67
0410	CHARGES FOR SERVICES	7,315.00	2,464.00	9,779.00	17,200.00	7,421.00
0210	OTHER NONBUSINESS LICENSES AND FEES	2,250.00	0.00	2,250.00	16,000.00	13,750.00
		875,694.35	357,985.07	1,233,679.42	3,312,460.00	2,078,780.58

TRANSFER OUT

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

PERSONAL SERVICES

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
3180	SHIFT DIFFERENTIAL	30.38	0.00	30.38	0.00	-30.38
3170	OVERTIME PAYMENTS	1,671.20	0.00	1,671.20	3,771.00	2,099.80
3160	TEMPORARY APPOINTMENTS	2,620.05	0.00	2,620.05	3,920.00	1,299.95
3110	CLASS/UNCLASS SALARY & PER DIEM	248,135.33	47,453.70	295,589.03	1,099,464.00	803,874.97
3220	PUBLIC EMPLOYEES' RETIREMENT SYSTEM	36,153.51	6,188.02	42,341.53	168,815.00	126,473.47
3221	PENSION BOND CONTRIBUTION	13,111.07	2,220.36	15,331.43	58,360.00	43,028.57
3250	WORKERS' COMPENSATION ASSESSMENT	126.31	21.61	147.92	552.00	404.08
3270	FLEXIBLE BENEFITS	58,999.36	10,257.95	69,257.31	244,224.00	174,966.69
3260	MASS TRANSIT	1,436.88	258.69	1,695.57	6,881.00	5,185.43
3230	SOCIAL SECURITY TAX	19,252.58	3,644.58	22,897.16	87,416.00	64,518.84
3210	ERB ASSESSMENT	67.20	11.52	78.72	352.00	273.28
3190	ALL OTHER DIFFERENTIAL	0.00	0.00	0.00	35,483.00	35,483.00
		381,603.87	70,056.43	451,660.30	1,709,238.00	1,257,577.70

SERVICES and SUPPLIES

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
4400	DUES AND SUBSCRIPTIONS	4,362.95	0.00	4,362.95	1,043.96	-3,318.99
4175	OFFICE EXPENSES	25,446.43	1,786.68	27,233.11	84,561.00	57,327.89
4575	AGENCY PROGRAM RELATED SVCS & SUPP	33,460.34	513.00	33,973.34	165,516.01	131,542.67
4125	OUT-OF-STATE TRAVEL	0.00	0.00	0.00	0.00	0.00

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
4100	INSTATE TRAVEL	8,153.83	2,158.04	10,311.87	49,208.00	38,896.13
4715	IT EXPENDABLE PROPERTY	601.00	1,509.32	2,110.32	5,421.00	3,310.68
4250	DATA PROCESSING	1,989.75	429.00	2,418.75	6,412.00	3,993.25
4150	EMPLOYEE TRAINING	13,022.13	0.00	13,022.13	68,577.04	55,554.91
4275	PUBLICITY & PUBLICATIONS	2,585.93	472.96	3,058.89	13,800.00	10,741.11
4200	TELECOMM/TECH SVC AND SUPPLIES	4,804.38	317.92	5,122.30	23,155.99	18,033.69
4315	IT PROFESSIONAL SERVICES	8,400.00	0.00	8,400.00	52,460.00	44,060.00
4300	PROFESSIONAL SERVICES	70,122.28	5,973.63	76,095.91	125,917.20	49,821.29
4650	OTHER SERVICES AND SUPPLIES	25,587.56	8,565.77	34,153.33	71,185.81	37,032.48
4425	FACILITIES RENT & TAXES	45,075.42	6,466.25	51,541.67	154,455.00	102,913.33
4225	STATE GOVERNMENT SERVICE CHARGES	18,704.98	412.43	19,117.41	39,124.99	20,007.58
4325	ATTORNEY GENERAL LEGAL FEES	26,384.00	0.00	26,384.00	224,149.00	197,765.00
4375	EMPLOYEE RECRUITMENT AND DEVELOPMENT	0.00	0.00	0.00	655.00	655.00
4700	EXPENDABLE PROPERTY \$250-\$5000	0.00	0.00	0.00	5,421.00	5,421.00
4475	FACILITIES MAINTENANCE	0.00	0.00	0.00	542.00	542.00
		288,700.98	28,605.00	317,305.98	1,091,605.00	774,299.02

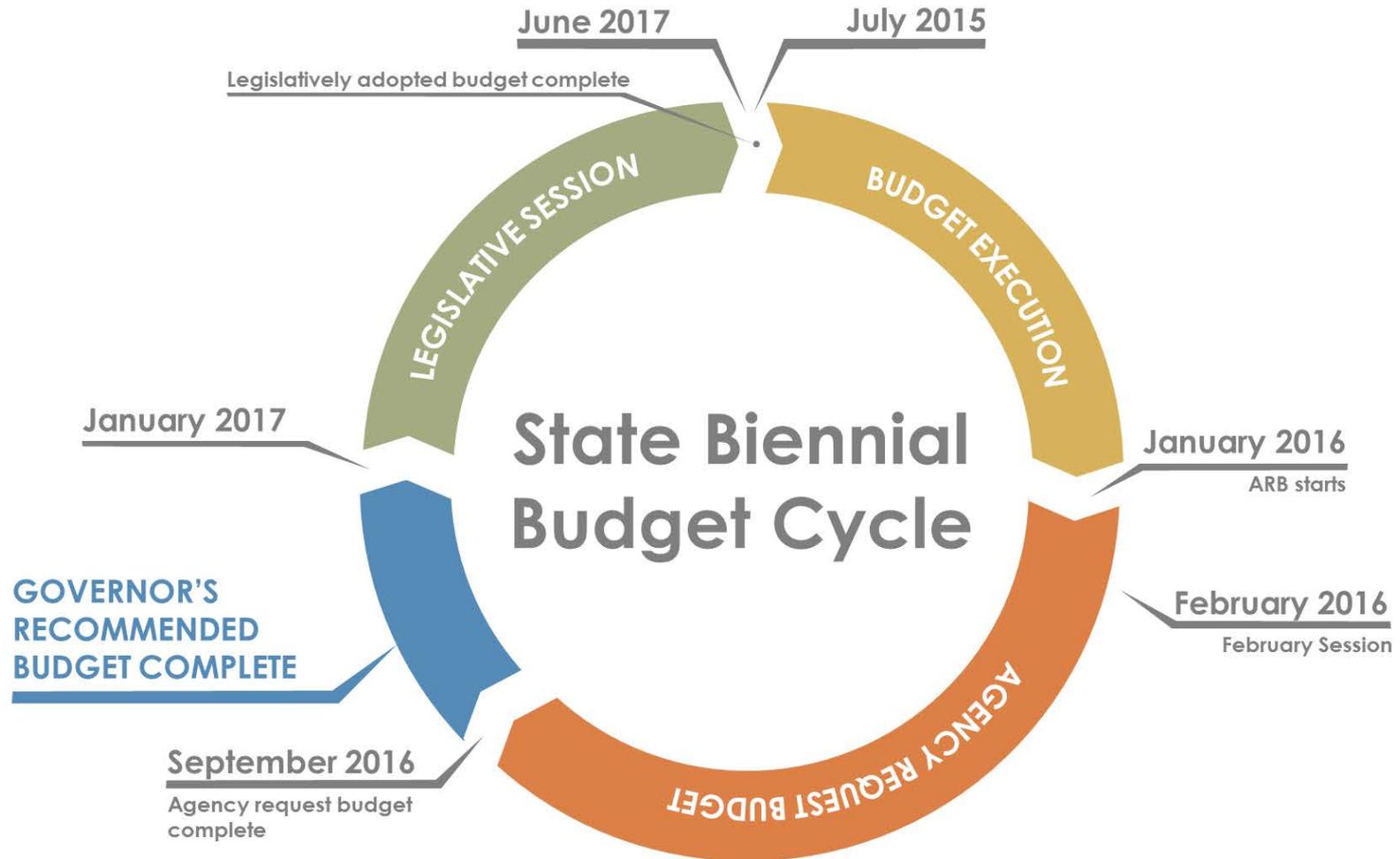
SPECIAL PAYMENTS

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
6443	DIST TO OREGON HEALTH AUTHORITY	32,922.00	0.00	32,922.00	185,128.00	152,206.00
		32,922.00	0.00	32,922.00	185,128.00	152,206.00

		3400		
		Monthly Activity	Biennium Activity	Financial Plan
REVENUES	REVENUE	357,985.07	1,233,679.42	3,312,460.00
	Total	357,985.07	1,233,679.42	3,312,460.00
EXPENDITURES	PERSONAL SERVICES	70,056.43	451,660.3	1,709,238.00
	SERVICES AND SUPPLIES	28,605	317,305.98	1,091,605.00
	SPECIAL PAYMENTS	0	32,922	185,128.00
	Total	98,661.43	801,888.28	2,985,971.00
TRANSFER OUT	TRANSFER OUT	0	0	216,000.00
	Total	0	0	216,000.00

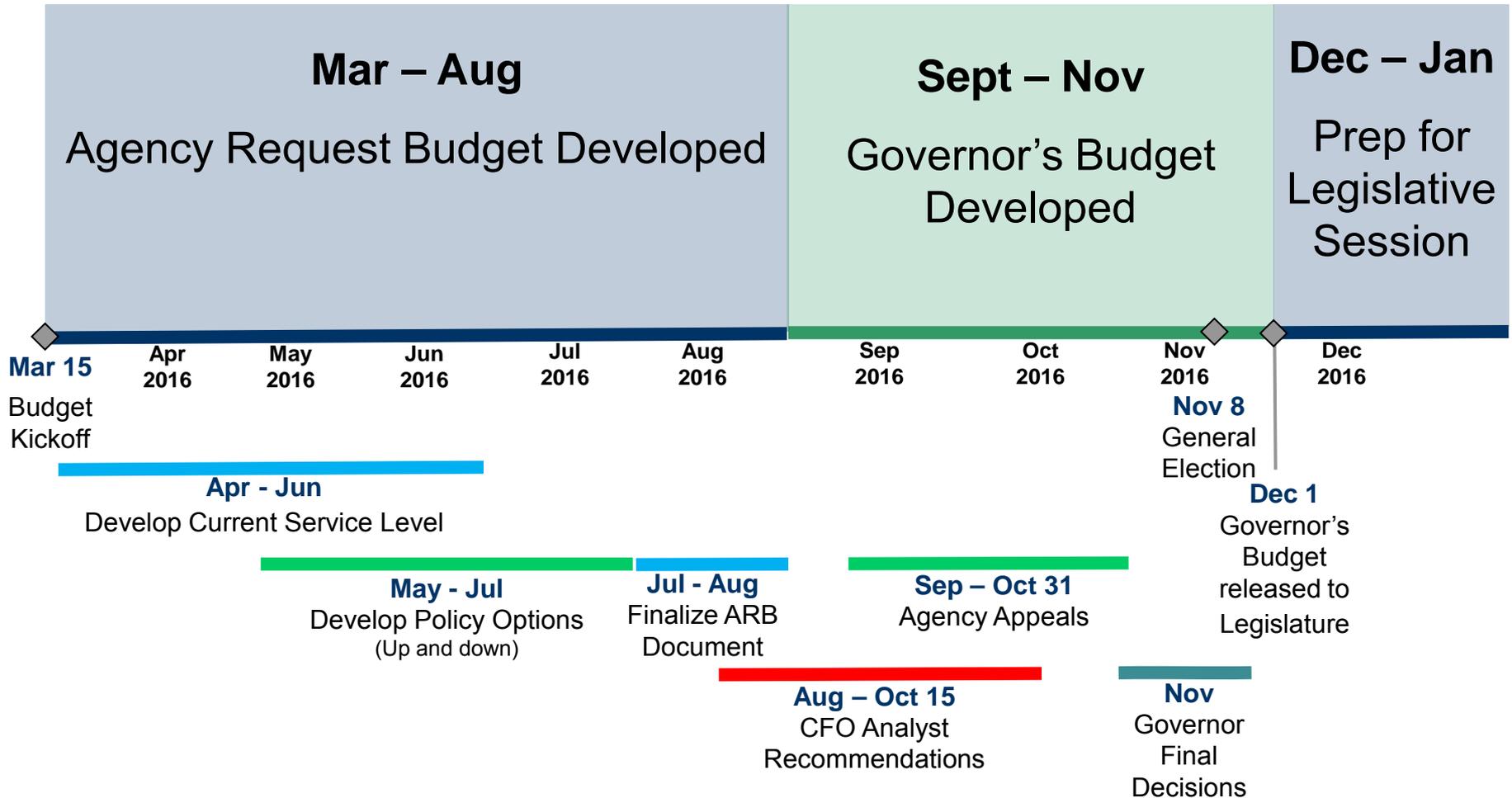


Oregon's Budget Process





Budget Development Timeline



2017-19

Budget & Legislative Concepts Instructions

March 2016

State of Oregon
Department of Administrative Services
Chief Financial Office



DAS Department of Administrative Services
George Naughton, Interim Director
155 Cottage St. NE, Salem, Oregon
<http://www.oregon.gov/das>

Department of Administrative Services

CHIEF FINANCIAL OFFICE

George Naughton	Chief Financial Officer	503-378-5460
Brian DeForest	Deputy Chief Financial Officer	503-378-5442
Kristin Keith.....	Processes/Procedures.....	503-378-6203
Bonnie Mathews.....	Receptionist	503-378-3106
Kim Wisdom.....	CFO Executive Assistant.....	503-378-5087
Kay Erickson	Budget Policy Manager	503-378-4588
Dustin Ball	Policy and Budget Analyst	503-378-3119
Tamara Brickman.....	Policy and Budget Analyst	503-378-4709
Cathy Connolly.....	Policy and Budget Analyst	503-373-0083
Patrick Heath.....	Policy and Budget Analyst	503-378-3742
Michelle Lisper	Policy and Budget Analyst	503-378-3195
Tom MacDonald	Policy and Budget Analyst	503-378-3619
Anthony Medina	Assistant Policy and Budget Analyst	503-378-3117
Bill McGee	Policy and Budget Analyst	503-378-2078
Robert Otero.....	Assistant Policy and Budget Analyst	503-378-3127
Lisa Pearson.....	Policy and Budget Analyst	503-378-7501
Linnea Wittekind	Policy and Budget Analyst	503-378-3108
Jean Gabriel	Finance & Planning Section Manager	503-378-3107
Daniel Christensen	Senior Planner.....	503-569-8981
Keith Johnston	Administrative Specialist.....	503-378-2414
Mark Miedema	Capital Finance Analyst	503-378-4735
Rhonda Nelson.....	Capital Finance Analyst	503-378-8927
Sandra Rosier	Financial Coordinator.....	503-378-8996
Lyndon Troseth.....	Financial Coordinator.....	503-378-3105
Eugene VanGrunsven.....	Data Analytics and Systems Analyst.....	503-383-5439
Alice Wiewel	State Architect & Director of Facilities Planning.....	503-383-6513
Sandy Ridderbusch	SABR Section Manager	503-378-2277
April Carpenter	ORBITS Auditor.....	503-373-0211
Shawn Miller.....	Budget Systems Analyst	503-378-2227
Michele Nichols.....	Senior SABRS Auditor	503-373-1863
John Poitras	Senior Systems Analyst	503-378-3163
Patrick Sevigny	PICS Auditor.....	503-378-8203

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Executive Summary

The last several biennia have seen significant changes in state government. After weathering one of the worst recessions in our history, Oregon has recovered much of its economic momentum. Our unemployment rate is down and our job gains are outpacing those in the typical state, as are wages for Oregon workers. While the recovery has been slowly building momentum, it provided steady growth benefitting many of our communities.

At the same time, we have tackled significant issues and reinvested in K-12 education and the dream of college education through the Oregon Promise. We have expanded health care coverage for Oregon families, while limiting the rate of growth for health care expenditures. We have also invested in affordable housing, seismically retrofitting our schools and helping local communities manage their water supplies. Our investments will pay dividends for many years to come.

As we begin planning for the 2017-19 biennium, our investment choices need to remain focused on how we achieve our long term vision. As Governor Brown builds her agenda for the next several years, it centers around a strategic plan that includes five areas of focus for state government. Those focus areas include:

- A Seamless System of Education;
- A Thriving Oregon Economy;
- Excellence in State Government;
- Safer, Healthier Communities; and,
- Responsible Environmental Stewardship

As agencies build their specific budget proposals for 2017-19, they should articulate how their proposals fit into the Governor's five focus areas and our longer term strategic vision. In some cases, agency proposals will be integrally tied to key Governor change initiatives in one or more of our focus areas. In many other cases, however, agency funding requests may be only loosely linked to fundamental change proposals. In both cases mentioned above, the budget instructions which follow provide the context and technical requirements for how state agencies are to develop their 2017-19 Agency Request Budgets.

Timely submission of budget materials by established deadlines is essential to budget development. Agencies need to ensure that key policy decisions inform budget planning, to ensure that these decisions are translated into agency budget documents. Incremental changes to the budget process over previous biennia have enabled both agencies and the CFO to better meet these deadlines. However, if there is a change in an agencies' circumstances or critical information emerges late in the budget process that materially impacts an Agency Request Budget, these may be addressed within the final Governor's Budget.

The basic structure of budget development remains the same:

1. The 2015-17 Legislatively Approved Budget provides the foundation for the Base Budget. The adopted budget is adjusted for Legislative Sessions, Emergency Board actions (if any), and non-limited administrative actions through April 2016, resulting in the Legislatively Approved Budget. The approved budget is also adjust for projected personal services growth from PICS and scheduled debt service supplied by CFO. Capital Construction budgets approved in 2015-17 are not included in the 2017-19 Base Budget.

Executive Summary

2. Essential packages are added to the Base Budget to develop the Current Service Level; *i.e.*, the cost of continuing legislatively approved programs through the 2017-19 biennium. Inflation and phase-ins of legislatively approved program changes are examples.
3. Policy packages reflect other program and policy changes that will affect the budget if adopted.

Determine the budget building blocks early in the process:

1. Proposed changes to program unit cross-reference numbers for preparation of the 2017-19 budget are due to the CFO by March 31, 2016. Changes to agency cross-references require the concurrence of the CFO, Legislative Fiscal Office and affected agency.
2. Forecasts of all Lottery Funds (beginning balance only for Measure 76 agencies), Other Funds, and Federal Funds revenues are due by March 31, 2016.
3. Exception request concepts must include preliminary financial estimates, and are due to CFO by March 31, 2016.

Standard inflation factors and the Department of Administrative Services' (DAS) [Price List of Goods and Services](#) will specify how to determine price changes and cost estimates. The standard biennial inflation factors are: 3.7 percent for general inflation, 4.1 percent for non-state employee personnel costs, and 4.1 percent for medical services. Non-standard inflation and cost increases will be evaluated on a case-by-case basis in accordance with the Exception Process.

Each agency will identify 10 percent reduction options from the current service level for programs supported by General Fund and/or Lottery Funds. Ten percent reductions from the modified CSL in Other Funds and Federal Funds will also be identified to comply with ORS 291.216, as amended by SB 1596 (2016).

New statewide employee compensation increases for the 2017-19 biennium, such as cost of living adjustments (COLAs), will not be included in Agency Request Budgets. Any proposed increase will be in the Governor's Budget as a statewide request. Pension Obligation Bonds, which were issued in 2003-05 to reduce the PERS unfunded actuarial liability, are repaid by agencies. Specific Pension Obligation Bonds budget information will be provided to agencies in a separate communication later.

Agency budgets should be focused on achieving outcomes. Agencies will continue to develop and report Key Performance Measures, and other internal agency measures when appropriate. Agencies will include specific outcome measures with each policy package requested.

Current and proposed investments in information Technology (IT), should align with the Governor's goals and initiatives and the Enterprise Information Resources Management Strategy. Proposed IT investments should be clearly linked with agency strategic and business plans and be justified on the basis of a sound business case. Information about IT investments with estimated total costs of \$150,000 or greater must be entered into the Enterprise Project and Portfolio Management (PPM) system. For IT investments exceeding \$1million, agencies are also required to comply with the Joint State CIO/LFO Stage Gate Review process. Estimation of the total costs across all biennia must include any hardware, software, contract services, internal staff, capital costs, and indirect and overhead costs expected to be incurred during the 2017-19 biennium regardless of whether the agency intends to fund the project through its base budget or a policy package. Additionally, agencies must provide the Office of the State CIO (OSCIO) with planning information that includes a list of all IT projects and business case documents for major IT projects the agency plans to initiate in the 2017-19 biennium. This information should be provided to the OSCIO at the same time the agency submits its Agency Request Budget document to the CFO. These are to be included in the Special Reports section of the Budget Binder.

Executive Summary

Agencies should update their revenue estimates with the most current information available at the time they submit their Agency Request Budget. *This means that agencies can continue to update their revenues even after they have finished their CSL audit.*

Any agency proposing a policy package that impacts another agency's budget should coordinate with the affected agency early in the process. For instance, an agency planning its budget for vehicle purchases should coordinate with the Department of Administrative Services (DAS), Enterprise Asset Management (EAM) so that DAS can also take those purchases into account. The same holds true if an agency is proposing an office expansion; work with DAS EAM. Similarly, agencies should work with the State Data Center when proposing IT projects that may affect workload or hardware needs in the Data Center.

CHANGES FROM THE PRIOR BIENNIA BUDGET INSTRUCTIONS

- The basic construct of budget policy is unchanged. However, these instructions have been reformatted and rearranged. Hopefully, they are also easier to understand. The general format of the instructions now follows more of a chronological order through the budget preparation cycle. Each section contains the policy, theory and detailed instructions for a particular phase of the budget process. For instance, Base Budget explains how the base is established, the options available to the agency, and instructions on how to make changes.

- SB 1596 (2016) provides minor process changes to budget development and clarifies some archaic language, thus modernizing the statutes using current language and terminology. One important change to agencies that have General Fund debt service is an addition to ORS 291.206:

“(3) As supplemental information, each agency request budget shall include options for a 10 percent reduction from the estimate of the projected costs of continuing currently authorized activities or programs for the next biennium, **excluding debt service**. Each state agency shall describe the 10 percent reduction in terms of the activities or programs that the agency will not undertake. The activities or programs must be ranked in order of importance and priority on the basis of lowest cost for benefit obtained.” (Emphasis added)

- New this year, agencies must comply with the OSCIO Stage Gate Review process for all new or continuing IT projects of \$1 million or greater. See Appendix A for specific requirements.
- Agencies with Federal Maintenance of Effort requirements must be prepared to share the methodology and calculations with CFO and LFO analysts upon request.
- While agencies will not be required to reorganize their administrative budget structures, they should be prepared to present the amount they spend on Information Technology, Human Resources, Procurement, and Fiscal Services upon request.

Executive Summary

2017-19 BUDGET DEVELOPMENT SCHEDULE

March 4, 2016	Actuals audit transmittals due to SABRS.
March 15, 2016	Agency Budget Kickoff Meeting at the Cascade Hall, Oregon State Fairgrounds
March 18, 2016	February session actions (input spreadsheets) due to SABRS
March 31, 2016	<ul style="list-style-type: none">• SCR/DCR changes due to CFO – Agency, CFO & LFO consensus needed for budget prep• Revenue estimates and methodology due to CFO• Current service level exception requests due to CFO
April 11 or 15, 2016	Last date to submit legislative concepts to DAS is April 15, 2016. Agencies with 10 or more concept requests must submit requests by April 11, 2016.
April 21, 2016	SABR kickoff meeting at Employment Building Auditorium. PICS and ORBITS systems open.
April 29, 2016	<ul style="list-style-type: none">• Last date for CFO approval on current service level exception requests• Last date to submit Performance Measure change request form to CFO, LFO
May 6, 2016	PICS start-up transmittals due – “Base” positions frozen in PICS for all agencies
May 16, 2016	Last date to submit Article XI-Q Bond and Lottery Revenue Bond Financing Request forms.
May 31, 2016	<ul style="list-style-type: none">• PICS CSL information and audit transmittal due to SABRS• ORBITS CSL information and audit transmittal due to SABRS – early submittal agencies only
June 30, 2016	<ul style="list-style-type: none">• PICS ARB information and audit transmittal due to SABRS – all agencies• ORBITS CSL information and CSL audit transmittal due to SABRS – all remaining agencies• ORBITS ARB information and audit transmittal due to SABRS – early submittal agencies only
July 29, 2016	ORBITS ARB information and audit transmittal due to SABRS – all remaining agencies
August 1, 2016	2017-19 Agency Request Budget narrative due to CFO and IT project reporting – early submittal agencies only
September 1, 2016	2017-19 Agency Request Budget narrative due to CFO and IT project reporting – all remaining agencies
To Be Announced	<ul style="list-style-type: none">• Audit request(s) to SABRS for 2017-19 Governor's Budget.• Last date to submit Annual Performance Progress Report (as part of the GB).• Agency's 2015-17 Governor's Budget document delivered to CFO and the Legislature.
90 days after session	Audit request(s) to SABRS for 2017-19 Legislatively Adopted Budget
120 days after session	Agency's 2017-19 Legislatively Adopted Budget document to CFO and LFO

Executive Summary

EARLY SUBMITTAL AGENCIES

The agencies listed below are considered "early submittal" agencies for CSL audit and ARB submission. CSL audit transmittals are due to the CFO no later than May 31, 2016 for agencies listed below. All others are due no later than June 30, 2016. Final Agency Request Budgets (ARB) are due from early submittal agencies on August 1, 2016 and all other agencies on September 1, 2016.

Accountancy, State Board of	Land Use Board of Appeals
Advocacy Commissions Office, Oregon	Library, State
Agriculture, Department of	Liquor Control Commission, Oregon
Aviation, Oregon Department of	Marine Board
Blind, Commission for the	Medical Board, Oregon
Chiropractic Examiners, Board of	Military Department, Oregon
Clinical Social Workers	Nursing, Board of
Columbia River Gorge Commission	Oregon Health and Science University
Construction Contractors Board	Parole and Post-Prison Supervision, Board of
Consumer and Business Services, Dept. of	Pharmacy, Board of
Counselors and Therapists	Psychiatric Security Review Board
Criminal Justice Commission	Psychologist Examiners, Board of
Dentistry, Board of	Public Employees' Retirement System
District Attorneys and their Deputies	Public Safety Standards and Training, Dept. of
Employment Department	Public Utility Commission
Employment Relations Board	Racing Commission
Energy, Department of	Real Estate Agency
Geology and Mineral Industries, Dept. of	State Lands, Department of
Government Ethics Commission	Tax Practitioners, State Board of
Health Related Licensing Boards	Teacher Standards and Practices Commission
Housing and Community Services, Oregon	Veterans' Affairs, Department of
Labor and Industries, Bureau of	Water Resources, Department of
Land Conservation & Dev., Dept. of	

Key Economic and Demographic Trends

- Following recent years when virtually every economic indicator was signaling good news, recent months have brought deterioration to a few key measures. Led by stock market declines, along with manufacturing weakness, more analysts and economists are wondering if the next recession is coming sooner than they expected just a few months ago. While the risk of recession this year remains low, according to the Wall Street Journal's Economic Forecasting Survey, the chance of a downturn has risen from 10 percent over the summer to 17 percent at the beginning of 2016.
- Oregon continues to see full-throttle rates of growth. Job gains are outpacing those in the typical state, as are wages for Oregon workers. The state's average wage today, while still lower than the nation's, is at its highest relative point since the mills closed in the early 1980s. Furthermore, these wage increases are not confined to certain industries or regions of the state. Rather, wage gains are seen statewide and across all major industries.
- Oregon's recovery has become more broad-based. Every region of the state is now adding jobs, the long-term unemployed are finding jobs at much higher rates, and Oregon has recovered more than half of the middle-wage jobs that were lost during the recession.
- Heading into the 2017-19 biennium, Oregon's rate of job growth is expected to slow somewhat as the economic expansion matures. At that point, Oregon's labor market will have returned to balance. Although Oregon has already recovered all of the jobs lost during the recession, and unemployment rates are low, there is still some slack in the local labor market. By the beginning of 2017-19 it is expected that there will be enough jobs to absorb all of the new workers that have moved to Oregon as well as the discouraged ones who are now reentering the workforce.
- Rising interest rates and the retirement of many workers in the baby boom population cohort will put downward pressure on growth. Although economic growth is expected to persist throughout the biennium, employment and income gains are expected to remain subpar by historical standards.
- Although the rate of recovery will not match that seen in previous business cycles, Oregon's economy is expected to outperform those in other states. Oregon's population growth advantage has returned, and while there is some risk from weakness among trading partners, Oregon's major manufacturers continue to outperform their peers in other states.
- Oregon's population is expected to continue growing, but at a slower pace than during the past two decades. The total population is forecast to increase by 97,200 during the 2017-19 biennium, with 79 percent of the change coming from net migration. Oregon's population has exceeded 4 million in 2015.
- Although overall population gains will be modest during 2017-19 (2.4%), growth will be paced by older seniors (age 75-84 years old; 11.7%) followed by the youngest seniors (age 65-74 years old; 8.3%). Gains among the oldest seniors (85 years and older) will be rather small (1.1%). Growth among other budget-driving population cohorts is as follows: Head Start/Childcare (0-4 years: 1.5%), TANF/Foster Care (0-17 years: 0.5%), K-12 Education (5-17 years: 0.1%), Youth Correctional (12-17 years: 0.8%), Higher Ed (18-24 years: 0.5%), Prison Inmate (Male 18-44 years: 2.8%).
- The prison inmate population is expected to grow at a rate of 1.3 percent during the 2017-19 biennium, from 14,745 in July 2017 to 14,930 in July 2019. Growth would be stronger if not for

Key Economic and Demographic Trends

the expected impact of sentencing reforms passed during the 2013 legislative session. The prison population forecast is at risk. Significant population reductions due to sentencing reforms have yet to materialize in the data.

REVENUE OUTLOOK

General Fund/Lottery

- Based on the March 2016 forecast, General Fund revenues are projected to grow to \$19,418.6 million. Personal income tax constitutes 89 percent of the total, with corporate income tax contributing an additional 5 percent.
- Lottery resources are expected to be \$1,302.7 million for the 2017-19 biennium, an increase of 7 percent relative to the current biennium. Video lottery will account for around 90 percent of lottery resources.
- Significant risks to the revenue forecast remain. Oregon's economic recovery remains subject to the tide of global economic conditions. Also, due to the volatile nature of Oregon's personal income tax, changes in economic conditions or the value of investments can have dramatic effects on revenue collections.

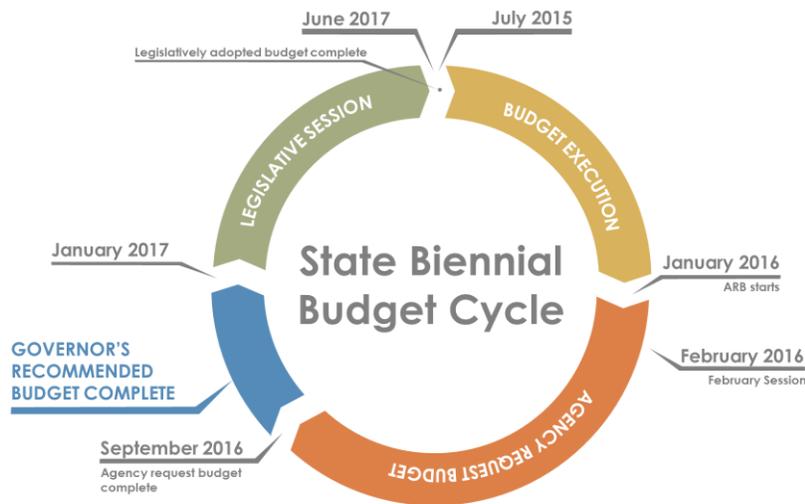
Tobacco/Health Plan

- Cigarette and Other Tobacco taxes dedicated to the General Fund are forecast to total \$127.1 million in the 2017-19 biennium.
- Cigarette and Other Tobacco taxes dedicated to the Oregon Health Plan are forecast to total \$288.5 million for the 2017-19 biennium. An additional \$40.8 million in tobacco taxes will be available for Mental Health, and \$15.2 million will be available to fund the Tobacco Use Reduction Account.

Budget Overview

PHASES OF THE BUDGET PROCESS

The budget development process has three major phases: the Agency Request Budget (ARB), the Governor's Budget, and the Legislatively Adopted Budget (LAB)—during the interim between ARB and LAB there are a number of budget execution tasks and many opportunities for adjustments (*e.g.*, Emergency Boards).



Agency Request Budget (ARB)

Agencies initiate the budget process early in even-numbered years. Under ORS 291.208, DAS requires agencies to submit a two-year budget by August 1 or September 1 of each even-numbered year. The Agency Request Budget (ARB) is the first phase in the budget process. In the ARB, agencies describe their core mission, objectives, and program priorities and provide budget information on past, current, and future biennia. The ARB reflects the agency's policy agenda and the financial plan it would like the Governor to recommend to the legislature. Prepared under guidelines set by the Governor through DAS, the document consists of descriptive narratives, budget forms, and audited ORBITS reports. As a part of this process agencies will review their current service level (CSL) budget to determine if there are any technical corrections or exceptions that need to be made to their current biennium budget.

Typically, agency budgets are organized by program unit. Program units align with an agency's major program and/or policy issues. In smaller agencies, a single program unit may cover an entire agency. Program units are represented in ORBITS (the state's budget system of record) by Summary Cross Reference (SCR) numbers and in lower level Detail Cross Reference (DCR) numbers. The SCR and DCR numbers generally show the relationship between the agency organization and the budget structures.

It is important that agencies consider how their program changes may impact other agencies. Agencies must communicate early in the budget process when inter-agency revenue transfers are involved. For example, the Department of Revenue collects tobacco taxes that are transferred to multiple agencies. To pass audit, the transfer amounts to and from the agencies must match in the budget system. This requires that the two agencies agree both on the amount of funds to transfer and the treatment of those

Budget Overview

funds within their respective budgets. In some cases, prior transfers may not continue unchanged into next biennium. Generally, the agency sending the funds determines the transfer amount. However, each of the affected agencies' budget and program staffs should be engaged in the discussion.

Governor's Budget (GB)

The Governor and CFO review agency request and analyst recommended budgets to compile the Governor's Budget.¹ That budget reflects the Governor's priorities and the policies set in statute as well as any changes proposed by the Governor. Once final, the recommended budget and a series of statewide numbers are collected and printed as the Governor's Budget. ORS 291.218 requires transmission of the printed budget to each member of the legislature by December 1st of each even numbered year. The Governor's Budget is the starting point for budget negotiations during the Legislative Session. A Tax Expenditure Report, compiled by the Department of Revenue, is published concurrently with the Governor's Budget.

ORS 291.216 requires the Governor's Budget to include specific information set out in varying levels of categorical detail. This list includes among many other details:

- A budget message prepared by the Governor that describes the important features of the budget.
- A general budget summary that sets forth the aggregate figures and demonstrates a balanced relationship between the total proposed expenditures and the total anticipated revenues.
- Supporting schedules or statements that classify expenditures by program units, objects, and funds; the income by organization units, sources and funds, and the proposed amount of new borrowing; and proposed new tax or revenue sources, including a single comprehensive list of all proposed increases in fees, licenses, and assessments assumed in the budget plan.
- A detailed estimate of expenditures and revenues including any statements of the bonded indebtedness of the state government, showing the actual amount of the debt service for at least the past biennium, and the estimated amount for the current biennium and the ensuing biennium.

Much of the detailed information agencies are required to submit in the Agency Request Budget ensures that the Governor's Budget meets these criteria.

After publication of the Governor's Budget, each agency prepares a Governor's Budget binder to show the changes the Governor made to the Agency Request Budget. This document is used for presentation of the agency budget during the legislative session.

Legislatively Adopted Budget (LAB)

The Governor's Budget is presented to the legislature during the full legislative session in odd numbered years. Committees, typically the Joint Committee on Ways and Means or one of its subcommittees, review revenue and expenditure information. These committees hold public hearings to hear from each agency and the public. Votes on each bill produce the Legislatively Adopted Budget. The committee recommendations are presented in budget reports for each budget bill. The budget bills set out General Fund appropriations; Lottery Funds allocations and expenditure limitations; and Other Funds and

¹ The OSCIO reviews and make recommendations to the Governor and the Legislative Assembly concerning state agency information technology budget requests pursuant to ORS 291.039 (4)(a)(D).

Budget Overview

Federal Funds expenditure limitations. The budget report, while not a legal document, includes a summary of committee actions and provides a greater level of budget detail. This detail includes the assumed position authority for the agency in the budget.

Each agency prepares a Legislatively Adopted Budget document to show the changes the legislature made to the Governor's Budget. Agencies implement, or execute, the budget over the biennium. There are also several points in time when the Legislative body can meet and modify the Legislatively Adopted Budget. There is a short Legislative session in February of even-numbered years. The Emergency Board meets between sessions and can make certain changes to the budget. Special sessions may also be called to deal with emergent budget issues.

BUDGET OUTLINE

2015-17 LEGISLATIVELY ADOPTED BUDGET

Budget Overview

+ Plus **Legislative & E-Board Actions** through April of the even year

= 2015-17 LEGISLATIVELY APPROVED BUDGET (LAB)

+ Plus or **Statewide Administrative Adjustments**

- Less
 - Net Cost of Position Actions
 - Base Debt Service Adj.
 - Non-limited Adj.
 - Capital Construction

= 2017-19 BASE BUDGET

+ Plus or **Essential Packages**

- Less
 - Package 010
 - Vacancy Factor
 - Non-PICS Personal Service Adj.
 - Package 021 Phased-In Programs
 - Package 022 Phased-Out Programs
 - Package 030 Inflation
 - Cost of Goods & Services Adj.
 - State Gov't Service Charges Adj.
 - Package 040 Mandated Caseload
 - Package 050 Fund Shifts
 - Package 060 Technical Adjustments

= CURRENT SERVICE LEVEL (CSL)

- Less **Revenue Reductions**

- Package 070 Revenue Shortfall

= MODIFIED CURRENT SERVICE LEVEL

+ Plus **Emergency Board Actions**

- Package 081 May 2016
- Package 082 September 2016

Policy Packages – Package Nos. 100+

= 2017-19 AGENCY REQUEST BUDGET (ARB)

+ Plus or CFO Analyst Adjustments

- Less

= ANALYST RECOMMENDED BUDGET (AnRec)

+ Plus Agency Appeal Adjustments

= 2017-19 GOVERNOR'S BUDGET (GB)

+ Plus or Legislative Session Adjustments

- Less

= 2017-19 LEGISLATIVELY ADOPTED BUDGET (LAB)

EXPENDITURE CATEGORIES

Oregon's budget and accounting systems uses defined expenditure categories and budget groupings. ORBITS has detail accounts for line item expenditures within those categories. Agency budget staff should review the categories and work with agency accounting staff to ensure expenditures are recorded appropriately and correcting entries are held to a minimum.

- **Personal Services** are employee gross compensation, also known as total compensation. This includes wages, benefits, temporary state staff, unemployment assessments, pay differentials, vacancy savings, and other personnel costs.
- **Services and Supplies** are non-personnel expenditures for agency operation and maintenance. This includes office supplies, professional services contracts, rent, telephones, personal computers, software, routine building repairs, and the like. Debt issuance costs related to bonds should be budgeted in the Services and Supplies category in the agency's operating budget, not in Capital Construction.
- **Capital Outlay** refers to expenditures for items not consumed in routine agency operations. These expenditures have a useful life of more than two years with an initial value of \$5,000 or more.
- **Special Payments** are transfers and payments to external entities. They include benefits payments to individuals; distributions to governments and others; distributions of contributions, loans, deposits, or collections; and other transfers or payments where goods and services are not received in return.
- **Debt Service** includes expenditures for principal, interest, discounts, and premiums related to payment of state debt. Debt includes financing agreements such as COPs. Discretionary bond-related program expenditures may relate to debt, but are not debt service. They include trust agreements, audit and compilation fees; travel costs; Bond Counsel, and general financial consulting, and should be budgeted in Services and Supplies.
- **Capital Improvement** and **Capital Construction** are expenditures for land, buildings and support systems, and equipment/information technology-related projects or systems. (These categories should not include routine maintenance and repairs.) While these are not expenditure categories, they are treated as separate program units in agency budgets.
- **Non-limited Expenditures.** As a rule, agencies can only spend within the limitations given them in the law enacting their budgets. General Fund and Lottery Funds expenditures are always limited. However, some Other Funds and Federal Funds expenditures are approved by the Legislature as Non-limited Expenditures. Non-limited Expenditures have been approved for cases when an agency's expenditures and corresponding revenues are driven by external factors. Examples are federal unemployment claim payments and repayment of bonded debt. Non-limited Expenditures may be reported in a separate program unit. Use the normal categories, such as Personal Services, Services and Supplies, Capital Outlay, and Special Payments. See the ORBITS/PICS User's Manual for more information.

Agency budgets are built using the Position Information Control System (PICS) and ORBITS. These systems provide statewide data for decision makers. Agencies enter the data which are then audited by CFO/SABRS before final documents can be completed. Deadlines for agencies to request audits are outlined on page 4 of these budget instructions. ORBITS has audit tools for both agencies and audit staff to help speed up the processing of audits. However, agency actions are critical to make sure the process flows smoothly.

Budget Overview

To help your audit process:

- Complete agency policy and program decisions well in advance of deadlines. If needed, schedule board or commission meetings for discussion of budget issues early in the budget development process.
- Allow enough time, or overtime, for agency staff to enter detail into PICS and ORBITS.
- Make sure data input in ORBITS is correct before asking for your agency's audit.
- Respond promptly to requests from CFO Analysts and SABRS staff during the audit process.

PROCESS RESOURCES

There are budgeting resources available to agencies on the SABRS website

<http://www.oregon.gov/DAS/Financial/Pages/SABRS.aspx> including:

- The budget instructions that describe state policy and the procedures to build a clear and complete budget.
- The ORBITS and PICS User's Manuals include instructions for the Position Information Control System (PICS) and the Oregon Budget Information Tracking System (ORBITS) systems.
- The DAS Price List of Goods and Services details assessments, service charges, and other costs.
- SABR Coordinator Presentations contain additional information regarding the various stages of audit.
- The Oregon Legislative Information System (OLIS) has links to budget bills, budget reports, and other actions for multiple sessions.

Budget Development

EARLY PREPARATION

JANUARY – MARCH

An agency request budget is built in three basic phases: the Base Budget, the Current Service Level (CSL) and finally the Agency Request Budget (ARB). Before these phases can be undertaken it is necessary to complete some early budget preparation including validating historical data in ORBITS, determining program units, submitting exception requests, and developing revenue estimates.

Historical Data in ORBITS

During January of even numbered years, the SABR section prepares the ORBITS system for the upcoming budget prep cycle, creating new column headers, indexing the database for the new biennium, and loading data elements and budget drivers. ORBITS stores historical budget data in columns, including the 2013-15 Actuals (revenues and expenditures) and the 2015-17 Legislatively Approved Budget. The 2013-15 Actuals column data are downloaded directly from accounting data in the Statewide Financial Management System (SFMA) and the agency will have the opportunity to review and modify the data. Agencies complete their review of the Actuals column and submit it to SABRS by March 4th. SABRS staff will review the Actuals column data for each agency to see if there are any audit errors. If audit errors are found, the agency will have to correct them before they pass this audit phase. Agencies may request access to the raw data through the SABR section and their CFO analyst. At this point, the agency should not adjust any expenditures in the Actuals Column between categories or programs. These changes will occur during the Base budget phase.

During March, agencies will provide detail information to SABRS regarding the 2016 Legislative Session actions for input into ORBITS. The SABR section will key all information related to the 2015-17 biennium into the Emergency Board Actions column, based on data provided by agencies.

Determining Program Units

Agency budgets are organized by program unit. Program units contain an agency's major program and policy issues. In some cases, one unit may cover an entire agency. An agency may also have program units for Capital Improvement, Capital Construction, Debt Service, and Non-limited Expenditures. Program units are represented in ORBITS by Summary Cross Reference (SCR) and Detail Cross Reference (DCR) numbers. SCR and DCR numbers generally show the relationship between the agency organization and the budget structure.

To start the budget preparation cycle, an agency must first decide whether the program units used for the last budget are still appropriate. Agencies should work with their CFO and Legislative Fiscal Office (LFO) analysts to ensure that program units adequately present the major policy issues and budget data. In some cases, agencies may have to revise their program units to better portray their programs and policy issues, or for cross-agency issues.

Accounting program structures should be aligned with ORBITS program units. When reviewing ORBITS detail cross references for 2017-19 budget development, agencies should keep in mind that any requested changes to cross reference structures must be accompanied by the necessary accounting structure changes.

Proposed changes to program units are due to CFO by March 31, 2016 for budget analyst approval. CFO, LFO, and the agency must work on proposed changes in advance of the deadlines, since they must concur on all changes.

Budget Development

Refer to the ORBITS/PICS User's Manual for the technical details for developing program units and the underlying cross-reference numbers. Cross-reference numbers must be in place early to allow the Agency Request Budget to be submitted on time.

Exception Requests

Exceptions requests are appropriate when there is documented evidence of extraordinary conditions where costs are increasing at rates outside of defined inflation factors, and not funding such exceptions would prevent agencies from maintaining current operational levels in the next biennium. Budget Instructions address standard conditions and cost drivers such as inflation, mandated caseloads, funding splits and phase-ins and outs. Standard drivers do not require an exception request.

Most exception requests will not reach the approval threshold of the Exception Committee, but may be serious enough to compel the agency (with CFO Analyst permission) to include additional policy packages as part of their Agency Request Budget.

Exceptions to Standard Inflation:

- Arise from extraordinary conditions and cost drivers;
- Are specific to an agency or small group of agencies;
- Differ from generic drivers, which are applied via budget instructions, across all agencies and have been included in standard inflation factors;
- Are fact based and not reliant on worst-case scenarios or anticipation of what might or could occur; and,
- Are beyond the control and authority of agency management.

Agencies should submit exception request concepts, including ballpark dollar estimates by fund type before the end of March 2016. The Exception process begins with the formation of the committee in March 2016. The committee discusses potential hot topics and exceptional cost drivers. The Committee may decide that special inflation factors be applied to select agencies. An example might include fuel costs. Fuel is a volatile commodity subject to extraordinary inflation and becomes a substantial cost increase to agencies that are fuel intensive such as the State Motor Pool and the Oregon State Police. Agencies need to request an exception, from the CFO Analyst, to receive it.

The Exception Committee will review concepts early in April 2016 and will approve or deny the concept. If approved, the analyst will request full documentation of proposed dollar amounts from the agency. Documentation must be provided by Summary Cross Reference, by Category, and by Fund Type. Account level detail may be necessary, as determined by the analyst. The analyst will fully review the documentation and work with the agency to clarify final dollars. The analyst is responsible for certifying the amount and communicating to both the agency and SABRS for audit purposes.

Only exceptions with sufficient documentation sent to agencies and SABRS before the CSL audit process can be included in the Agency Request Budget. However, agencies may need to continue to work with analysts after the deadline to include or modify Essential Packages as part of the CSL budget for the Governor's Budget.

Exception requests are required for certain items in Packages 030, 050 and 060, as described under those packages later in this document. The following will not be accepted as an exception request:

- Annual inflation. The lone exception is for annual appropriations as directed in Legislatively Adopted Budgets (State School Fund).

Budget Development

- Postage – now tied to inflation by the U.S. Postal Service.
- Rent above maximum non-state owned rate.
- Attorney General above maximum rate as established by the CFO.
- Request to “catch up” due to previous denials, reductions, etc.

This does not prohibit these requests from being submitted as policy packages. Significant disputes between analysts, agencies, or SABRS regarding amounts and approval authority will be resolved by the Exception Committee.

Estimating Revenues and Available Resources

Agencies should update their revenue estimates with the most current information available at the time they submit their Agency Request Budget.

Revenues must cover requested expenditures. Agencies that receive Other Funds or Federal Funds must project their revenues early in the budget process and update these estimates as needed. Revenue projections should be completed for both Limited and Non-limited expenditures.

All agencies must submit a spreadsheet with detailed revenue information, as well as an attached narrative document, to the CFO and LFO analysts by March 31, 2016. For each Other Funds and Federal Funds revenue source, the spreadsheet must include:

- Actual revenues for 2013-15.
- Updated revenue estimates for the 2015-17 biennium.
- Preliminary revenue estimates for the 2017-19 biennium.
- Estimated Beginning Balance for 2017-19.
- For fee-related revenues, data on rates and numbers of units expected for both 2015-17 and 2017-19.

For Lottery Funds which do not revert (specific to Measure 76 agencies and distributions), agencies need to report only estimated beginning balance for 2017-19. Agencies should include Lottery Funds on their final revenue form (107BF07) at Agency Request.

Templates are available for agencies to use if they choose (forms 107BF06a and 107BF06b). These templates might also be useful for budget staff who are requesting information internally. If agencies choose to use their own formats, the data reported should be at least as comprehensive as these templates.

For each Other Funds and Federal Funds revenue source, the attached narrative document should include:

- Highlight of major issues, if any.
- Forecast methods and assumptions.
- Fee schedules (if any), with any proposed fee increases or new fees.
- List of any programs where anticipated revenues are not expected to be sufficient to support current service level expenditures, if known this early.
- Revenue trends through 2021.

Budget Development

Agencies should work with their CFO analyst to determine the level of detail reported, *i.e.*, which programs should be reported separately and which can be combined. This is especially important for agencies with numerous revenue sources. If an agency has a few key programs that have significant revenue issues or changes, these should be split out separately.

Work with your CFO analyst if your agency has special circumstances, such as federal entitlement revenues that will not be known until later in the process.

Agencies can continue to update their revenues even after they have finished their CSL audit.

Agency Request revenues should be consistent with the June 2016 state revenue forecast for those agencies that produce General Fund revenues. If estimates change significantly between July and October, agencies should submit new information to their CFO analyst who can incorporate it into the Governor's Budget. Agencies should also be prepared to provide further updates to their legislative fiscal analyst during the legislative session.

There are four revenue categories used for budgetary purposes – General Fund, Lottery Funds, Other Funds, and Federal Funds. Agencies should estimate and budget all revenues at the program unit level. The CFO analyst must approve any request to combine revenues across program units or agency-wide.

General Fund

General Fund revenues include revenues that an agency collects, including tax collections and some fees and fines, which go into the state General Fund. These funds are recorded in the ORBITS system by the collecting agency as General Fund revenue, with a matching revenue transfer to the General Fund.

General Fund appropriations are used for program operations. In ORBITS, they are accounted for separately from General Fund revenue.

General Fund appropriations must match the program expenditures they fund. Appropriations cannot cross biennia so General Fund beginning or ending balance are not allowed in any agency budget. General Fund for Capital Construction is appropriated for six years; however, it is shown in ORBITS as having been fully spent in the biennium in which it is appropriated. Unspent Capital Construction General Fund is not included in beginning or ending balances in agency budgets.

Lottery Funds

Lottery Funds include any of the following: 1) funds allocated to an agency by the Legislature as Lottery Funds; 2) Lottery Funds revenue transfers between agencies, *i.e.*, Lottery Funds transferred by an agency must be receipted by the receiving agency as Lottery Funds; and 3) all interest earned on Lottery Funds while held by an agency.

Lottery Funds associated with Ballot Measure 76 (2010) require a greater level of reporting and accountability for the 15 percent of net lottery proceeds directed to parks and salmon restoration.² Agencies receiving these funds should expect to provide additional detailed expenditure information beyond that which is recorded in their budget. Of the 7.5 percent net lottery proceeds for salmon restoration, at least 65 percent must be spent as grants to entities other than state or federal government entities. Up to 35 percent may be spent for ongoing operations. Of the 7.5 percent net lottery proceeds for parks, at least 12 percent must be spent as local grants.

² Oregon Constitution, Article XV Section 4a (Parks) and Section 4b (fish and wildlife, watershed and habitat protection).

Budget Development

The Transfer In from DAS or Oregon Watershed Enhancement Board (OWEB) accounts are used to reflect new 2015-17 biennium revenue allocations. Unspent lottery fund balances proposed to be carried forward from earlier allocations should be shown in ORBITS as Lottery Funds beginning balance(s) in Base Budget. Lottery Funds beyond the June forecast for requested policy packages are budgeted as generic Transfers In – Lottery Proceeds at Agency Request, which is Account No. 1040 in ORBITS. By the Legislatively Adopted Budget, all these generic transfers must be replaced by transfers from specific agencies.

Other Funds

These are agency revenues that can be spent directly under an Other Funds expenditure limitation or as Non-limited Other Funds. They include revenues received from the public, other agencies, cities, or counties. Examples include licenses and fees, loan repayments, and charges for services. Federal Funds transferred from another agency are usually considered Other Funds in the receiving agency budget.

Agencies with programs supported by Other Funds revenues must retain enough ending balance to cover cash flow needs and contingencies. They must be sure to allow for enough ending balance to accommodate statewide salary and benefit increases that may be included in the Governor's Budget. An excessive ending cash balance, however, may suggest a need for revenue reductions. Agencies should work with their CFO analysts to determine ending balance needs.

Fee and assessment levels under current law are the basis for estimating revenues for existing Other Funds sources. These current law fee and assessment revenues should be budgeted in an agency's Base Budget. Any fees established or increased administratively during the 2015-17 biennium that were not approved by the 2015 or 2016 Legislatures must be estimated separately in the budget document's Revenue Forecast Narrative. Also, any proposed new sources of Other Funds revenues and any proposed increases in existing fees must be called out in the Revenue Forecast Narrative, even if the proposed increases are within current legal limits.

New or increased fees that were anticipated in the budgeting process and were included in the Legislatively Adopted Budget for the agency are considered permanent. These revenues should be included in the Base Budget.

However, any fees established or increased through the proper administrative process during the 2015-17 biennium that were not included in the Legislatively Adopted Budget are still considered temporary. **Do not include these revenues in Base Budget projections.** These revenues are to be included in a fee increase policy package, if applicable. They automatically cease at the end of the 2016 or 2017 Legislative Sessions (or July 1, 2017), whichever is later. They continue only if they are put into law, or "ratified." This includes fees established or increased through the Emergency Board process. (See ORS 291.055 for the requirements related to changing fees administratively.)

If an agency established or increased fees administratively during the 2015-17 biennium that were not included in the Legislatively Adopted Budget, then a fee ratification bill will be drafted by DAS. This fee ratification bill will "accompany" an agency appropriation bill through the legislative process. However, if an agency's fees are explicitly listed in statute, then any proposal to establish or increase fees during the 2017 Legislative Session must be submitted to DAS in the legislative concept process (see pages 64-66).

Here are a few examples to help clarify the preceding discussion:

- **Question:** My agency raised a fee administratively in January, 2016. We had been planning this for a long time, and so the fee increase was already included in our 2015-17 Legislatively Adopted Budget. What do we do for 2017-19 budget development?

Budget Development

Answer: Include the 2017-19 revenue resulting from the fee increase in your Base Budget.

- **Question:** My agency raised a fee administratively in March, 2016. We had not anticipated this increase during the 2015-17 budgeting process, and so the fee was not included in our 2015-17 Legislatively Adopted Budget. What do we do for 2017-19 budget development?

Answer: In your Base Budget, remove the 2017-19 revenue resulting from the fee increase. Include that revenue in a fee increase policy package. The CFO will draft a fee ratification bill (a budget bill) that will accompany your regular budget bill through the legislative process.

- **Question:** My agency wants to raise a fee during 2017-19. We can do this administratively, since our statutes already allow the increase. What do we do for 2017-19 budget development?

Answer: Include the 2017-19 revenue resulting from the fee increase in a fee increase policy package.

- **Question:** My agency wants to raise a fee during 2017-19. We need a change to our statutes in order to raise this fee. What do we do for 2017-19 budget development?

Answer: Submit a Legislative Concept to change your statute to allow the new fee level requested. Legislative Counsel will draft a substantive bill for you. Include the 2017-19 revenue resulting from the fee increase in a fee increase policy package.

Agencies must report detailed information on all fee increases, establishments, or decreases included in the 2017-19 Agency Request Budget, using form 107BF22 Fee Change Detail Report. The form and accompanying cover memo must be submitted electronically to the agency's CFO analyst at the same time the Agency Request Budget is submitted.

Note: By statute, DAS must report all current fees to the Legislature at the beginning of each legislative session. To do this, agencies will be required to update the statewide fee database during the fall of 2016. This will allow agencies to include any fees that were changed during the 2015 and 2016 Legislative Sessions or changed administratively during the interim. This database should not include fee changes being proposed in the 2017-19 budget but not yet implemented. Instructions for using the database will be posted to the CFO website. An email to SABR coordinators will be sent notifying agencies when the database is open.

Federal Funds

These are revenues received from the federal government. They are spent under a Federal Funds expenditure limitation or as Federal Funds Non-limited expenditures. Federal Funds may come as direct revenue or as matching fund reimbursement for state expenditures. Federal Funds received from another agency instead of from the federal government, in general, are received and expended as Other Funds.

Use the most recently completed congressional action to estimate Federal Funds revenues. As soon as the funds are documented as authorized and appropriated, provide that information to the CFO analyst. Agencies must revise Federal Funds revenue estimates periodically as federal authorizations and appropriations change, and notify the CFO analyst.

Because most Federal Funds are provided on a reimbursement basis, most agencies include the necessary Federal Funds revenues in each Essential and Policy Package. There is no Beginning or Ending Balance. However, there are a number of exceptions to this policy. Work with your CFO analyst and SABRS staff if you have questions.

Revenue Transfers and Special Payments between State Agencies

Agencies must communicate early in the budget process if they send revenues to or receive revenues from another agency. The two agencies need to agree on the amount of funding being transferred and the budget treatment of the transfer. Prior transfers might not continue unchanged into the next biennium. Generally, the agency sending the funds determines the transfer amount. However, budget and program staff from all affected agencies should be in on the discussions.

ORBITS has an on-line report (AUD004) to help agencies review transfers for budget development. Instructions for using this screen are in the ORBITS/PICS User's Manual. Agencies must balance, or at least have documented agreement with other agencies, on all interagency Revenue Transfers and Special Payments before requesting an ORBITS audit.

BASE BUDGET

APRIL - MAY

The budget for the new biennium is built in phases, the first phase being the Base Budget. The starting point for the base budget is the 2015-17 Legislatively Adopted Budget, as approved by the 2015 Legislature. Any February Session, Special Sessions, Emergency Boards, or Non-limited administrative changes approved by DAS, through April 2016, are added to the Legislatively Adopted Budget. The result is the 2015-17 Legislatively Approved Budget. The final step to calculating the base budget includes adjustments for Personal Services generated by PICS, scheduled debt service payments, Non-limited expenditures, and Capital Construction expenditures.

- **Personal Services Adjustments** – PICS generates the Personal Services dollars for the base budget. Salaries and related Other Payroll Expenses (OPE) expenditures are calculated from PICS position data on the PICS freeze date. That date is projected to be mid-April 2016, after all changes are entered into the system for the February 2016 Legislative Session. PICS will base funding for vacant positions on the next to lowest step of the salary range. Do not include position reclassifications or other changes not yet administratively or legislatively approved in the current service level.
- **Base Debt Service Adjustment** – This shows any expected change in scheduled debt service for the 2017-19 biennium, for financing already done or authorized by the Legislature. Changes to base budget debt service are provided by DAS Capital Finance and Planning Section. The base budget should not include debt service for any financing that is not already authorized. Requests for new debt service authority should be included in policy packages.
- **Base Non-limited Adjustments** – Changes in programs with approved Non-limited Other Funds and Non-limited Federal Funds expenditures should be shown here. Requests for new Non-limited expenditure authority should be requested in policy packages.
- **Capital Construction Adjustment** – Capital Construction expenditure authority approved by the 2015 Legislature, the February 2016 Session, or by the Emergency Board prior to April 2016, should be eliminated here so that it is not included in the base budget or current service level. Requests for new Capital Construction authority should be included in policy packages.

If necessary, agencies should use the Base Budget to move amounts among line items within the same expenditure category in order to “true up” their budget. This should **not** be done in Package 030. The net result of such moves must equal \$0, and generally must not affect the higher inflation line items of Attorney General, Rent, State Government Service Charges, and Professional Services accounts.

CURRENT SERVICE LEVEL (CSL)

MAY - JUNE

The current service level (CSL) is required by law and is an estimate of the cost to continue current legislatively approved programs into the 2017-19 biennium—it is built agency by agency. The calculation starts with the agency's base budget.

Emergency Board actions or other changes after April 2016 are not included in the current service level during the agency request phase. Agencies may request continued funding for these actions in Policy Package(s) No. 08X. In some cases, adjustments to the current service level may be made at later phases of budget development, if the CFO, CIO (if IT-related), and LFO concur in the adjustment. The Summary of 2017-19 Budget form (ORBITS) presents the agency budget, including the current service level estimate. The form is presented at the program unit level and summarized at the agency-wide level. Although agencies have prepared this form manually in the past, ORBITS has been programmed to produce the form. Following is more detail on the current service level.

Essential Packages

The essential packages in budget development are assigned the ORBITS package numbers discussed below. Agencies are responsible for supplying supporting documentation for all packages to the CFO analyst. The documentation provided must include expenditures by SCR, by budget category by fund type. The analyst may also require account level detail if necessary. Agencies should work with their CFO analyst to put issues in the correct packages, and to document all packages by the end of May 2016. The documentation must be provided by Summary Cross Reference, by Category, and by Fund Type. In some cases, account level detail may be required, as determined by the analyst.

Essential Package No. 010 | Vacancy Factor and Non-PICS Personal Services

Usually the PICS system will automatically update positions costs to include 24-month pricing and identified salary adjustments that affect the next biennium. The goal of the ***Vacancy Factor*** calculation is to project budget savings reasonably expected from staff turnover in the 2017-19 biennium. The CFO will provide data on employee transfers and separations for the agency to use in projecting savings from vacancies, *i.e.*, *Vacancy Savings* form. It does not require an exception request. The change in projected vacancy factor savings is entered into ORBITS as an adjustment to the vacancy factor amount already included in the 2017-19 Base Budget—it can be either an increase or decrease. It is also reported on the Summary of 2017-19 Budget form.

Non-PICS Personal Services cost are inflation adjustments for items not included in the PICS-generated total, including: unemployment assessments, overtime, temporary employees, shift differentials and Mass Transit taxes. Apply the general inflation factor outlined in the Package 031 discussion for these items. Cost increases for these items above the standard inflation rate must be requested in a policy package. The one exception is for agencies that have both mandated caseload and 24/7 facilities, such as the Department of Corrections and Oregon Youth Authority. These agencies should work with their CFO analyst to negotiate adjustments based on specific bargaining units. A formal exception request is not required. For Pension Obligation Bonds (POB), the CFO will supply each agency the 2017-19 amount to use in the Agency Requested Budget. Agencies should not apply inflation factors. Package 010 will represent the difference between the 2017-19 Base POB amount and the value supplied by the CFO. In the case of mass transit taxes, use the formula outlined in the DAS Price List of Goods and Services, in the Other Payroll Expenses section. There should be no PICS driven changes in this package.

Essential Package No. 021 & 022 | Costs of Phased-in/Phased-out Programs and One-time Costs

Agencies are responsible for identifying budget adjustments resulting from program phase-ins (programs funded < 24 months during 2015-17 biennium), phase-outs (programs that will be suspended during the 2017-19 biennium) and other one-time costs. These will generally be found in Services and Supplies, Capital Outlay and Special Payments expenditures. A description of each program phase-in or phase-out must be included in the narrative portion of this package. Include the assumptions used to calculate the adjustment. Agencies should enter phase-ins in essential package 021 and phase-outs and one-time cost eliminations in essential package 022.

Phased-in programs include new programs and expansions of non-mandated caseload programs funded for less than 24 months during the prior biennium, but require a full 24 months in the next biennium. Package 021 should reflect the added cost of the program above the 2017-19 Base Budget level, after adjustments for program start-up costs and any other one-time expenditures funded in 2015-17. PICS will adjust for most legislatively approved position phase-ins or eliminations in its Personal Services calculation for the new biennium. To reflect full cost the agency calculates remaining adjustments for non-PICS OPE (if any) and for Services and Supplies. Agencies should *include* inflation on the phased-in programs as well. All other adjustments to reflect full costs are calculated by the agency. **Note: Include inflation on the phased-in programs in Package 021, NOT in Essential Package No. 031. Package 021 amounts are NOT part of the new inflation auto-calculating function in ORBITS.**

Phase-outs are the result of decreased costs from the elimination of pilot or other programs, and other one-time costs not funded in the 2017-19 biennium. PICS will adjust for legislatively approved position phase-outs in its Personal Services calculation. Find and deduct any other costs that should be phased out from the 2017-19 Base Budget level (for example, Services and Supplies costs associated with 2015-17 limited duration positions). Be sure to deduct programs approved by the Legislature under the expectation that a review would occur before further funding. Also deduct other one-time expenditures, like a new computer system or other large IT projects that have been completed. Capital Construction expenditure authority established in the 2015-17 biennium should be eliminated as a base budget adjustment rather than an Essential Package No. 022 adjustment. **Note: Package 022 entries must be entered into ORBITS prior to using the new inflation auto-calculating function in ORBITS. Package 022 amounts are part of the new ORBITS functionality.**

These packages do not require exception requests. However, they do require agency documentation and analyst approval by the end of May.

Package 020 Tips:

- Most phase in/out packages can be identified shortly after the end of session (sine die). Agencies are recommended to construct a list as soon as possible after the session ends while this information is fresh.
- The LFO or Agency produced Fiscal Impact Statement corresponding to new partial biennium funded program increases should provide the amount necessary for the next biennium. However, this figure will NOT include inflation. Use this information and other budget report data to review proposed phased in/out costs.
- Though not often, there may also be some phase in/out costs that come out of Emergency Board meetings.
- Remember, most position costs will be automatically priced at 24 months by PICS, so be sure not to double count these costs.
- Make sure to adjust for any one-time costs when calculating the phase-in need.

Essential Packages No. 031, 032 and 033 | Inflation and Price List Adjustments

The inflation factors in these instructions and the DAS Price List of Goods and Services are the basis for calculating cost increases in Services and Supplies, Capital Outlay, and Special Payments. Changes in volume or usage are not allowed as part of inflation packages.

Biennial inflation factors for 2017-19 include 3.7 percent for general inflation, 4.1 percent for non-state employee personnel costs (contract providers), and 4.1 percent for medical services. Agencies need to notify their CFO analyst if they plan to use the medical services inflation factor.

Only programs that have annual appropriations in statute (i.e. the State School Fund) may use an annual inflation factor and should work directly with their CFO analyst on the inflation formula.

Package 030 is broken into three parts in order to isolate the incremental impacts of certain inflation factors. This is unchanged from last biennium. Conceptually, packages 031 and 032 are the same in that they both involve pre-determined allowable rate increases that agencies can use. They are separated only because, for audit purposes, package 032 requires more documentation. Only a few agencies will need to use package 032.

031 - Standard inflation and State Government Service Charge

This package will include the following “standard” inflation factors and do not require any special approval:

- A general inflation factor that applies to most Services and Supplies and non-PICS Personal Services costs, Capital Outlay, and some Special Payments. The standard inflation factor for 2017-19 development is **3.7 percent**.
- The non-state employee personnel costs (contract providers) rate, as applied to the *Professional Services* line item. This rate is **4.1 percent** for 2017-19.
- Published rates for both uniform and non-uniform rent. As in the past, DAS EAM will identify a non-DAS office rent inflation factor for the biennium. With documentation, analysts can approve increases above standard inflation, up to this rate.
- All items reported in the State Government Service Charge line item (including Treasury charges that are usage-based). This consists of certain Price List items that include assessments and charges by DAS; Secretary of State; Minority, Women, and Emerging Small Business; State Library; the Law Library; Central Government Service Charges; and Oregon Government Ethics Commission. A complete list is provided below.
- The standard rate portion (**3.7 percent**) of the following:
 - Medical cost increases.
 - Non-state employee personnel costs, as applied to Special Payments.
 - Usage-based price List items.

032 - Above standard inflation with CFO Analyst Approval.

This package includes the amount above the inflation in package 031 for a limited set of factors. The agency must get analyst approval and provide detailed documentation in order to apply these inflation factors. An exception request is not required.

This package will include factors such as:

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- Medical services inflation that applies to medical costs, such as Oregon Health Plan provider expenditures, amounts above standard inflation up to **4.1 percent**. It is also for medical service costs in child foster care, programs for the developmentally disabled, mental health services, and nursing homes. The medical services inflation factor will be allowed only in programs that rely heavily on skilled medical staff (doctors, dentists, and registered nurses), advancements in medical technology, or high cost prescription drugs.
- DAS Price List items that are usage-based such as motor pool and printing services, amounts above standard inflation.
- Non-state employee personnel costs (contract providers), as applied to *Special Payments*, amounts above standard inflation up to **4.1 percent**.

033 - Exception Committee Decisions Above Analyst Approval

This package includes inflation amounts over and above standard **and** analyst approved inflation amounts in packages 031 and 032. An exception request is required. These changes are above established maximums, such as medical inflation, and are limited to extraordinary factors as determined by the CFO Exceptions Committee. See the Exceptions section above for more information on Exceptions.

Inflation Summary

Below is a checklist summarizing the items included in each package.

- **Pkg 031 - Standard Inflation**
 - Standard (3.7 percent)
 - Non-state employee personnel costs (4.1 percent) applied to the *Professional Services* line item
 - All Attorney General
 - All Rent - Uniform and Non-uniform
 - All SGSC (including Treasury)
 - Standard portion of Medical
 - Standard portion of Non-state employee personnel costs applied to *Special Payments*
 - Standard portion of Price List items that are usage based
- **Pkg 032 - Above Standard Inflation**
 - Price List items that are usage based - above standard inflation
 - Medical - above standard up to Medical rate (additional 0.4 percent for a total of 4.1 percent)
 - Non-state employee personnel costs - applied to *Special Payments* above standard up to published rate (additional 0.4 percent for a total of 4.1 percent)
- **Pkg 033 - Exceptional Inflation**
 - Exceptions
 - Medical-above Medical rate

Here is an example of how the inflation packages fit together. The Oregon Health Plan (OHP) is required to use a rate set by an agreement with the federal government. Therefore an additional inflation or utilization factor will be agreed upon for the Oregon Health Plan above the standard and medical inflation factor. Because it is above medical inflation, the agency would need to gain approval from the

Budget Development

Exception Committee to include it in their budget. So, assuming standard inflation is 3.7 percent, medical inflation is 4.1 percent and the OHP inflation rate is approved at 14.0 percent, the agency would include in package 031 the amount of 3.7 percent inflation, package 032 would include the amount of 0.4 percent inflation and package 033 would include 9.9 percent inflation for the 030 package total of 14.0 percent.

Inflation Reporting

The Summary of 2017-19 Budget form (ORBITS) will report the total net change as a result of Packages 031, 032 and 033. This is reported in two separate parts. First, the Cost of Goods and Services increase/decrease is the net inflation calculation for everything except State Government Service Charges. This is the inflation amount above the 2017-19 base budget, excluding Personal Services and program phase-outs and one-time expenditures eliminated in Essential Package No. 022.

Second, the Summary of 2017-19 Budget form includes a State Government Service Charges line. This is the net amount by which agency-specific charges in that ORBITS account are more or less than the 2017-19 Base Budget amount. An inflation factor is not applied to these charges. Note: Not all Price List charges are State Government Service Charges. Rent and other costs budgeted under other ORBITS accounts are included on the Cost of Goods and Services line.

State Government Service Charges

The Department of Administrative Services (DAS) publishes the State's Price List of Goods & Services. The Price List includes assessments and charges from agencies across state government. An electronic version of the 2017-19 Price List will be available on-line. Note that items in the Price List may change, based on more current information, during the budget development period.

The following assessments should be budgeted in ORBITS account 4225 State Government Service Charges:

- Central Government Service Charges
- Secretary of State, Archives Division
- Secretary of State, Audits Division
- Certification Office for Business Inclusion and Diversity
- Oregon State Library
- State of Oregon Law Library
- Oregon Government Ethics Commission
- DAS Policy Functions:
 - Chief Operating Office
 - Chief Financial Office
 - Office of the Chief Information Officer
 - Chief Human Resource Office
- DAS Service Delivery Offices
 - OSCIO State Data Center (assessment portion only)
 - Enterprise Asset Management
 - Enterprise Goods & Services
 - Risk Management Services
- Treasury Banking Services Charges
- Treasury Debt Management Services

Budget Development

Essential Package No. 040 | Mandated Caseload

Mandated caseload changes included in this essential package are based on caseload changes for programs that the federal government (federal entitlement programs), the state constitution, or court actions require. Mandated caseload costs include the cost of additional staff, although appropriate staffing levels are subject to further analysis. The budget instructions include an updated list of programs considered to fall within the mandated caseload definition.

Mandated caseload programs include:

- Oregon Health Plan – Medicaid only.
- Other Medicaid expenditures within medical assistance programs.
- Crisis services for adults with developmental disabilities.
- Crisis services for children with developmental disabilities.
- Non-crisis in-home care for adults with developmental disabilities.
- Non-crisis, comprehensive care for adults with developmental disabilities.
- Civil and criminal commitments for people with either mental illness or developmental disabilities.
- Community-based and nursing home care.
- Adoption Assistance.
- Children’s Foster Care.
 - Other foster care placement alternatives:
 - Subsidized Guardianship.
 - Statewide Residential Treatment Programs.
 - Treatment Foster Care.
 - Family Shelter Care.
 - Family Group Home.
 - Native American Relative Foster Care.
 - Other Tribal Programs.
- Food Stamps.
- State School Fund.
- Early Interventions/Early Childhood Special Education.
- Juvenile Corrections: DOC youth and Public Safety Reserve population only (at population forecast level).
- Adult corrections, including community corrections (at population forecast level).
- Department of Justice Criminal Appeals.
- Unemployment Insurance.

This list covers programs in the Executive branch. The Judicial branch reports its own mandated caseload programs.

Mandated caseload programs should reflect changing costs from caseload or cost-per-case fluctuations, plus any inflation. Examples include changes in the number of clients served or in the cost of services purchased. The costs associated with phasing in a new mandated caseload program should be placed in Essential Package No. 021. Policy changes that increase or decrease costs in mandated caseload programs should be included in a policy package. Examples of policy changes include adding services, restricting eligibility, or increasing reimbursement rates.

Methods used to forecast caseload or cost-per-case must be clearly articulated in the narrative portion of this package and discussed with/approved by CFO analysts prior to CSL finalization. Comparative data from other jurisdictions for similar caseloads is useful.

Budget Development

Workload increases are not considered caseload increases, even in a statutorily required program. A policy package may be used to request expenditure increases for increased workload.

Adjustments for standard Mandated Caseloads listed in the Budget Instructions require agency documentation and analyst approval by the end of May 2016. No exception request is required. Expanding to the approved mandated caseload list will not be considered. Additional adjustments based on updated information may be included by the analyst in the Governor's Budget.

Essential Package No. 050 | Fund Shifts

This package is for significant revenue changes in existing programs. The change may have occurred during the 2015-17 biennium, or may be expected during the 2017-19 biennium. For example: a legislatively approved budget planned on Other Funds for a program, but Federal Funds are being used instead. These packages should be net-zero in Total Funds cost.

Agencies should request General Fund replacement of Lottery Funds, Other Funds or Federal Funds only for a mandated caseload program (see above) or if those funds have been interchanged with General Fund in past biennia. Any other request for General Fund backfill must be in a policy package, not this essential package.

Do not use this package to reduce expenditures below current service level due to revenue shortfalls. If revenues are insufficient to maintain current service level, reduce expenditures in Policy Package No. 070 (see Modified Current Service Level).

This package requires agency documentation and analyst approval by the end of May 2016. It *may* require an exception request if the proposal is new or unusual. Agencies should work with their analyst to determine if an exception request is necessary.

Essential Package No. 060 | Technical Adjustments

This package is to be used for technical budget adjustments, such as agency reorganizations and expenditure category shifts that do not fit into the standard Essential Packages No. 010 - 050. Use of this package requires prior approval by the CFO analyst and SABRS manager. Agencies must provide documentation and obtain final analyst approval by the end of May 2016.

MODIFIED CURRENT SERVICE LEVEL – REVENUE SHORTFALLS

The Current Service Level is the estimated cost of continuing current programs into the next biennium, as required by law. The modified current service level reduces current service level expenditures to accommodate available Other Funds and Federal Funds revenues. Expenditure reductions due to revenue shortfalls should be included in Policy Package No. 070. The Summary of 2017-19 Budget form (ORBITS) will include a subtotal for modified current service level that includes base budget, Essential Packages No. 010 - 060 and Policy Package No. 070.

Policy Package No. 070 | Revenue Shortfalls

This package should include only Lottery Funds, Other Funds and Federal Funds expenditure reductions necessary to adjust the current service level to available revenues which are normally budgeted in the Base and/or Essential Packages 010-060 (for Federal Funds). Reductions should be sufficient to leave ending balances where appropriate. If an agency seeks restoration of some of all of the reductions, the agency will need to propose traditional policy packages to increase revenues and restore expenditures that are reduced in Policy Package No. 070.

AGENCY REQUEST BUDGET – POLICY PACKAGES

MAY – JULY

The final phase of the budget building process is to add policy enhancements on top of the Essential or Modified Essential Budget Level. Policy decision to reduce or increase programs or expenditures will be made through a series of policy packages described below.

Policy Packages No. 081 & 082 | Emergency Board actions after April

Agencies use this package to enter all expenditure and revenue actions taken by the Emergency Board not included in the base budget. Usually this means all actions taken after April of the even numbered year that will carry forward to the next biennial budget. The amount in the Policy Package No. 081 and No. 082 are biennialized and inflated using standard inflation rates. In some cases, changes to mandatory caseload figures may be adjusted in package 040, or changes to fund shifts may be taken in 050 in order to keep the Essential Budget Level “true.”

Policy Package No. 100+ | Program or other proposed enhancements

Policy packages reflect policy and program changes affecting an agency's budget. The sum of an agency's base budget, essential packages, and policy packages comprise its agency request budget.

Position Actions – When agencies are preparing requests for positions they should prepare and have ready to submit upon request position descriptions, organization charts, and classification analyses for position actions, including reclassifications and new positions. If the CFO analyst is considering approval of the positions requested, the analyst will instruct the state agency to forward the supporting information for those positions. The CFO analyst will then submit the information to DAS CHRO to be reviewed.

A single position description will be sufficient for multiple positions with the same classification and duties (e.g., only one position description is necessary for all corrections officer positions with identical responsibilities requested by the Department of Corrections). Agencies without expertise to allocate positions to classes should call CHRO for help as early in the process as possible.

While not an exhaustive list, agencies should develop policy packages for each affected program unit to:

- Form new programs or expand existing ones.
- Reduce or end programs.
- Implement partnership programs among agencies. This includes actions to formalize interagency program coordination efforts.
- Transfer programs between agencies, if the transfer has not been legislatively approved.
- Shift from one fund type to another, if the shift does not match past budget policy.
- Establish or increase fees, including fees changed administratively during the 2015-17 biennium that were not approved by the Legislature. Modified current service level budgets cannot include revenues or expenditures supported by fees that require legislative ratification in the 2017 Legislative Session. If an agency raised fees administratively during the interim and those fees were not already approved by the Legislature, then CSL expenditures must be reduced in Policy Package No. 070 to match revenues budgeted in Base without the increased fees. Restoration of these expenditures and increased revenues can be requested in a policy package contingent upon legislative ratification of the fee increase.
- Implement reorganization or reinvention proposals. This includes establishing, abolishing, and reclassifying positions.

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- Fund legislative concepts to be considered by the 2017 Legislative Assembly. A legislative concept with a fiscal impact must be linked to a policy package or the concept will not be approved for pre-session filing, even if the concept has been approved conceptually. An agency proposing any legislative concept with a fiscal impact on another agency (such as proposals to establish new crimes or increase the penalties for existing crimes that increase the Department of Corrections prison population) must ensure that the concept is linked to a policy package in the affected agency's budget.
- Propose Capital Construction projects. These packages should be included in the Capital Construction program unit.
- Request new debt service authority. Debt service authority for debt that will be issued in the 2017-19 biennium must be included in a policy package(s) along with any related issuing and financing costs. For Capital Improvement and Capital Construction projects, requests for new debt service authority should be placed in a policy package(s) in agency operating program units/SCRs rather than in the Capital Improvement or Capital Construction program units/SCRs. For other types of projects that require debt financing (such as information technology and systems development related projects), the agency may include the request for debt service authority and any related issuing and financing costs in the same package as the request for project funding in the operating budget. However, if an agency has a Debt Service SCR it may budget (as part of the package) the new Debt Services in that SCR.
- Request new Non-limited authority. Requests to shift limited expenditures to Non-limited or to shift Non-limited to limited expenditures must be included in a policy package.
- Implement or expand Information Technology-related Projects/Initiatives. Agencies will be expected to separately track all expenditures in IT policy packages for future reporting purposes, including portions of projects that are continued in base budget in future biennia (expenditure limitation associated with large IT projects should be phased out when the project has been completed.) All new or expanded IT-related projects/initiatives that require new funding, new expenditure limitation, or new positions must be included in policy packages. Information about IT investments with total estimated costs of \$150,000 or greater must be entered into the Enterprise Project and Portfolio Management (PPM) system. Information Technology-related Projects/Initiatives in excess of \$1,000,000 require additional documentation (a business case). Agencies shall submit the original approved business case and/or an updated business case for any changes to the IT project schedule, budget or scope that exceeds five percent of the original project schedule, budget or scope. Agencies must submit a business case for the project and a detailed project plan if the continuing IT project does not have an approved business case on file with the State CIO.

The ORBITS/PICS User's Manual describes the process for entering data for policy packages into the PICS and ORBITS systems. The presentation of policy packages for the budget document is described in The Budget Document section of these instructions.

REDUCTION OPTIONS

The Governor or the Legislative Assembly may need to consider revenue or expenditure plans that require program reductions. Agencies must propose reduction options of 10 percent, preferably in five percent increments. **Please note that with the passage of SB 1596 (2016) the reduction options no longer apply to the debt service portion of the CSL.**

Reduction options are based on the Modified Current Service Level (Base Budget plus Essential Packages, including Policy Package No. 070). Reductions should be presented separately for General

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Fund, Lottery Funds, Other Funds, and Federal Funds, and reported on form 107BF17. For each fund type, the reduction needs to be described in terms of activities or programs that will not be undertaken. Each activity or program not undertaken must be ranked on the basis of lowest cost for benefit obtained. The criteria and method(s) used to determine costs and benefits obtained must be explained.

Explain the impacts if reductions would affect other revenues, expenditures, or programs. For example, would a General Fund reduction result in the loss of matching Federal Funds? For revenue transfers, discuss possible reduction options with any other entities that might be affected.

Agencies will not be required to submit Legislative Concepts to implement the proposed reduction options. However, agencies will need to provide the required legislative changes necessary to implement the reduction options if so requested by the Governor or CFO analysts. Analysts may request more, or different, options if the options proposed are not feasible or are not consistent with other statewide efforts or policy.

Information on the budget reduction options must be included in the agency request narrative and should include summary information to allow consideration of each option. (See the Budget Document section for information on presentation.) ORBITS policy packages will be created if a reduction option is recommended by the Governor or adopted by the Legislature.

Finally, in preparing the Governor's Budget document, agencies should update form 107BF17 to show which, if any, proposed reductions were used by the CFO to develop the 2017-19 budget for the Governor. Agencies should use the strikethrough font format to indicate items and dollars that were used.

OTHER CONSIDERATIONS WHEN PREPARING THE BUDGET

- ***Federal Maintenance of Effort Requirements*** – The federal government is a significant partner in funding many of the services provided by state government to Oregonians. This partnership includes the federal government sharing in the costs of providing these services. Under these cost sharing relationships, the federal government often requires the state to maintain a certain level of financial commitment to the programs. These relationships are often referred to as Maintenance of Effort requirements. State agencies are required to maintain the documentation necessary to show the federal government that Oregon is complying with these requirements

At various points in the budget development process, especially when reductions need to be considered, it is necessary for CFO and LFO analysts to review the Maintenance of Effort (MOE) assumptions and calculations. It is impractical to require agencies to submit their MOE calculations at the time of submitting their Agency Request Budgets because state and federal fiscal years are not aligned, and the calculations are fairly fluid as agencies make actual expenditures. While it is impractical to require MOE submittals at the time of submitting the Agency Request Budget, agencies are required to produce MOE documentation and assumptions upon the request of either CFO or LFO analysts. This requirement extends to both current biennium MOE reporting and planned expenditures for the upcoming biennium.

- ***Administrative Services*** – For many years, there have been efforts to more efficiently and effectively provide administrative services to state agencies. In general, these efforts have focused on the provision of Information Technology, Human Resources, Fiscal and Procurement services. While agencies are not required to budget these services into separate program units, agencies should be prepared to provide budget information for these services upon request.

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- **Ballot Measure 30 (1995)** – Article XI, Section 15 of the Oregon Constitution requires that the state pay the costs of new work the state requires of local governments, under certain circumstances.
- **Ballot Measure 17 (1994)** – Article I, Section 40 of the Oregon Constitution requires inmates to work and be engaged in workforce development. State agencies are required to give priority to inmate services and products. Visit the Oregon Corrections Enterprises website at www.oregon.gov/OCE/ for more information.
- **Purchasing Printing and Copying Equipment** – ORS 282.050 authorizes DAS to control and regulate the performance and production of state agency duplicating work and the purchase and use of related equipment. Requests for approval of agency purchase and use of all state printing and copying and equipment must be submitted to the DAS Publishing and Distribution program by June 30, 2016. Additional information regarding equipment subject to evaluation under this statute and approval guidance is available by emailing order.info@state.or.us.
- **Purchasing Mailing Equipment** – ORS 283.140 authorizes DAS to approve or disapprove all state agency mail equipment or mail service acquisitions. Requests for approval of agency purchase and use of all state mailing equipment must be submitted to the DAS Publishing and Distribution program by June 30, 2016. Additional information regarding equipment subject to evaluation under this statute and approval guidance is available by emailing order.info@state.or.us.
- **Acquiring or Modifying Fiscal Systems** – Submit written requests to DAS for review as soon as the acquisition and/or modification of the fiscal system(s) are defined. DAS must review all new and proposed major modifications to existing fiscal systems. DAS defines fiscal systems as:
 - General ledger accounting and financial reporting systems that duplicate any functionality currently provided by Statewide Financial Management Application (SFMA) or interface data into SFMA.
 - Payroll and/or time and attendance systems that duplicate any functionality currently provided by Oregon Statewide Payroll Application (OSPA) or interface data into OSPA.
 - Financial data marts that duplicate any functionality currently provided by the SFMA and OSPA data marts.

Purchasing systems that duplicate any functionality currently provided by Advanced Purchasing and Inventory System (ADPICS).

Call DAS as early as possible to consult on proposed systems or modifications. Call Trudy Vidal at (503) 373-0170 for system application changes in accounting or purchasing. Call Oregon Statewide Payroll Services (OSPS), Seth Lewis at (503) 373-0198 for system application changes to payroll. Call Aaron Wallace for SFMA and OSPA financial data marts at (503) 373-0269.

- **Compensation Plan Adjustments** – Submit proposed compensation plan changes (represented, management service, unrepresented) to the [DAS Chief Human Resource Office \(CHRO\)](#). These are handled separately from the agency budget request. Approved changes will be included in a DAS compensation plan proposal. Do not add funding for these adjustments in the agency budget request. Call CHRO for help as early in the process as possible.
- **Space Planning** – For information concerning interior space square footage requirements, please refer to the State Office Standards (DAS Policy 125-6-100, dated July 23, 2003) published by Enterprise Asset Management. If you have changes to work space in space either owned by or

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leased through the Enterprise Asset Management, or other space planning services, please contact the DAS Planning and Construction Management Section at (503) 373-7148 or (503) 373-7147.

DAS Interior Project Managers can provide space-planning services at no charge to agencies housed in Uniform Rent buildings owned by DAS, to the extent workload allows. On a fee basis, DAS may also supply space planning services to agencies housed in self-support-rent buildings owned by DAS, in their own buildings, and in leased offices

- **Vehicle Purchases** – When planning to make vehicle purchases, refer to the DAS Statewide Fleet Management Standards (DAS Policy 107-009-040) published by Enterprise Asset Management. DAS Fleet has statutory authority to control and regulate the acquisition, operation, use, maintenance and disposal of, and access to motor vehicles used for State business. For additional information, contact the DAS Fleet and Parking Services Manager at (503) 373-7723, who can provide vehicle costing and delivery information.

If DAS Fleet provides vehicles for your agency, be sure to work with DAS Fleet Operations as you are planning your budget regarding any changes in agency program activities that will require additional new vehicles. Additional staff, reorganization, and increased field work, etc. that trigger the need for more vehicles mean the Fleet budget request will need a companion policy option package to buy those additional vehicles.

Capital Budgeting & State Facilities Planning

CAPITAL BUDGETING

Capital budgeting refers to planning for and establishing General Fund appropriations, Other Funds and Federal Funds expenditure limitations for capital improvement projects and major construction or acquisition projects. Major capital projects require advance planning. Often external financing is required for major projects. This section describes budget request information required for capital projects.

What are Capital Projects?

Capital Projects include land, building, and major facility renovations, additions, or improvement projects. They change a use, function, or cost in such a magnitude that approval by the Governor and the Legislature is warranted. Project costs may include planning, design, land acquisition, construction or implementation. Generally, capital projects must conform to the [Oregon Accounting Manual \(OAM\)](#) (policy 15.60.10) of the DAS Chief Financial Office (CFO) as it applies to capitalization of fixed assets.

Capital Projects are divided into two unique categories: (1) Capital Improvements and (2) Major Construction/Acquisition. The ORBITS/PICS User's Manual shows how to present these categories in the agency budget. Each capital project request should present the total project and construction costs. In addition, the agency should discuss the long-term operation and maintenance costs, or savings, of the project. DAS will prepare a separate appropriation bill or bills for capital construction projects in the Governor's Budget.

Capital Improvements Defined

A capital improvement project must meet the following criteria:

- The total project cost will be less than \$1 million including anticipated requests in future biennia, and
- Costs will be capitalized in accordance with OAM 15.60.10 (i.e. (a) the expenditure is for acquisition (including land) or construction of a new asset, or, (b) for existing assets, the expenditure significantly increases the value, extends the useful life, or makes it adaptable to a different use)

Land acquisition for a project that has total, complete project costs of less than \$1 million should be requested as a Capital Improvement Policy Package.

Major Construction or Acquisition Projects Defined

A Major Construction or Acquisition project must meet the following criteria:

- Costs will be capitalized as required by the OAM of the DAS CFO.
- The complete project cost will be \$1 million or more. Major projects normally follow a two-phase process. Phase one is planning and design; phase two is construction. This criterion applies to the combined total estimated costs of all phases of a project.
- It must build, acquire, adapt, replace, or change the use or function of an information technology-related system(s), a facility or group of related facilities (see reconstructions under Operating Expenditures).

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Capital Construction Project Limitation Expiration

Limitation Expiration Dates. Major Construction or Acquisition Project budget approvals have a life of six years from the effective date of the first approval of any element of the project (i.e. six years following the initial approval). *Note: Capital Construction Projects approved at \$1 "Placeholder" level are subject to this limit.* If an agency's six-year spending limitation is expected to expire before the project will be completed, the agency must request an extension as part of the agency's 2017-19 capital project budget requests. **Requests for extension of capital construction limitation expiration dates must also be made by email to Jean Gabriel at jean.l.gabriel@oregon.gov.** Any recommended extension is subject to legislative approval. Speak to your CFO analyst if you have any questions. Project expenditures cannot exceed amounts authorized for a specific capital construction limitation.

Operating Expenditures for Facilities are not Capital Projects.

Generally, activities and projects that keep the facility operating without increasing asset value or operating life, such as maintenance, repairs, replacement of components, or adaptation, are not capital projects. Projects that reduce maintenance costs or increase efficiency are generally not considered capital projects. However, major repair or maintenance initiatives such as substantial roof or flooring repairs, large scale painting projects or carpet replacements may be included in the Capital Improvements budget. Note however, that projects that do not qualify as capital under the OAM cannot be financed using Article XI-Q bonds.

Projects that enhance a facility beyond maintaining or restoring proper operating condition should be requested in the appropriate capital construction project program unit. Some asset protection items are of sufficient size or complexity to be presented as capital construction projects. Talk with the DAS Statewide Accounting and Reporting Services (SARS) and your assigned CFO analyst to determine how to categorize a large asset protection project.

Inclusion of Positions in Capital Construction Budgets

In some instances, it may be preferable to use state employees rather than contractors to perform tasks that are properly capitalized (and therefore appropriate as "capital construction" project costs). For budget purposes, capital construction limitations are considered fully expended during the biennium in which they were authorized. In ORBITS, the full amount of the project is shown as Capital Outlay in the Capital Construction summary cross reference. Charges against the limitation can still be made in subsequent biennia and are controlled through the allotment process.

Although capital construction positions may be required for multiple biennia, the PICS system does not allow a position to be budgeted for more than 24 months. Therefore, agencies desiring to use capital construction limitation to fund positions should establish those positions with a zero rate so they do not generate dollars in the budget but will provide position authority (position count and full-time equivalent) in both the budget and personnel systems. The payroll costs and appropriate services and supplies costs for these positions should be charged against the capital construction budget. In ORBITS, these costs should be displayed in account 5800 – Professional Services (Capital Outlay). PICS comments field can be used to ensure any permanent positions are phased out at the end of the six-year limitation.

Review of Major Construction or Acquisition Projects Prior to Budget Submission

The 1997 Legislature established the central Capital Projects Advisory Board (CPAB) to review all major construction projects and large lease projects prior to any agency's submission to CFO or introduction of a bill or Emergency Board request. In 2009, the Legislature re-established the Capitol Planning Commission (CPC) and transferred to it, from the CPAB, the responsibility for review of major construction projects within the

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boundaries of the City of Salem and the City of Keizer for compliance with the development standards and policies contained in the CPC adopted Area Plans. During calendar year 2016, the CPAB will review space need plans, construction project plans, building maintenance need plans, and facility inventories from each state agency (excluding OUS) that owns facilities anywhere in the state. During this same time period, the CPC will review project plans for major construction projects within the boundaries of the City of Salem and the City of Keizer for compliance with the Area Plans. The CPAB is also responsible for reviewing new space leases of 10,000 square feet or more with a lease term of 10 years (initial term plus possible extensions) or more. The information provided by agencies and the Board's and Commission's comments are shared with CFO and LFO for use in budget preparation and analysis.

Major construction or acquisition projects (\$1 million and more) must be publicly reviewed by CPAB and, if within the boundaries of the City of Salem or Keizer, the CPC prior to the agency's budget submission to CFO or introduction of a legislative bill, or an Emergency Board request. The Oregon University System projects are exempt from these requirements as are community college projects requested by the Department of Community Colleges and Workforce Development

The DAS CFO Capital Finance and Planning Section is staff and coordinator for the CPAB and for the CPC. Contact Alice Wiewel, State Architect and Director of Facilities Planning at (503) 386-6513 to request any information regarding this effort.

Long-Term Construction Budget Requirements

- **Four-Year Major Construction Budgets**

State agencies are required to request four-year major construction budgets (ORS 276.229). Four-year major construction budgets begin with a request for planning funds, which lead to project construction requests. Request planning funds with your 2017-19 budget request for major projects scheduled for construction in 2017-19. Your four-year budget request will consist of project construction approvals for the 2017-19 biennium for planned projects, and planning funds for projects you expect to request for construction approval in the 2019-21 biennium. Projects included in these budgets may be accelerated or deferred with Emergency Board approval.

- **Major Construction/Acquisition Six-Year Plan**

ORS 291.224 requires the Governor's Budget to include estimated biennial construction requirements for not less than six years. This plan should reflect the agency's four-year budget request and show major construction or acquisition projects expected two years beyond that. While four-year and six-year plans are required by statute, these budget instructions require plans to be reported over a ten-year period. Present your ten-year plan in the form of a table (use form 107BF13). Show requested and potential major construction or acquisition projects and planning funds for the 2017-19, 2019-21, 2021-23, 2023-25 and 2025-27 biennia.

This requirement does not apply to highway and bridge construction or repair by the Department of Transportation; park improvements; or road infrastructure work performed under timber sale contracts with the State Forester

- **Capital Financing Six-Year Forecast**

ORS 291.216(11) requires the Governor's Budget to compare the State Debt Policy Advisory Commission's report of net debt capacity to state agencies' capital financing six-year forecast. This is in addition to the major construction/acquisition six-year plan.

Use the Capital Financing Six-Year Forecast Summary (form 107BF12) to show your agency's six-year forecast of financing needs, by debt type and repayment source.

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Provide projected financing needs by use as follows:

- Major construction or acquisition projects including highway and bridge repair projects that will be financed by debt issuance.
- Equipment purchases or information technology-related projects or systems that will cost \$500,000 or more and will be financed by debt issuance.
- Other state agency debt issuance for grant or loan purposes.

Debt type means general obligation bonds or revenue bonds (certificates of participation have been replaced by Article XI-Q general obligation bonds). Repayment source means General Fund, Lottery Funds, Other Funds, or Federal Funds. If your agency has more than one financing program, please identify debt issuance plans by program. Contact your CFO analyst or the CFO Capital Finance and Planning Section if you have questions.

Financing Agreements and Article XI-Q Bond (XI-Q) Financing

Note: Article XI-Q bonds, for which enabling legislation was approved in 2011, have replaced Certificates of Participation (COPs) for financing real and personal property that will be owned and operated by the State.

Oregon law and the XI-Q program procedures provide a centralized structure to process requests by state agencies for financing projects. The XI-Q program is managed as a central service function by DAS CFO, Capital Finance and Planning Section. Centralized control assures that financing agreements and XI-Q bonds are used only for projects approved by the Legislature and the Executive Branch. XI-Q bonds can be used to finance real or personal property (including software) that is capitalizable under generally accepted accounting principles and will be owned or operated by the state. Therefore, any non-capital costs of a project will need to be funded through other sources.

If your agency plans to use XI-Q bonds or other financing agreements (e.g. capital lease) in an amount exceeding \$100,000, approval by DAS and the Legislature is required. Your budget must include the revenue source (e.g. XI-Q proceeds) and necessary expenditure limitations, including debt service. Work with your assigned CFO Analyst and the Capital Finance and Planning Section to obtain debt service estimates.

To request XI-Q bond authority, complete the Article XI-Q Bond Financing and Financing Agreements Request Form (107BF15). Itemize each stand-alone project for which financing is requested in 2017-19. ***XI-Q Financing request forms must be completed and e-mailed to Jean Gabriel on or before May 16, 2016 at jean.l.gabriel@oregon.gov.*** The requests are evaluated on factors including priority of need, effectiveness, and repayment source. This review determines which requests are included in the Governor's Budget. Questions should be directed to Jean Gabriel, Capital Finance and Planning Manager, at (503) 378-3107.

- Financing agreements or bond proceeds to restore or acquire real property must meet the following criteria:
 - The project will acquire, construct or improve the safe, economic operation of the property.
 - The costs of the project to be funded with XI-Q bond proceeds are capitalizable under generally accepted accounting principles (as found in OAM policy number 15.60.10).
 - The property will be essential to state services.

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- The property will have a useful operating life at least commensurate with the term of financing.
- The property is free and clear of all liens and financial security claims.
- The amounts for restoration or renovation will substantially improve the property.
- The financing has specific, stable sources of repayment.
- Financing agreements or bond proceeds to finance equipment acquisition or system development projects must meet the following criteria:
 - The equipment or system will contribute substantially to a more effective or cost-saving method of delivering state services.
 - The costs of the project to be funded with XI-Q bond proceeds are capitalizable under generally accepted accounting principles (as found in OAM policy numbers 15.60.10 and 15.60.40).
 - The equipment or system will be essential to priority state services.
 - The equipment or system will have a useful operating life at least commensurate with the term of financing.
 - The project components are free and clear of all liens and financial security claims.
 - The financing has specific, stable sources of repayment.

Accounting and Budgeting Requirements

Accounting and budgeting for purchases using financing agreements and XI-Q bonds is done at the agency level. Each agency is responsible for recording revenues and expenses associated with the issuance of these obligations. Where XI-Q bonds are used, the XI-Q disbursing agent holds bond proceeds in trust until expended as budgeted at the request of the agency. These transactions need to be recorded on the agency books. The Oregon Accounting Manual (OAM) provides instructions of accounting for bonds.

Project Budget – Base or Policy Package?

Projects acquired with financing agreements and XI-Q bonds are not included in an agency's base budget. They must be phased out at the end of each biennium. Address each project in one or more separate policy packages that discuss use of XI-Q sale proceeds, interest income, acquisition or construction costs, and XI-Q issuance costs. Record the asset acquisition cost in the appropriate Capital Outlay account, ORBITS account number series 5XXX. XI-Q issuance costs and related fee expenditures are current biennium operating costs and are budgeted as Services and Supplies in ORBITS account number 4650, Other Services and Supplies. XI-Q bond sale proceeds (revenue) are budgeted in ORBITS account numbers 0555 if debt service is expected to be paid primarily from the General Fund, or account number 0560 if debt service is expected to be paid primarily from non-General Fund sources. COP interest income estimates are budgeted in ORBITS account number 0610 Interest Income COP. XI-Q interest income estimates are budgeted in ORBITS account number 0605 Interest Income.

For Capital Improvement and Capital Construction projects, asset acquisition (project) costs and the XI-Q bond sale proceeds (revenues) and interest income to cover those costs are budgeted in the Capital Improvement or Capital Construction program units. For other types of projects, project costs, bond sale proceeds revenues, and interest income are included in the appropriate operating budget program unit. XI-Q bond issuance costs and related fee expenditures and the XI-Q revenues and interest income to cover those costs and expenditures are always budgeted in the appropriate operating budget program unit.

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Debt Service – Limited or Non-limited?

2015-17 Debt Service requirements for XI-Q bonds and finance agreements can be requested in agency budgets as limited or non-limited, depending on the funding source. Repayment from General Fund appropriations and Lottery Funds must be budgeted as Limited Debt Service. Repayment from Other Funds or Federal Funds revenues may be budgeted as Non-limited Debt Service; your CFO Analyst should confirm this. If repayment is from multiple fund types and General Fund or Lottery Funds are involved, the entire repayment expenditure limitation must be requested as limited debt service.

Limited Debt Service and Non-limited Debt Service are budgeted in ORBITS using unique appropriated fund types and accounts. The debt service aspect of a project can be included in the policy package that requests the actual project expenditures and revenues, with the exception of Capital Improvement and Capital Construction packages. The debt service for these packages must be requested in a policy package in an operational program unit.

Debt Service Revenue and Expenditure Accounts

Revenues to pay debt service may be budgeted in a variety of ways. Agencies might record Other Funds and Federal Funds revenues in the debt service policy package as account 1010, Transfer In – Intrafund, with an off-setting entry to account 2010, Transfer Out – Intrafund, in the budget unit from which the revenue is being transferred. In the case of General Fund appropriation, Lottery Funds, or new Other Funds or Federal Funds revenues, these are to be recorded directly in the debt service policy package using appropriate ORBITS appropriated fund types and revenue accounts.

A unique series of ORBITS appropriated fund types and expenditure accounts (series 7XXX) are available for use in recording budget requests for Debt Service. For COPs, use ORBITS accounts 7200 Principal – COP and 7250 Interest – COP. For XI-Q bonds, use accounts 7100 and 7150 for principal and interest respectively. Refer to the ORBITS/PICS User’s Manual Chart of Accounts in the Appendix for the full account listing. Use of these accounts is required when entering data in ORBITS. (Note that these accounts are different than SFMS or agency account classifications for accounting entries).

Financing Agreements Other Than COPs

Agencies involved in leases or financing agreements other than COPs should be familiar with the guidelines provided in the OAM. It is critical that agencies inform the Capital Finance and Planning Section of any planned financing agreements for capital items so that authority can be requested in the biennial “Bond Bill.” Estimates for non-COP financing agreements (e.g. capital leases) should be provided to Jean Gabriel by May 16, 2016. The OAM explains in detail requirements for capitalizing or expensing components of these transactions. Capitalized components and related debt service presentation are also clearly discussed. Agencies with capital leases, or other forms of financing agreements as described in Oregon Administrative Rules 122-070-0110 are required to budget debt service accordingly. Leases that do not meet the criteria for capital leases should continue to be budgeted as operating lease payments in the appropriate Services and Supplies account.

Lottery Revenue Bond Financing Requests

The Lottery Revenue Bond program is centrally managed by the DAS CFO, Capital Finance and Planning Section. Use form 107BF09 to request issuance of Lottery Revenue Bonds during the next biennium beginning July 1, 2017. Subject to the provisions of Article XV, Section 4 of the Oregon Constitution and ORS 286A.560 - 286A.585, Lottery Revenue Bonds may be issued to finance programs or projects for which the Legislature finds the use of lottery bond proceeds will: create jobs; further economic development; finance public education; or restore and protect parks, beaches, watersheds and native

Capital Budgeting & State Facilities Planning

fish and wildlife. Generally, bonds are limited to capital costs in order for the State to obtain the lowest cost of funds when issuing bonds.

Questions?

For questions concerning Article XI-Q bonds, financing agreements, form 107BF15, Lottery Revenue Bonds or form 107BF09, contact Jean Gabriel, Capital Finance and Planning Manager at (503) 378-3107.

For questions concerning how to request capital projects, work with your CFO analyst. For questions on how to record within the budget system capital projects, XI-Q bonds, financing agreements, lottery revenue bond projects and debt service refer to the ORBITS/PICS User's Manual.

STATEWIDE FACILITIES PLANNING

The programs and services administered by the State of Oregon, through various agencies, boards and commissions, require physical assets. These assets, in total, represent a significant financial outlay that must be understood to ensure proper stewardship for both long term utility and strategic investment purposes. ORS 276.227 charges DAS with managing a statewide facility planning process. The process, administered by the Facilities Planning Unit (FPU) within the Capital Finance and Planning section of the Chief Financial Office (CFO), provides an objective evaluation of our state portfolio for making long-range, strategic investment decisions that prioritize (among other factors) liability and risk, programmatic need, and community benefit. The purpose of this effort is to ensure the state is making rational, data-driven investment decisions using a multitude of dimensions, and providing facilities that are as efficient and effective as possible in delivering responsive government services.

Facilities Planning Guiding Principles

The Facilities Planning Unit (FPU) established six core principles that guide the statewide enterprise of capital investment planning and project development. While these guiding principles are not specific project evaluation criteria, they serve as the underpinnings of best practices in capital planning.

- *Design for Quality* - Good building design contributes to higher employee productivity and better public service. Aspire for the highest feasible level of environmental and architectural design.
- *Steward our Investments* - Public investments must be properly maintained to ensure safety and reduce long-term cost. Design high-performance buildings with the lowest total cost of ownership.
- *Right-Size our Portfolio* - Buildings have large environmental footprints, and are costly to build, operate and maintain. Prioritize adaptive reuse of buildings and projects that maximize efficiency and long-term utility.
- *Contribute to the Whole* - Our buildings serve key roles across the state and represent sizable community investments. Consider how a project impacts the community and helps achieve statewide priorities.
- *Convey our Identity* - Our buildings represent the aspirations, integrity, and legacy of Oregonians. Ensure buildings contribute to an “image of accessibility and responsiveness of government”.
- *Be Resilient* - We build for resilience using science, data and community wisdom to protect against and adapt to risks, thereby making people, communities and systems better prepared to withstand catastrophic events—both natural and man-made—and able to bounce back more quickly and emerge stronger from these shocks and stresses.

Capital Budgeting & State Facilities Planning

Statewide Facility Planning Process

FPU administers a statewide facility planning process that requires biennial submission of key facility-related information to satisfy the statutory requirements of ORS 276.277. This important information allows agencies and leadership to evaluate state facility condition and needs for developing financing and budgeting strategies that address these needs. It also informs FPU- DAS in establishing guidelines and standards for acquiring, managing and maintaining state facilities that best serve the strategic, long-range interests of the state.

Statewide Budget and Capital Prioritization

The Statewide Facility Planning Process (SFPP) is tied closely with the statewide budget development process and is intended to align capital needs with the Governor's priority outcomes.

To accomplish this, DAS established a prioritization process that reviews and scores projects relative to key criteria, including:

- Alignment with State's long-term planning priorities
- Cost Savings
- Need and Capacity
- Finish What We Start
- Leveraged Dollars
- Environmental and Social Sustainability

This project prioritization criteria is subject to change and may evolve from biennium to biennium. These changes are reflected in each biennium's budget instructions.

Metrics: Effective, Efficient and Affordable

FPU has identified three key performance measures intended to gauge the state of our portfolio. The information provided through the SFPP inform these measures at an agency and statewide level, and provide a relevant "snapshot" that speaks to effectiveness, efficiency, and affordability:

- **Facility Condition Index (FCI)** – A calculated measure of facility condition relative to its current replacement value (expressed as a percentage) and represented by the following categories:
 4. **Good (0 - 5%)** - In new or well-maintained condition with no visual evidence of wear, soiling or other deficiencies
 5. **Fair (5 - 10%)** - Subject to wear and soiling, but is still in a serviceable and functioning condition
 6. **Poor (10 - 60%)** - Subjected to hard or long-term wear. Nearing the end of its useful or serviceable life
 7. **Very Poor (>60%)** - Has reached the end of its useful or serviceable life. Renewal now necessary
- **Space Utilization** – A calculated measure of how efficiently space is being used, this metric varies for different space types, with greater emphasis on office/administrative uses. The State of Oregon is moving toward a new guideline of 175 Usable Square Feet (USF)/Position for office/administrative uses. For other uses, a secondary metric is used.³

³ **Note.** For agency facilities (or portions of facilities) used for office/administration activities, a standard metric of Usable Square Feet (USF)/Position Count is calculated. For agencies with less than 10% office/administrative spaces,

Capital Budgeting & State Facilities Planning

- **Operation and Maintenance Cost per Gross Square Foot** – a standard measure of affordability, this metric varies by building and operational type.

FACILITIES MAINTENANCE & MANAGEMENT

ORS 276.229(2) requires state agencies to include the biennial costs associated with maintenance, major repairs or building alterations in their regular budget presentations to the Legislative Assembly. Agencies are required to include in their budget presentations short-term and long term plans to reduce or eliminate any existing backlog of deferred maintenance. ORS 276.227(5) requires state agencies to establish and implement long-range maintenance and management plans for facilities for which this state is responsible to ensure that facilities are maintained in good repair and that the useful lives of facilities are maximized.

Facilities Maintenance forms have been designed to address statutory requirements for maintenance budget reporting using established requirements, such as Capital Projects Advisory Board (CPAB) and Risk Management reports to the greatest extent possible.

These forms are required only for agencies that own buildings.

What is Facilities Maintenance?

The International Facilities Management Association (IFMA) indicates that maintenance costs can be described in four major categories for non-manufacturing entities:

- **Interior System Maintenance** – This category includes electrical systems (including elevators, alarm systems, lighting, etc.); mechanical systems (HVAC, boilers, plumbing, refrigeration, etc.); base building general maintenance (interior walls, doors, ceilings, pest control, etc.); and administrative support services (trouble desks, etc.)
- **External System Maintenance** – Costs to maintain roof, skin (siding, masonry, windows), signage, etc.
- **Roads and Ground Maintenance** – Costs associated with landscaping, parking structures and lots, roadways, sidewalks, parking lots, storm sewers, underground fire systems and hydrants, etc.
- **Utility/Central System Maintenance** – This category includes costs to maintain internal systems to generate/distribute electricity and internal mechanical systems such as steam plants and hot and cold water systems.

Agencies with significant facilities operations may include support staff if directly associated with facilities maintenance activities. Do not include other overhead items such as accounting, central government charges, etc.

What is an Operations and Maintenance Budget?

Industry standards generally include two other closely related cost categories when evaluating facilities management. In addition to the maintenance categories described above, a facilities operations and maintenance budget includes utilities and janitorial costs.

FPU is requesting an agency-specific metric (see Facility Summary Narrative 107BF16a) that provides insight into how agencies with primarily non-office-based operations determine their space needs. Essentially, what is the relevant metric each agency uses as a measure of their space needs, and by extension, their space efficiency?

What is Deferred Maintenance?

Deferred Maintenance is maintenance that was not performed when it should have been. It may also include maintenance needs resulting from unforeseen circumstances such as wind storms, premature failure of facilities components, etc. It is typically measured in terms of a budget cycle. It is widely believed that deferred maintenance costs are significantly higher than corresponding routine maintenance costs in achieving the same stewardship objectives.

Categories of Deferred Maintenance

Policymakers benefit from having deferred maintenance needs prioritized. DAS Enterprise Asset Management (formerly Facilities Division) has developed the following categories to be used for budget presentation:

Priority One: Currently Critical

Priority One projects are conditions that require immediate action in order to address code and accessibility violations that affect life safety. Building envelope issues (roof, sides, windows and doors) that pose immediate safety concerns should be included in this category.

Priority Two: Potentially Critical

Priority Two projects are to be undertaken in the near future to maintain the integrity of the facility and accommodate current agency program requirements. Included are systems that are functioning improperly or at limited capacity, and if not addressed, will cause additional system deterioration and added repair costs. Also included are significant building envelope issues (roof, sides, windows and doors) that, if not addressed, will cause additional system deterioration and added repair costs.

Priority Three: Necessary - Not Yet Critical

Priority Three projects could be undertaken in the near to mid-term future to maintain the integrity of a building and to address building systems, building components and site work that have reached or exceeded their useful life based on industry standards, but are still functioning in some capacity. These projects may require attention currently to avoid deterioration, potential downtime and consequently higher costs if corrective action is deferred.

Priority Four: Seismic and Natural Hazard Remediation

Priority Four projects improve seismic performance of buildings constructed prior to 1995 building code changes to protect occupants, minimize building damage and speed recovery after a major earthquake. Projects also include those that mitigate significant flood hazards.

Priority Five: Modernization

Priority Five projects are alterations or replacement of facilities solely to implement new or higher standards to accommodate new functions, significantly improve existing functionality as well as replacement of building components that typically last more than 50 years (such as the building structure or foundations). These standards include system and aesthetic upgrades which represent sensible improvements to the existing condition. These projects improve the overall usability and reduce long-term maintenance requirements. Given the significant nature of these projects, the work typically addresses deficiencies that do not conform to current codes, but are 'grandfathered' in their existing condition to the extent feasible.

The Budget Document

THE BUDGET DOCUMENT

JULY – AUGUST

The budget document presents budget and policy issues to decision makers. It must be clear and understandable. Using the formats and forms in this manual gives all budgets a common framework, making it easier for readers to find and understand the information. Within that framework, agencies should tailor their documents to their needs. These instructions are presented in the traditional “hard-copy” form. Agencies should convert to electronic form for customer ease of use. For instance, use of hyperlinks on table of contents and tabs.

The “Agency Summary” section of the budget document identifies the major issues and context of the agency’s activities. The “Program Unit” sections provide supplemental budget and program detail.

It is helpful to review past budget documents and legislative presentation materials early in the budget development cycle. That allows time to make changes before the budget document is due. Graphics can replace or explain text to help decision makers understand complex or controversial issues or programs. The goal is a concise presentation that makes complex facts and issues easy to understand.

Agencies submit three separate budget documents in the budget process: the Agency Request Budget, the Governor’s Budget, and the Legislatively Adopted Budget. All are public records when published. Agencies will need to update the Agency Request Budget at the right times to reflect changes and decisions by the Governor and the Legislature.

The budget document is a compilation of narrative, ORBITS reports, budget forms, and agency-supplied information. Agencies may enter budget narrative directly into ORBITS, or may choose to use the old narrative form 107BF02. The applicable ORBITS component(s) and/or budget form(s) are noted in the instructions for each section of the document.

All of the CFO-supplied materials are available in ORBITS, from CFO, or on the web at

<http://www.oregon.gov/DAS/Financial/Pages/Budgetinstruct.aspx>.

The following pages explain how to assemble the budget documents.



The icon pictured to the left indicates that a divider “TAB” should be used at this point in the printed document. For electronic documents, this means major section identifiers and hyperlinks.

DOCUMENT FORMAT

Budget documents are submitted at three points in the process. See below and on the following page for details on when to submit. These guidelines will help you prepare your document in hard-copy and electronic formats.

- All budget pages, including ORBITS produced forms, must be 11 x 8 1/2 inches. Orient pages as “landscape.”
- All typing and graphics should be landscape-oriented. Lines should run the full page width or be in two columns.
- Side margins should be a minimum of ½ inch.
- Budget forms are available at:
<http://www.oregon.gov/DAS/Financial/Pages/Budgetinstruct.aspx>.

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- Do not write or type on ORBITS reports other than to add page numbers.
- Produce budget documents at the lowest cost that yields readable, informative documents. Customer service representatives from DAS Publishing and Distribution (P&D) can help with page layout or production issues to control costs. You may contact DAS P&D at (503) 378-1700.

Hard-copy Document

- Use 20-pound bond paper to make photocopies. Double-side all copies.
- All forms and narratives must be three-hole punched at the top 11-inch edge. Organize the final document in three-ring, vinyl binders.
- Use staggered divider tabs between sections along the document's bottom 11-inch edge. Use plastic dividers only if they are recyclable.
- Label binders on both the outside front cover and spine. Binders with title page inserts in a clear plastic cover are useful to keep labels from falling off.

Electronic Document

- All electronic documents should be digitized utilizing optical character recognition (OCR), so that printed text can be searched electronically.
- PDF and CD/DVD documents should be bookmarked at each section.
- Electronic files should contain appropriate hyperlinks to important sections of the document.
- Embed fonts and create a printable PDF prior to saving your document to CD/DVD.

DUE DATES, DOCUMENT TITLES AND COPY REQUIREMENTS

Agencies must update forms, narratives, and graphics in the agency request document at each step to reflect decisions by the Governor and the Legislature. The document format remains the same. The due dates, document titles, and copy requirements for each are:

Agency Request Budget

- Due to the CFO by September 1, 2016 from all agencies.
- Title: "Agency Name" 2017-19 Agency Request Budget.
- Number of copies to be submitted: **Two, plus an electronic copy for the CFO and a CD/DVD for the LFO library.** One binder must include certification page with an **original** authorized signature. The agency is also required to publish the ARB on its website and forward the hyperlink to the document to CFO.

Governor's Budget

- Due to CFO in early 2016. Actual due date will be supplied before then.
- Title: "Agency Name" 2017-19 Governor's Budget.
- Number of copies to be submitted: To be determined. One binder must include certification page with an **original** authorized signature. The number of copies will depend on the number of

The Budget Document

members in a designated budget committee, as well as the number of members that would prefer electronic copies only. Check with your CFO analyst.

Legislatively Adopted Budget

- Due to CFO within 30 days of the date the agency is through SABRS audit process and receives ORBITS budget support documents.
- Title: "Agency Name" 2017-19 Legislatively Adopted Budget.
- Number of copies to be submitted: **To be determined**. One binder must include certification page with an **original** authorized signature.

BUDGET OUTLINE



INTRODUCTORY INFORMATION

1. Table of Contents
2. Certification (107BF01)



LEGISLATIVE ACTION

1. Budget Report(s)
2. Emergency Board Minutes (if applicable)



AGENCY SUMMARY

1. Agency Summary Narrative (107BF02)
 - Budget Summary Graphics
 - Mission Statement and Statutory Authority
 - Agency two-year Plan
 - Program Descriptions
 - Environmental Factors
 - Initiatives and Accomplishments
 - Criteria for 2017-19 Budget Development
 - Major Information Technology Projects/Initiatives
 - Other Considerations
2. Summary of 2017-19 Budget (Agency-wide and Program Unit levels) (ORBITS)
3. Program Prioritization for 2017-19 (107BF23)
4. Reduction Options (107BF02 and 107BF17)
5. 2015-17 Organization Chart
6. 2017-19 Organization Chart (if changes proposed)



REVENUES

1. Revenue Forecast Narrative/Graphics (107BF02)
2. Detail of Fee, License, or Assessment Revenue Proposed for Increase (107BF08)
3. Detail of Lottery Funds, Other Funds, and Federal Funds Revenue (Agency-wide level (107BF07)

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PROGRAM UNITS

1. Program Unit Organization Chart(s).
2. Program Unit Executive Summary (107BF02).
3. Program Unit Narrative (107BF02).
4. Essential and Policy Package Narrative and Fiscal Impact Summary (ORBITS BPR013).



CAPITAL BUDGETING

1. Financing Agreements and COPs.
2. Capital Improvement.
 - Capital Improvement Narrative (107BF02).
 - Detail of Lottery Funds, Other Funds, and Federal Funds Revenue (BPR012).
3. Capital Construction (Major Construction/Acquisition).
 - Major Construction/Acquisition Narrative (107BF02 and 107BF11).
 - Major Construction/Acquisition Six-Year Plan (107BF13).
 - Capital Financing Six-Year Forecast Summary (107BF12).
 - Project Narrative.
 - Detail of Lottery Funds, Other Funds and Federal Funds Revenue (ORBITS BPR012 and 107BF07).
4. Facilities Maintenance and Management
 - Facilities Maintenance Narrative (107BF02).
 - Facilities Maintenance Summary Report (107BF16a).
 - Facilities Operations and Maintenance and Deferred Maintenance Report (107BF16b).



SPECIAL REPORTS

1. Information Technology-related Projects/Initiatives (Information Technology Project spreadsheet).
2. Annual Performance Progress Report (not required for ARB, include in GB/LAB)
3. Audit Response Report.
4. Affirmative Action Report.

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BUDGET DETAIL



INTRODUCTORY INFORMATION

The first two items in the budget document are the Table of Contents and the Certification. They precede the Legislative Action tab.

1. Table of Contents (no form).
2. Certification page (use form 107BF01). With this form, the agency certifies the accuracy of the budget document.

This certification must be completed and signed by the agency head or, if the agency is under control of a board or a commission, by the chairperson. The agency head or chairperson must sign the certification **each** time the budget document is updated. An **original** signed certification form must be included in the Agency Request Budget, the Governor's Budget, and the Legislatively Adopted Budget documents.



LEGISLATIVE ACTION

1. Budget Report(s)
2. Emergency Board Minutes (if applicable)



AGENCY SUMMARY

1. Agency Summary Narrative (107BF02)

This section presents policy issues and agency business plans for the 2017-19 biennium. An outline can be used if the information is complete.

The following headings and information must be in the narrative:

a. Budget Summary Graphics

This section must provide pie charts or other graphics that depict the proposed budget, including:

- How the budget is allocated among programs or activities.
- Distribution by fund type.
- Comparison of 2015-17 Legislatively Approved Budget (as of April 2016) with the 2017-19 Agency Request Budget.

Update these graphics for the Governor's Budget and the Legislatively Adopted Budget.

b. Mission Statement and Statutory Authority

This section explains the authority and direction of the agency. It must:

- Clearly and concisely state what the agency seeks to achieve.
- Cite Oregon Revised Statutes and Oregon Administrative Rules chapters containing the agency's authorities and duties.

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c. Agency Strategic or Business Plans

This section requires development of short-term and long-term strategic goals and plans. Agencies should link the long-term goals to pertinent high-level outcomes, and identify associated performance measures.

d. Criteria for 2017-19 Budget Development

Using the short-term and long-term plans, identify the goals, objectives and/or outcomes used as a basis to develop the budget proposal.

e. Performance Measures

Include the Annual Performance Progress Report for the fiscal year ending June 2016. See page 62 for more details.

f. Major Information Technology Projects/Initiatives

Identify and develop a business case document for major information technology-related projects/initiatives, equal to or exceeding \$1,000,000 and follow the Joint State CIO/LFO Stage Gate Review Process. Describe how those major projects/initiatives:

- Align with and support agency strategic/business plans.
- Align with and support the Governor's goals, priorities and initiatives, the Enterprise Information Resources Management Strategy, and other IT-related statewide plans, initiatives, goals and objectives.

The full business case document for these projects should be included in the Special Reports section of the budget document. This agency narrative section should be a summary of that document. For continuing IT projects in excess of \$1,000,000, the agency must submit the originally approved business case and/or an update to the business case for any changes to the IT project schedule, budget or scope that exceeds five percent of the originally approved project schedule, budget or scope. If the continuing IT project does not have a business case that received State Chief Information Officer approval, the agency must submit a business case for the project and a detailed project plan.

2. Summary of 2017-19 Budget (ORBITS)

This form is produced directly out of ORBITS. It reports the base budget, the essential packages that bring the budget to the current service level, and any policy packages in the budget. Both the agency summary and program unit levels are reported. Rerun the report, as stages are completed, for the Governor's Budget and the Legislatively Adopted Budget.

3. Program Prioritization for 2017-19 (form 107BF23)

This form is required for the Agency Request Budget. Priorities are listed for each Program Unit/Division as well as agency-wide.

4. Reduction Options

Present General Fund, Lottery Funds, Other Funds, and Federal Funds reduction options (see page 28 for details). Rank them in order, by lowest cost for benefit obtained. Number the first option to be implemented as number one, the second as two, etc.

10% Reduction Options Form (107BF02, and form 107BF17). For each option, provide:

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- Activity or Program – Describe the activity or program that would not be undertaken if the reduction were adopted.
- Describe Reduction – Describe the reduction and tell how it would be implemented. Describe program impacts from the option, including how the proposed action would affect the agency's mission, strategic plan, other agencies, and local governments. Identify any statutory changes needed to implement the reduction and whether a legislative concept has been filed. List positions and full-time equivalent positions affected by the option. If the option would be phased in, show the 2017-19 impact and the full 24-month projected 2019-21 impact.
- Amount and Fund Type – Identify the amount of the reduction and the fund type. If Other Funds or Federal Funds are affected, identify the amount and source, and indicate if there are restrictions on use of the funds for other activities or programs.
- Rank and Justification – Each activity or program not undertaken must be ranked on the basis of lowest cost for benefit obtained. Explain the criteria and methods used to determine costs and benefits obtained.

If one option includes multiple elements, provide this information for each element.

Although dollar amounts for reduction options are not entered into ORBITS in the Agency Request Budget, agencies should be prepared to provide their CFO and LFO analysts detailed information by category. This will allow analysts to form policy packages quickly if the options are recommended by the Governor or adopted by the Legislature. See page 33 for instructions on displaying reduction options that were actually used in the Governor's budget.

5. Organization Chart(s) 2015-17

Include a copy of the agency's current organization chart.

6. Organization Chart(s) 2017-19

If the 2017-19 budget includes organizational changes, include a chart of the proposed structure.

- A chart should summarize the agency structure in one or two pages.
- Include the number of positions and full-time equivalent (FTE) in each unit of the agency.
- Note any positions eliminated from or added to the 2015-17 Legislatively Adopted Budget to date.
- Show proposed 2017-19 biennium changes by shaded or dashed boxes.
- Use summary footnotes to save space. More detailed charts will be included in the program unit sections of the budget.

7. Agency-wide Program Unit Summary (ORBITS BPR010)

This report will summarize the budget by program unit and fund type. It will show Capital Improvement and Capital Construction (Major Construction/Acquisition) as program units.

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REVENUES

This section presents revenues at the agency-wide level.

1. Revenue Forecast Narrative (107BF02)

Explain the total estimated Lottery Funds, Other Funds, and Federal Funds revenues. For each source of Lottery Funds, Other Funds, and Federal Funds describe:

- The source of funds. For Federal Funds, name the federal program and agency.
- Any required matching funds, including the percentage and type of match.
- Agency programs funded with the revenue.
- General limits on use of funds.
- Basis for 2017-19 biennium estimates. For fees or assessments, describe who pays, the number of payers, and rates.
- Proposed changes in revenue sources or fees.
- Proposals for new legislation.

Include graphics or other aids to provide a clear, concise report. A more detailed revenue narrative is required for each program unit.

2. Detail of Fee, License, or Assessment Revenue Proposed for Increase (107BF08)

Describe the fees, licenses, and assessments to be established or increased in the 2017-19 budget. Include those established or increased administratively during the 2015-17 biennium, only if they were not approved by the Legislature and included in the Legislatively Adopted Budget. In the explanation section, describe and contrast any increases in volume versus any increases in rate.

Although not included in the budget binder, agencies must report detailed information on all fee increases, establishments, or decreases included in the 2017-19 Agency Request Budget. This is reported on form 107BF22 Fee Change Detail Report. The form and accompanying cover memo must be submitted electronically to the agency's CFO analyst at the same time that the Agency Request Budget is submitted.

3. Detail of Lottery Funds, Other Funds, and Federal Funds Revenue (Form 107BF07 must be included.)

Itemize Lottery Funds, Other Funds, and Federal Funds for the agency as a whole by type of funds and source. Entries must match fund sources in the Revenue Forecast Narrative.

PROGRAM UNITS

Present each program unit under a separate tab in the budget. Generally, a program unit has a base budget and may have essential or policy packages.

An agency that presents its entire budget as a single program unit may combine this section with the Agency Summary section as long as all required information is included.



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Program Unit (Title)

Organize each program unit under its tab as follows:

1. Program Unit Organization Charts

Include a copy of the current organization chart for each program unit. If the 2017-19 budget makes organizational changes, include a chart of the 2015-17 structure and one of the proposed 2017-19 structure.

- Charts should summarize the program unit's structure in one page if possible.
- Include the number of positions and FTE in each unit of the program unit.
- Note any positions eliminated, added, or transferred during the 2013-15 biennium to date between program units from the 2015-17 Legislatively Adopted Budget.
- Show proposed 2017-19 biennium changes by shaded or dashed boxes.
- Use summary footnotes to save space.

2. Program Unit Executive Summary (107BF02)

During the 2013-15 budget development process, state agencies summarized their program level budgets using a bid form. Those bid forms forced agencies to summarize their programs in a concise manner, while hitting the major elements that help decision-makers understand the core elements of the agency proposals. This concise format was very useful in the budget development process.

For the 2017-19 biennium, agencies will continue to incorporate the information that was contained in the prior bid forms into the Agency Request budget narrative as a "Program Unit Executive Summary." As with the bid forms, agencies should limit this executive summary to no more than four pages. This Executive Summary should orient readers to the core functions of the program unit, summarize the requested funding level for the upcoming biennium, and articulate the expected performance that will be achieved if the requested funding level is approved.

The Program Unit Executive Summary should be organized in the same manner as presented in the 2013-15 bid forms. The specific sections that will be required include:

- a. Long Term Focus Areas that are impacted by the program. All agency programs will be mapped to the five long term focus areas identified by Governor Brown. In this section, highlight which focus areas have a Primary, Secondary or Tertiary linkage to the program.
- b. Primary Program Contact. Identify a person who can answer questions about program operations.
- c. Graphical representation of the program unit's Total Funds Budget over time and the program performance that corresponds for the same period. This graphic is designed to provide historical and future context for decision-makers so they can see the relationship between funding levels and program performance. Most programs should be able to provide five biennia of history, the current biennium, and at least the funding and performance levels expected in the 2017-19 biennium, if the agency proposal is approved. If your agency can not provide this history, work with your assigned CFO analyst to determine an appropriate graphical representation.

While the information provided above is the minimum expected of agencies, it will be most helpful to decision-makers if an estimate of future costs is also included through the 2021-23 biennium. This is especially important for program changes that will be proposed for 2017-19 that may need to

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roll-up in future biennia. Providing this information now will avoid surprises in future biennia if increased funding is requested at a later time. In preparing future cost estimates, use the same methodology used to develop the agency Current Service Level. As a general guideline, the following inflation factors should be used:

	Standard Inflation	Non-State Employee Personnel Costs	Medical Inflation
2017-19	3.7	4.1	4.1
2019-21	3.8	4.3	4.7
2021-23	4.1	4.4	5.0

- d. **Program Overview.** In one or two sentences, describe what the program does and why it is important.
- e. **Program Funding Request.** Summarize the proposal you are submitting to the Governor. Include the amount of resources you are requesting for this program and the performance you will achieve if this proposal is funded. Include the proposal costs and performance for the 2017-19 biennium and estimated costs and performance through the 2021-23 biennium.
- f. **Program Description.** Provide a description of the program, the clients that it serves and the frequency at which those clients receive service. Describe the purpose of the program and how it achieves that purpose. Describe how the program is delivered and what partners are necessary to guarantee success of the program. Describe the major cost drivers that affect this program, and whether there are opportunities to improve performance through alternative delivery methods.
- g. **Program Justification and Link to Long Term Outcomes.** Describe linkage between program performance and the long term outcomes. At a minimum there must be a logical connection between the performance of this program and our long term goals. At best, the program can provide research or nationally recognized best practices to justify the argument that investment in this program will help Oregon achieve its long term goals. If there are long term performance indicators that are directly impacted by the performance of this program, identify those indicators and how they move with changes in program performance.

Provide similar information for any secondary or tertiary outcomes connected to this program.

- h. **Program Performance.** In this section provide tables or charts that show the performance of the program over time. Preferably, the performance should have 10 years of history and at least the projected performance during 2017-19 if the program proposal is accepted by the Governor. Optimally, the program would be able to provide information for all four of the following performance indicators over time:

- Number of people served/items produced
- Quality of the services provided
- Timeliness of services provided
- Cost per service unit

For whichever performance metrics are used, describe the metric, what it measures, and why the metric is important for understanding the program performance. Where trends or data

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anomalies exist, explain the nature of the anomalies. At a minimum, report the same information that was used for 2015-17.

- i. Enabling Legislation/Program Authorization. Describe if the program is mandated by the US Constitution, Oregon Constitution or Federal Law. Cite the enabling legislation that mandates the program. If the program is authorized, but not mandated by federal law or if the program is mandated by Oregon law, cite the enabling legislation.
- j. Describe the various funding streams that support the program. Include a description of leveraged funds and the nature of how Oregon qualifies to receive the additional resources (competitive grant, federal matching program, private donation, performance bonuses, etc). If the program has a dedicated funding stream, describe the dedicated source and the nature of the dedication (constitutional or statutory) providing legal citations to the dedication.
- k. Describe how the 2017-19 funding proposal advanced by the agency compares to the program authorized for the agency in 2015-17. Describe if the funding proposal maintains the program at Current Service Level, or increase/decreases it. If the proposal alters the program from the Current Service Level, describe the nature of the change and why the agency is proposing to make changes.

3. Program Unit Narrative (107BF02)

This section provides additional information beyond the Program Unit Executive Summary mentioned above. This section will cover more detailed information related to the budget information for the major program and policy issues of the program unit. Discuss the base budget, essential packages, and policy packages for the unit. Agencies with questions about writing the narrative should check with their CFO analyst for examples or suggestions.

The narrative must concisely describe:

- Expenditures by fund type, positions and full-time equivalents.
- Activities, programs, and issues in the program unit base budget that may require further explanation than allowed in the Program Unit Executive Summary.
- Any additional important background for decision makers that is not mentioned above. Include trends in caseload, workload or other external factors that may influence the operation of the program.
- Revenue sources and proposed revenue changes. For Lottery Funds, Other Funds, and Federal Funds revenues, discuss:
 - The source of funds. For Federal Funds, name the federal program and agency.
 - Any required matching funds. Include the percentage and type of match.
 - Programs in the program unit funded with each revenue source.
 - General limits on use of funds.
 - Basis for 2017-19 estimates. For fees or assessments, describe who pays, the number of payers, and the rates.
- Proposed new laws that apply to the program unit.

Balance the amount of detail against the need to be brief and to discuss key issues. An outline format can be used if it provides complete information. Use graphics or charts as aids to understanding.

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4. Packages (107BF02 and BPR013)

Packages propose budget, policy, and program changes. Packages are of two kinds: essential or policy packages. Place the unit's essential packages first and then its policy packages. Rank policy packages in overall agency-wide priority order. Number one would be the highest priority to the agency, number two next, etc. Present them in that order.

- A package based on new or increased Federal Funds should be based on completed congressional action with documentation that funds are authorized and appropriated. Exceptions may be made if funding is reasonably certain.
- Highlight any actions that would:
 - Produce substantial matching revenues from other jurisdictions.
 - Generate new or increased revenues.
 - Eliminate revenues received by the agency during the 2017-19 biennium.
 - Note whether package revenues are available only for the purposes described or could be used to finance other programs.

Descriptions of a program unit's essential packages can be combined on one or two pages, but each policy package should be on its own page. The Policy Package narrative should summarize the agency's business case for new funding proposals. The narrative should describe the issue to be addressed, the solution proposed by the agency, the resources needed to implement the solution, and how the agency proposes to quantify its success if the package is approved. Each package should be presented as follows:

- a. Package Narrative (107BF02) – Include these headings and information:
 - Purpose – Describe the issue or problem that needs to be addressed and the agency's proposed solution. Explain how the proposed action advances our long term goals, key change initiative, agency's mission, strategic plan, and any applicable Benchmarks or key performance measures.
 - How Achieved – Explain how the proposed action will address the problem. This explanation should include the agency's implementation strategy with a detailed timeline for key activities. Summarize the planning activities leading to the development of the proposal, including employee or stakeholder involvement in the planning process. Describe the alternatives that were considered and why the agency's proposed action is preferred. If the proposal requires new statutory changes, include them in the legislative concept process. Describe any impacts on other agencies or governments and how the proposal is being coordinated with them.
 - Staffing Impact – List positions and full-time equivalent required for the proposed action. For phased actions, show the 2017-19 impact and the full 24-month projected impact for 2019-21.
 - Quantifying Results – Describe how your agency will quantify your results if the proposal is approved (policy packages only). Once the method of quantifying the results has been described, include a timeline with periodic performance target milestones. These measurements do not need to be limited to agency Key Performance Measurements, but could include agency operational measures.

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- Revenue Source – Show the revenue sources that would fund the package and the amount assumed from each source. Highlight any new revenues expected, any revenue savings, or any change in fees assumed in the package.

If a package includes multiple elements, provide this information for each element.

- b. Essential and Policy Package Fiscal Impact Summary (BPR013) – Show fiscal details for each package by category and fund type. Include Personal Services, Services and Supplies, Capital Outlay, Special Payments, Positions, FTE, and all related costs of the package. Estimate the fiscal impact in the 2019-21 biennium for any phased actions or if the funding base will change.
- c. Policy packages involving IT projects/initiatives. Agencies must enter information into to the Enterprise Project and Portfolio Management (PPM) System for each IT project/initiative with estimated total costs of \$150,000 or greater.
 - Agencies must complete and submit a formal business case document for each IT project/initiative that exceeds \$1,000,000 in total estimated cost. This document should also be included in the Special Reports section of the budget document.
 - For continuing IT projects in excess of \$1,000,000, the agency must submit the originally approved business case and/or an update to the business case for any changes to the IT project schedule, budget or scope that exceeds five percent of the originally approved project schedule, budget or scope. If the continuing IT project does not have a business case that received State Chief Information Officer approval, the agency must submit a business case for the project and a detailed project plan.

5. Detail of Lottery Funds, Other Funds, and Federal Funds Revenue (107BF07)

Itemize Lottery Funds, Other Funds, and Federal Funds revenues for the program unit by type of funds and source. The total revenues described for all program units should equal the totals in the Revenue section of the agency budget document.

CAPITAL BUDGETING & FACILITIES MAINTENANCE

Capital Budgeting & Facilities Maintenance Forms

XI-Q Bonds and Financing Agreements

Article XI-Q Bond Financing and Other Financing Agreements Request Form for 2017-19 Biennium (107BF15) – If your agency is requesting XI-Q bond financing or capital lease financing, this form must be completed and returned to Jean Gabriel, on or before **May 16, 2016**. Bond financing may be for capital acquisition, construction or improvement of real property, equipment, or IT systems.

Lottery Revenue Bond Financing Request Form for 2017-19 Biennium (107BF09) – If your agency is requesting lottery revenue bond financing, this form must be completed and returned to Jean Gabriel, on or before **May 16, 2016**.

Capital Improvements

- **Capital Improvement Narrative (107BF02)** – See form for instructions.
- **Detail of Lottery Funds, Other Funds, and Federal Funds Revenue (ORBITS BPR012 and 107BF07)** – List each source and amount of Lottery Funds, Other Funds, or Federal Funds.

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Major Construction/Acquisitions

- **Major Construction/Acquisition Narrative** (107BF02 and 107BF11) – Provide a general description of the agency's business plan or facilities master plan that is the basis for the request. Describe the basic assumptions that support the request. Provide a description of the project purpose, project scope and alternates considered and project budget for each major construction or acquisition project. These might include demographic changes, trends, economic factors, federal mandates, etc. Complete a separate form for each project. A separate form is included for the Higher Education Coordinating Commission for reporting public university and community college plans (form 107BF11a). All other agencies will continue to use form 107BF11.
- **Major Construction/Acquisition Ten-Year Plan** (107BF13) – Show each requested project by biennium. Put them in numbered priority (No. 1 being highest). Include the estimated cost to complete. List all costs by fund source (General, Lottery, Other, Federal) and show totals. For projects in future biennia, list a planning cost estimate in the appropriate biennium. Include a discussion of operating and maintenance costs. A cost breakdown by program or institution is acceptable.
- **Capital Financing Six-Year Forecast Summary** (107BF12) – There is a separate summary form for each biennium of the forecast. Show the total principal amount of XI-Q bonds to be issued for major construction/acquisition projects costing over \$1 million, and equipment/information technology-related projects or systems costing over \$500,000, and loan and grant programs. Show your issuance plans for each financing program. For each category, provide total project costs to be repaid by General Fund, Other Funds, or Lottery Funds. Do not show debt service on this form.

Please attach a sheet to the summary form detailing your planned debt issuance. Include specific information on the source of Other Funds used to repay debt. For example, you might show Other Funds - loan repayments, or Other Funds - licensing fees, if applicable.

This information will show planned use of debt capacity. It will be compared to the debt capacity recommendations issued by the State Debt Policy Advisory Commission.

Detail of Lottery Funds, Other Funds, and Federal Funds Revenue (ORBITS BPR012 and 107BF07) – List each source and amount of Lottery Funds, Other Funds, or Federal Funds.

Facilities Maintenance Forms Descriptions

- **Facilities Maintenance Narrative** (107BF02) – Discuss the key drivers for your agency's facility needs, and how the agency measures space/facility demand. Discuss the key facility related challenges over the next 10 years including maintenance needs. Discuss the agency approaches and strategies to meet these needs.
- **Facilities Maintenance Summary Report** (107BF16a) – Provide summary data on owned facilities over \$1 million, owned facilities under \$1 million and leased facilities. For facilities over \$1 million in value, provide a measure of the space utilization of the facility per the instructions. Provide facility and lease data as reported to the CPAB
- **Facilities Operations & Maintenance Budget and Deferred Maintenance Plan** (107BF16b) – Provide information on your operations and maintenance (O&M) budget and deferred maintenance plan by biennium and fund type. This **does not** include Capital Improvements. Use the definition of maintenance described in the *Budget Instructions* above. If staff performing maintenance functions also performs other duties, make your best estimate of the portion of time and costs to allocate to

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maintenance. **Include amounts for janitorial and utilities costs by biennium for state-owned facilities.** If maintenance costs are not included in a distinct DCR, please retain worksheets used to estimate your O & M budget. The Legislative approved column should reflect approved amounts as of April 2016. Provide O&M and Short and Long Term Deferred Maintenance data by priority as reported to the CPAB.

SPECIAL REPORTS

Information about IT investments with estimated total costs of \$150,000 or greater must be entered into the Enterprise Project and Portfolio Management (PPM) system. Estimation of the total costs must include any hardware, software, contract services, internal staff, capital costs, and indirect and overhead costs to be incurred during the 2017-19 biennium regardless of whether the agency intends to fund the project through its base budget or a policy package.

The spreadsheet is in the Budget Forms section of these instructions. Agencies should work with the Office of the State Chief Information Officer, to complete the spreadsheet. Agencies are required to submit this information to the OSCIO, at the same time they submit their Agency Request Budget to CFO. This spreadsheet should be included in the budget document under Special Reports.

For IT investments exceeding \$1 million, agencies are also required to comply with the Joint State CIO/LFO Stage Gate Review process—including the development of a business case.

The business case should clearly describe how the project/initiative:

- Aligns with and supports agency strategic/business plans.
- Aligns with and supports the Governor's goals, priorities and initiatives and the [2015-2020 Enterprise Information Resources Management Strategy](#).

This document should be included in the budget document under Special Reports, and submitted to the Office of the State Chief Information Officer at the same time agencies submit their Agency Request Budgets to CFO.

The business case should also include the following information:

- Subject, Purpose, and Scope.
- Projected cash flows across timeline (lifecycle or other).
- Alternatives Analysis (to the extent possible at this point in the project lifecycle).
- Assumptions and Methods that the investment is based on.
- Costs and Benefits – Financial and Non-financial (to the extent possible at the point in the project).
- Estimated costs must include the total cost estimate for hardware, software, contract services, internal staff, capital costs, and indirect and overhead costs for 2017-19 regardless of whether the agency intends to fund the project through its base budget or a policy package. OSCIO ETS customer agencies must confirm OSCIO ETS involvement in creating the cost estimate and separately identify the estimated costs related to OSCIO ETS provided products and services.
- Critical Success Factors.
- Risk Assessment (to the extent possible at this point in the project lifecycle).

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For continuing IT projects in excess of \$1,000,000, the agency must submit the originally approved business case and/or an update to the business case for any changes to the IT project schedule, budget or scope that exceeds five percent of the originally approved project schedule, budget or scope. If the continuing IT project does not have a previously submitted business case that received State CIO approval, the agency must submit a business case for the project and a detailed project plan.

Annual Performance Progress Report/Key Performance Measures

In 1993, the Legislative Assembly required agencies to include benchmark-based planning in performance measurement and budget policy. In 2001, the Legislative Assembly added specific requirements for how performance measures should be developed and reported. ORS 291.110 specifies that DAS, in consultation with the Legislative Fiscal Office, shall ensure the development of a statewide system of performance measures designed to improve the efficiency and effectiveness of state programs and services. State agencies are expected to continue to track and report annually on a set of Legislatively Approved Key Performance Measures (KPMs), and request changes to improve their KPMs as part of the budget development process.

The process for proposing and approving agency KPMs for the 2017-19 biennium will be the same as for previous biennia. KPM resources can be found: <https://www.oregonlegislature.gov/lfo/Pages/KPM.aspx>

Step 1: March – April

Agencies who wish to make changes to their KPMs need to input their change requests into the automated KPM system and notify their CFO/LFO analysts that they are requesting changes by April 30th, 2016. CFO/LFO analysts will review the requests and provide feedback by June 30, 2016. Agencies can make adjustments to proposed changes based on feedback received.

Step 2: August – December

Agencies will submit a copy of their Annual Performance Progress Report (APPR) for the fiscal year ending June 30, 2016, with their Governor's Budget. Agency Summary narratives should summarize the outcomes sought, the measures used, and the results achieved based on the agency's most recent APPR.

It is possible that agencies will not have complete data on some measures for this submission. In this event, update the data in the automated system as soon as possible and include an updated APPR with your Governor's Budget request.

Step 3: January – June 2016

Agencies provide KPM presentations to Joint Committee on Ways and Means. The Committee reviews proposed changes and makes a determination of the final Legislatively Approved KPMs as part of the budget approval process.

Step 4: June 2016

A list of legislatively approved KPMs for 2017-19 will be attached to each agency's final Budget Report.

Audits Response Report

In the budget request, include a written summary of responses to any financial or performance audits by the Secretary of State or the Joint Legislative Audits, Information Management and Technology finished in the 2013-15 or 2015-17 biennia to date. Report any major findings or recommendations, and the agency response to the audit. Outline options for addressing the issues raised. Discuss management actions the agency has taken, and any related policy packages in the Agency Request Budget. Update this report for the Governor's Budget document.

Affirmative Action Report

Each agency must keep affirmative action records (ORS 659A.012 – 659A.015). Agencies must budget resources to support agency affirmative action goals. The Governor’s Diversity and Inclusion Director will use each agency’s report to prepare a statewide summary report to the Legislature.

The Governor’s Equity and Community Engagement office will provide an update on each agency’s progress toward goals for the 2015-17 biennium and projected goals for the 2017-19 biennium. Each agency’s affirmative action report should contain proposed affirmative action programs and outcomes in two-year and six-year plans. The report should include a brief discussion of progress over the past two years in reaching the parity percentage calculated by the Equity and Community Engagement office. (For details, see "Current vs. Baseline Analysis Affirmative Action Report from DAS Personnel Services," report NAAPRGRS-G.) Agencies that did not meet those percentages must explain the circumstances and the agency’s plans to meet them in the future. Call Serena Stoudamire Wesley, Director of Equity and Community Engagement, Office of the Governor, at (503) 378-8474 with any questions.

Legislative Concept Procedures

For a successful 2017 Legislative Session, legislative concepts and budgets should be developed together, both of which must be measured against the Governor's policy priorities. The budget and legislative concept processes should be used to examine priorities, look for solutions and outcomes rather than programs and activities, and look for partnerships that can achieve outcomes more effectively and economically than going it alone.

To help with this process, DAS and the Governor's Office will review and approve all legislative concepts. During these reviews, agencies may be asked to provide more information or documentation. Complete submittals will help the process. Contact Barry Pack at (503) 378-2168, if you have questions.

The last day to submit legislative concepts to DAS is April 15, 2016. Agencies with 10 or more requests must submit by **April 11, 2016.**

Placeholders will be accepted only when it can be shown that the concept is essential and that timely completion was beyond the control of the agency and its governing body. For example, placeholders may be necessary to provide for proposed initiatives that may be approved by voters at an upcoming election, to provide for anticipated changes in federal laws, or in anticipation of the results of a governor's or legislatively mandated task force. Placeholders still need an explanation of the policy objective of the concept, and draft language. An agency should have a good idea of what they are trying to affect even though they may be waiting on input from a task force. Additional placeholder information must be submitted to DAS by June 24, 2016. Agencies with five or more placeholders must submit additional information by June 22, 2016. All information submitted for placeholders must be within the scope of the placeholder as originally described.

Agencies may ask the Department of Justice to draft proposed language. Although this may be helpful, it does not affect the schedule requirements for submitting information to DAS or Legislative Counsel. Also, Legislative Counsel may choose not to use the DOJ proposal when preparing the draft legislative concept.

LEGISLATIVE CONCEPT POLICY GUIDELINES

No executive branch agency may cause a bill or measure to be introduced before the Legislative Assembly without the approval of the Governor. Concepts that have been approved during the early stages of the process may be disapproved prior to pre-session filing.

A concept should accomplish some of these goals:

- Achieving the Governor's policy priorities.
- Achieving solutions and outcomes rather than adding programs and activities.
- Replacing systems and programs that do not produce results.
- Achieving more effective and economical essential services.
- Developing or expanding partnerships across levels of government to achieve better results.
- Making necessary changes required by court decisions and federal changes.
- Fostering public trust and participation in government.

Legislative Concept Procedures

No concept should be proposed if it:

- Moves or creates programs without needed resources.
- Contains needless red tape.
- Charges fees or assessments without comparable benefit.
- Puts power in one agency when collaboration among entities is needed.
- Will not be supported by adequate data in time for the session.

Concepts usually fall into three categories: 1) major policy and program changes, 2) minor program changes, and 3) housekeeping. Housekeeping means purely technical adjustments or corrections with no policy issues.

The estimated fiscal and revenue impact of a legislative concept must be identified at the time the concept is proposed. If the concept is approved for legislative filing, the amount of the fiscal impact must be included in the Agency Request Budget.

The fiscal impact of a legislative concept must be included in the Governor's Budget in a policy package or the concept will not be approved for pre-session filing, even if the concept has been approved conceptually. This includes concepts with fiscal impacts on other state agencies. For example, proposals to create new criminal penalties or increase the penalties for existing crimes that would increase populations in the Department of Corrections or Oregon Youth Authority must be linked to policy packages in those agencies.

Conversely, policy packages that require statutory changes for which legislative concepts have not been submitted will not be included in the Governor's Budget.

The Governor will pre-session file all approved agency bills. The name of the requesting state agency will also appear on the face of the bill. Some bills related to budget will be filed by DAS.

LEGISLATIVE CONCEPT FORM INSTRUCTIONS

Clear ideas and a detailed explanation of what you are trying to achieve are absolutely necessary to produce a bill that meets your intent. Obtain all internal reviews and approvals before submitting a concept to DAS. Consult with the Department of Justice General Counsel Division as needed. Develop the concept in concert with any state and local agencies and all entities affected by it.

The Concept Form

Use the Agency Legislative Concept Request Form to submit concepts to DAS. Include all the detailed information necessary to draft a bill, including draft statutory language. Submitting proposed statutory language does not substitute for a clear explanation of the problem and the proposed solution.

Legislative Counsel's experience over the years is that rewriting unclear language is more time-consuming and less accurate than starting from a clear statement of the problem and solution. However, your best attempt at preparing draft statutory language is especially helpful for DAS and the Governor's internal review process.

Draft language can be a photocopy of the statute with hand-written changes. If a hand-written version is not clear, type a document with brackets and underlines (similar to any bill). The draft need not be in perfect format. You can also copy and paste current statutes from the legislative web site. Make sure to use the 2015 Oregon Revised Statutes.

Legislative Concept Procedures

Please also include contact information for persons in your agency who have direct information about the problem and solution that the concept is to address.

Notes on Concept Contents

Be sure to read the instructions with the form. They are not repeated here.

Fees and Assessments

If a concept would increase a fee or assessment, you must attach form 107BF22 providing detailed information on the fee increase. Attach required narratives (see form instructions). Explain whether the agency can make the change by rule or only through legislation.

Fiscal Impacts

Include a complete Fiscal Impact Estimate form and attachments for each concept. Be sure approved concepts with a fiscal impact are included in the Agency Request Budget.

The Concept Process

DAS will notify agencies as concepts are approved or denied. DAS will send approved concepts to Legislative Counsel for bill drafting. Counsel will send drafts directly to the agency. After receiving Legislative Counsel's first draft, the agency may request changes to the draft only ONCE. This request for a revision must be made by September 30, 2016 or 14 calendar days from the date on the bill draft, whichever is sooner. Work with Legislative Counsel to reach a final draft. Agencies must send final concepts and one-page summaries to DAS for review and approval by the Governor's Office. Upon final approval, DAS will coordinate pre-session filing of agency bills. DAS will file major budget-related concepts.

Read the development schedule on the next page carefully! Meeting the deadlines is the only way to ensure that a concept becomes part of a legislative package supported or authorized by the Governor.

Legislative Concept Procedures

LEGISLATIVE CONCEPT DEVELOPMENT SCHEDULE – 2017 SESSION

Prior to April 15, 2016	<ul style="list-style-type: none">• Develop concept in conjunction with state and local agencies and others that could be affected by the statute or program change.• Submit concept, detailed explanation, draft language, and Fiscal Impact Estimate to DAS.
April 15, 2016 (or April 11, 2016)	LAST DAY to submit concepts to DAS. Agencies with 10 or more concept requests must submit by April 11, 2016.
April 15, 2016 to June 3, 2016	<ul style="list-style-type: none">• CFO analysts and other key staff review concepts for policy and fiscal issues and contact agencies when questions arise.• Governor’s Policy Advisors review requests and recommend whether or not to approve or deny concept to move forward for drafting.• DAS notifies agency of final action.• DAS sends approved concepts to Legislative Counsel for drafting.
June 3, 2016	LAST DAY for DAS to submit approved concepts to Legislative Counsel for drafting.
June 3, 2016 to June 24, 2016	Agencies continue to work on placeholder concepts (additional substantive or administrative details for concepts submitted to DAS by April 15, 2016.)
June 24, 2016 (or June 22, 2016)	LAST DAY to submit additional placeholder information to DAS. Agencies with 5 or more placeholders must submit by June 22, 2016.
June 24, 2016 to August 1, 2016	<ul style="list-style-type: none">• CFO analysts and other key staff review additional information for policy and fiscal issues and contact agencies when questions arise.• Governor’s Policy Advisors review additional information and recommend whether or not to move forward.• DAS notifies agency of final action.• DAS sends approved placeholder information to Legislative Counsel.
July 29, 2016	LAST DAY for DAS to submit approved placeholder information to Legislative Counsel for drafting.
July 29, 2016 to November 1, 2016	Legislative Counsel continues to work on bill drafts – consulting with agencies as necessary. Counsel will allow ONLY ONE REVISION after the first draft.
September 30, 2016 <u>OR</u> 14 calendar days from the date on the bill draft, whichever is sooner	LAST DAY to request revisions to first draft of legislative concepts. One revision opportunity per concept.
November 1, 2016	Legislative Counsel stops ALL drafting on agency concepts.
As Final (no later than November 16, 2016)	Final concepts, fiscal impact estimates and “one-page” bill summaries due to DAS for final review and approval by the Governor’s Office and DAS.
December 9, 2016	LAST DAS to pre-session file bills for 2017 Legislative Session. With approval from Governor, DAS pre-session files agency concepts.

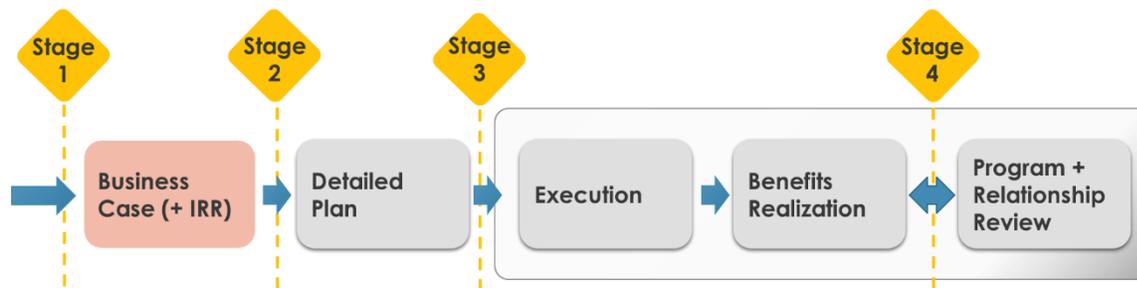
Appendix A. IT Project Reporting & Stage Gate Review

Agencies proposing information technology (IT) investments that exceed \$150,000 in total costs, are required to enter project information into the Office of the State CIO's (OSCIO) Enterprise Project and Portfolio Management (PPM) system. The PPM tool will be used for all project review, approval, project status and closeout reporting activities throughout the project lifecycle. Estimation of the total costs must include any hardware, software, contract services, internal staff, capital costs, and indirect and overhead costs incurred during the 2017-19 biennium regardless of whether the agency intends to fund the project through its base budget or a policy package.

STAGE GATE REVIEW

For IT investments exceeding \$1million, agencies are also required to comply with the Joint State CIO/LFO Stage Gate Review process. There are four (4) Stage Gate Endorsements in the Joint State CIO/LFO Stage Gate Review Process, including: high-level planning; detailed business case development and foundational planning; detailed planning; and execution.

Stage Gate. Simple Model



Stage Gate Narrative

The Joint State CIO/LFO Stage Gate Review process is an incremental funding and development model that is intended to ensure alignment between business strategy and IT decision-making, surface business requirements and mitigate the risk of IT project failure. The transition from one stage to another requires the submission of required artifacts utilizing the Enterprise PPM system, joint OSCIO/LFO review and a stage endorsement from the OSCIO.

Stage Gate 1 High-level Planning

Stage 1 activities are performed during the budgeting process and corresponds to a project's Concept / Origination Phase.

- Artifacts that support this Stage Gate are expected to be high level.
- Agencies are free to produce/submit more detailed artifacts that would normally be expected to be produced/delivered by Stage Gate 2 Endorsement or Stage Gate 3 Endorsement.
- From the perspective of a project's authorized budget, the goal in Stage 1 is to secure funding for the preparation of a detailed Business Case and to perform project planning.

Appendix A. IT Project Reporting & Stage Gate Review

Stage Gate 2 Detailed Business Case & Foundational Planning

Stage 2 activities are performed during preparation of a detailed Business Case / Information Resource Request (IRR), designed to produce foundational planning artifacts, and corresponds to a project's Initiation Phase.

- The goal in Stage 2 is OSCIO approval of a project's preferred solution approach (part of the project's business case), requirements that can support a formal RFP, and a "+/- 50% plan" with respect to scope, schedule, budget, resources, and quality.
- This Stage is expected to occur substantially before the release of a formal Request for Proposals (RFP) process to procure the project's Prime Contractor (also known as the System Integrator, Implementation Contractor, Design-Development-Implementation (DDI) Contractor, etc.).
- Prior to Stage Gate 2 Endorsement, the agency should assign or obtain project management resources and obtain independent Quality Assurance (QA) services (i.e. Preliminary QA and other Quality Management Services).
- Independent project risk assessment and Quality Control review of important foundational planning artifacts needs to occur before Stage Gate 2 Endorsement; including review of the Requirements and Statement of Work that support the RFP process to procure the project's Prime Contractor.
- Agencies are free to produce/submit more detailed artifacts that would normally be expected to be produced/delivered by Stage Gate 3 Endorsement.
- From the perspective of a project's authorized budget, the goal in Stage 2 is to secure funding for Detailed Planning.

Stage Gate 3 Detailed Planning

Stage 3 activities are performed during preparation of a project's Detailed Plan, an updated business case, and correspond to a project's Planning Phase. Stage 3 ends with Stage Gate 3 Endorsement if OSCIO approves.

- This is the period when a project has substantial details about the specific implementation approach to be adopted; usually just prior to or around the release of the RFP(s) for the Prime Contractor.
- During this period, a re-baseline of the Project's plan to achieve a "+/- 10% plan" and a Business Case/IRR Update (to be approved by the State CIO) are expected.
- The Detailed Plan is expected to be updated once the Prime Contractor has been procured and, as appropriate, throughout the project lifecycle.
- Agencies and their contractors may not begin project execution work before receiving Stage Gate 3 Endorsement.
- From the perspective of a project's authorized budget, the goal in Stage 3 is to secure funding for Project Execution.

Stage Gate 4 Execution

Stage 4 activities cover a project's main implementation work and correspond to a project's Execution Phase and Closing Phase.

Appendix A. IT Project Reporting & Stage Gate Review

- Status Reviews depend on the specific software development lifecycle adopted by a project; and the size, complexity, and risk of the project.
- During this period and for projects with an Independent QA contractor, OSCIO expects: Independent Quality Management Services that cover quality planning, quality control (QC) reviews of important project work products and IV&V testing, quality assurance, and risk assessment (See Statewide Policy for Independent Quality Management Services - 107-004-030).

ARB - Business Case Submission

Consistent with the Stage Gate 2 endorsement, agencies are required to develop a **business case** document for each major IT project/initiative that is anticipated to exceed \$1 million. The business case should clearly describe how the project/initiative:

- Aligns with and supports agency strategic/business plans.
- Aligns with and supports the Governor's goals, priorities and initiatives, the [2015-2010 Enterprise Information Resources Management Strategy](#), and other IT-related statewide plans, initiatives, goals and objectives.

This document should be included in the budget document under Special Reports, and submitted to the Office of the State Chief Information Officer at the same time agencies submit their Agency Request Budgets to CFO.

The business case should also include the following information:

- Subject, Purpose, and Scope.
- Projected cash flows across timeline (lifecycle or other).
- Alternatives Analysis (to the extent possible at this point in the project lifecycle).
- Assumptions and Methods that the investment is based on.
- Costs and Benefits – Financial and Non-financial (to the extent possible at the point in the project).
- Estimated costs must include the total cost estimate for hardware, software, contract services, internal staff, capital costs, and indirect and overhead costs for 2017-19 regardless of whether the agency intends to fund the project through its base budget or a policy package. OSCIO Enterprise Technology Services (ETS) customer agencies must confirm ETS involvement in creating the cost estimate and separately identify the estimated costs related to ETS provided products and services.
- Critical Success Factors.
- Risk Assessment (to the extent possible at this point in the project lifecycle).

For continuing IT projects exceeding \$1 million, the agency must submit the originally approved business case and/or an update to the business case for any changes to the IT project schedule, budget or scope that exceeds five percent of the originally approved project schedule, budget or scope. If the continuing IT project does not have a previously submitted business case that received State CIO approval, the agency must submit a business case for the project and a detailed project plan.

Agencies are required to submit all the information listed above to the Office of the State Chief Information Officer at the same time they submit their Agency Request Budget to CFO.

Appendix A. IT Project Reporting & Stage Gate Review

Key dates for IT-related reporting are listed below:

- June 30, 2016 – Last date for special approvals for specific IT-related projects.
- August 1, 2016 or August 29, 2016 – Last date to submit 2017-19 Agency Request Budget document to CFO and information resource management planning information (i.e. Required entry of IT project information into the Enterprise PPM System and submission of business case documents for major IT projects) to the State Chief Information Office.

For additional information regarding business case development or requirements for entering information about IT projects into the Enterprise Project and Portfolio Management (PPM) System, please contact Dagny George within the OSCIO Strategic Technology Office at (971) 283-5345 or email at Dagny.GEORGE@oregon.gov.

Appendix B. Glossary

Adaptation, adapt <i>(in facilities)</i>	Changes to the interior arrangements or other physical characteristics of a facility or permanent installation of equipment enabling a building to be better used for its current purpose or adapted to a new one. Adaptation can include code compliance.
Allocation	Allocations refer specifically to revenues. An allocation is a cash transfer of either Lottery or Criminal Fine Account (CFA) funds to an agency by the Legislature. Allocated funds cannot be spent without expenditure limitation.
Allotment	An allotment is an agency's plan of estimated expenditures, revenues, cash disbursements, and cash receipts for each month of the biennium. It is used to monitor quarterly spending of an agency. Agencies must submit their allotment to the Department of Administrative Services each quarter for review. Upon approval, the requested funds are made available to the agency.
Analyst	The Department of Administrative Services Chief Financial Office (Budget and Management section) analyst assigned to an agency.
Appropriated Funds	A coding structure that reflects revenues and expenditures by funding source and purpose.
Appropriation	An amount of money from the General Fund approved by the legislature for a certain purpose.
Approved Spending Level	The actual amount of spending authority an agency has for a particular budget cycle. Typically, this is called the legislatively approved budget; however, the Governor may lower the General Fund amount that can be spent if the revenue forecast falls to the point of putting the state in a deficit situation. In that case, the Governor does not actually reduce the statutorily approved amounts, but simply reduces the amount that agencies will be allowed to spend. The approved spending level is the amount approved by the Legislature, less any allotment reductions implemented by the Governor to balance the budget.
Article XI-Q Bond	A bond authorized to be issued to finance real and personal property owned or operated by the state. Article XI-Q bonds, for which enabling legislation was approved in 2011, have replaced Certificates of Participation (COPs) for financing projects.
Authorization	The substantive legislation that establishes the purpose and guidelines for a given activity and usually sets a limit on the amount that can be appropriated or spent. The authorization does not provide actual dollars for a program.
Backfill	One-time funds used to replace discretionary funding in an agency's budget. These are typically Other or Federal Funds used to replace General or Lottery Funds. They are used extensively when General and Lottery Funds are at a premium, and continue programs that would otherwise be eliminated. While one-time funds continue the program for a certain period, the program must then revert to the original funding source once the "backfilled" funds go away.

Appendix B. Glossary

Base Budget	The starting point for budgeting. To budget for the upcoming biennium, the base budget begins with the current biennium Legislatively Adopted Budget (LAB). The LAB is adjusted for Emergency Board, February even-year session, special session, and administrative actions through a designated date in the current biennium, and personal services changes from the Position Information Control System (PICS). The result is the base budget.
Biennium	A period of two fiscal years. Oregon state government's biennium runs from July 1 of an odd-numbered year through June 30 of the next odd-numbered year. Regular sessions convene twice per biennium: for 160 days in the odd-numbered year, and 35 days in the even-numbered year.
Bond	A debt instrument issued through a formal legal procedure and secured either by the pledge of specific properties or revenues or by the general credit of the state.
Budget Document	The detailed material prepared by agencies as directed by the Department of Administrative Services Chief Financial Office for all phases of budget development.
Budget Note	Included in a Budget Report, it is a formal directive to a state agency expressing legislative intent for a particular budget issue. A budget note is technical in nature, directing an agency to take administrative and managerial action relating to the agency's execution of its biennial budget. A budget note is of limited scope, not intended to circumvent, supplant, or replace other substantive or policy measures or law. The directive of a budget note typically expires at the end of the biennium for which it pertains. Budget notes are neither required nor necessary for every Ways and Means measure.
Budget Report	An official report on any bill approved by the Joint Committee on Ways and Means that appropriates General Fund or establishes expenditure limitation for Lottery Funds, Other Funds, and Federal Funds. The report summarizes any discussion by the Committee and contains the recommendations to the Legislature on the bill. In addition to the recommended expenditures and revenues, it also lists the recommended number of positions and full-time equivalent positions.
Capital Assets	Tangible or intangible assets held and used in state operations which have a service life of more than one year and meet the state's capitalization policy. Capital assets of the state include land, infrastructure, improvements to land, buildings, leasehold improvements, vehicles, furnishings, equipment, collections, and all other tangible and intangible assets that are used in state operations.
Capital Outlay	Expenditures for the acquisition or major repair of fixed assets intended to benefit future periods. As an expenditure category, capital outlay is limited to items that: (i) are not consumed in the usual course of agency operations; (ii) can normally be used more than once; (iii) have a useful life of more than two years; and, (iv) have an initial value of \$5,000 or more.
Certificates of Participation (COP's)	A financing agreement used to finance real and personal property owned and operated by the state. Article X-Q bonds have replaced COPs for financing projects.

Appendix B. Glossary

Cross Reference Number	A computerized table in ORBITS that specifies the organizational structure under which an agency builds and presents its budget. A Summary Cross Reference (SCR) is a program unit, and is composed of two or more Detail Cross References (DCRs).
Construction	Building, installing, or assembling a new structure. Adding to, expanding, altering, converting, or replacing a structure. Moving a structure to a new location. Includes site preparation and equipment installed and made part of the structure.
Construction Costs	Direct costs, including labor, materials, and equipment rental. For total related costs, see <i>Project Costs</i> .
Current Service Level	A projected expenditure level representing the estimated cost of providing currently authorized services in the ensuing biennium. It is calculated using current appropriations, the bow wave of legislative intentions assumed in existing appropriations (costs or savings), Emergency Board actions through May and adjustments for trends in entitlement caseload/enrollment, inflation and other mandatory expenses, less one-time costs, program phase-outs and pilot programs. This number establishes a theoretical base from which changes are made to create a new budget.
Debt Service	Expenditures for principal, interest, discounts, and premiums related to payment of state debt.
Deferred Maintenance	Facilities Maintenance that was not performed when it should have been or a backlog of activities that agencies deem necessary to bring facilities into good repair. Deferred maintenance is generally work that is left undone due to the lack of resources or perceived lower priority than projects funded. Failure to perform deferred work may result in the progressive deterioration of the facility condition or performance, and if not addressed, will significantly increase restoration cost. It may also include maintenance needs resulting from unforeseen circumstances such as wind storms, premature failure of facilities components, etc.
Emergency Board	The legislative committee with constitutional and statutory authority to make fiscal decisions for the legislature when the legislature is not in session.
Emergency Fund	A fund from which the Emergency Board can provide General Fund appropriations to agencies for needs that arise after their budget is approved, or for programs approved but not funded during the legislative session.
Essential Package	A package to adjust the base budget, not to request new programs or expansions. Essential Packages may adjust for one-time costs, programs phased in or out, vacancy factors, non-PICS Personal Services costs, inflation, price list cost changes, fund shifts, and mandated caseload changes. An agency's base budget, plus essential packages, is its current service level.
Executive Branch	The branch of state government that carries out and enforces state laws. In common use, refers to all of state government outside the Legislative Branch and the Judicial Branch. Sometimes refers only to the governor and agencies that answer directly to the governor. Rarely used in statute. The state constitution actually names four "departments": the Executive, Administrative, Judicial, and Legislative.

Appendix B. Glossary

Executive Service	Commonly used for certain unclassified or exempt employees. Most are department heads, administrators, and deputies; their executive assistants; and certain principal assistants.
Expenditures	Decreases in net current financial resources. Expenditures include disbursements and accruals for the current period. Encumbrances are not included.
Expenditure Limitation	A spending limit set by the legislature identifying the maximum amount of Lottery Funds, Other Funds, or Federal Funds an agency may spend. Defined in an agency's budget. If an agency receives more Other Funds or Federal Funds than the Legislature approved them to spend, they must obtain an increase in their expenditure limitation from the Legislature or the Emergency Board in order to spend the revenue.
Facility	A building or structure, including utility and other support systems. A real property improvement. A campus or group of structures. See <i>Real Property Improvements</i> .
Emergency Board	The joint committee of Senators and Representatives that meets during the interim periods to address state fiscal and budgetary matters.
Federal Funds	Money a state agency receives directly from the federal government. It is spent under a Federal Funds expenditure limitation or as Nonlimited Federal Funds.
Fee	A fee is a charge, fixed by law, for the benefit of a service or to cover the cost of a regulatory program or the costs of administering a program for which the fee payer benefits. For example, professional license fees which cover the cost of administering and regulating that category of professions are fees. Other charges that are categorized as fees include tolls and tuition. Fees must be authorized in statute. The Legislature may set the rates in statute or authorize a state agency to set rates using administrative procedures.
Financing Agreement	Any agreement to finance real or personal property, which is or will be owned and operated by an agency. Includes lease-purchase, installment sale, or loan agreements and Certificates of Participation.
Fiscal Year	The state government fiscal year runs from July 1 of one calendar year to June 30 of the next. See <i>Biennium</i> .
Full-Time Equivalent (FTE)	The standard unit for budgeting positions. An FTE is the number of months in the biennium for which the position is budgeted, divided by 24. One FTE equals one full-time position budgeted for the entire biennium. A permanent, part-time position budgeted for 12 months is 0.50 FTE. A full-time, limited duration position phased in 6 months after the start of the biennium (or budgeted for 18 months) is 0.75 FTE.
General Fund	Money available for the state budget that is not dedicated to a specific agency or purpose and that can be used for general purposes of state government. Most General Fund money in Oregon derives from personal and corporate income taxes. Some revenue from liquor, cigarettes, and other sources also go into the General Fund. See <i>Appropriation</i> .

Appendix B. Glossary

Governor's Budget	The constitutionally-required budget recommended to the legislature by the Governor. The Governor first reviews and decides on agencies' requests for funding. The Governor's Budget must be submitted by December 1 of even-numbered years. A newly-elected Governor has until the following February 1 to publish a budget.
Interagency Transfer	A transfer of funds between agencies. Agencies must balance all interagency transfers before requesting an ORBITS audit.
Joint Committee on Ways and Means	A standing committee of senators and representatives appointed by their presiding officers. The Committee reviews the management and recommended budgets of entities that receive or administer state funds. It recommends the amounts of revenues and expenditures for the legislatures approved budget.
Judicial Branch	The branch of state government that interprets all state laws. Includes state courts. The Chief Justice of the Supreme Court is the chief executive of the branch.
Legislative Branch	The Legislative Assembly and its staff. The branch of state government that enacts state laws, grants agencies statutory powers and duties, and adopts the state budget. The Legislative Branch in Oregon consists of a Senate with 30 elected members and a House of Representatives with 60 elected members.
Legislative Fiscal Office	Analyzes and presents a wide range of budget and related data on state programs to the legislature. Staff to the Joint Committee on Ways and Means, the Joint Legislative Audit Committee, the Joint Legislative Committee on Information Management and Technology, and the state Emergency Board.
Legislative Concept	Relating to an agency or statute. Major or minor policy and program changes and non-policy technical adjustments or corrections to the current Oregon Revised Statutes. Approved concepts are sent to Legislative Counsel for bill drafting.
Legislative Session	The Legislative Assembly convenes annually in February. Sessions may not exceed 160 days in odd-numbered years and 35 days in even-numbered years. Five day extensions are allowed by a two-thirds vote in each house. Special sessions can occur at other times.
Legislatively Adopted Budget	The budget approved by the legislature during the regular legislative session. It sets maximum spending and staffing levels. It can be modified by actions of the Emergency Board or special sessions.
Legislatively Approved Budget	The legislatively adopted budget as modified by Emergency Board or other legislative action.
Lottery Funds	Money received by a state agency from lottery proceeds. The Legislature decides how much to provide and for what purpose. The state constitution restricts use of these funds. Lottery Funds include any of the following: (1) funds allocated to an agency by the legislature as Lottery Funds; (2) Lottery Funds revenue transfers between agencies, i.e., Lottery Funds transferred by an agency must be receipted by the receiving agency as Lottery Funds; (3) all interest earned on Lottery Funds while held by an agency. Lottery Funds lose their identity, for budget purposes, when expended. Ballot Measure 66 requires that certain Lottery Funded agencies track and report Lottery Funds expenditures at a more detailed level.

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Maintenance	Keeping property in good operating condition. Does not add value to or extend the economic life of a property. Commonly includes inspecting, calibrating, lubricating, and cleaning. Maintenance costs are categorized as Services and Supplies expenditures.
Maintenance of Effort	A requirement contained in certain legislation, regulations, or administrative policies that a recipient must maintain a specified level of financial effort in the area for which federal funds will be provided in order to receive federal grant funds. This requirement is usually given in terms of a previous base-year dollar amount.
Management Service	Supervisory, confidential, or managerial employees excluded from collective bargaining.
Modified Current Service Level	Current service level less adjustment for revenue reductions.
Non-add Expenditures	Generally, these are inter-agency and intra-agency expenditures that fund administrative functions and are paid for by other programs. This results in a double-count in total statewide expenditures. While the expenditures are included for both programs for reporting purposes, the nonadd expenditures are usually shown as an informational tool to indicate where the budget contains expenditures that are counted twice. Many of the programs at the Department of Administrative Services (DAS) are considered nonadd because they assess agencies for the costs of the programs. The agency shows an expenditure to DAS for their services and DAS then has expenditures to provide those services.
Nonlimited Expenditures	<p>Expenditures for which the legislature defines purposes, but sets no dollar limits. They are subject to allotment control and the appropriation bill defines their allowed purposes. These expenditures can only be supported by Other and Federal Funds and revenue may be continuously appropriated for them. The expenditures are for programs that have a single source of revenue and support programs that have expenditures that are often outside of the agency's control, as other factors often limit their ultimate costs.</p> <p>An example would be Unemployment Insurance during the 2009-11 biennium. Nonlimited expenditure limitation for the Oregon Employment Department was increased by almost \$3.3 billion from the adopted budget because of federal legislation and the economic situation. The Department was able to increase its limitation and pass those payments through without having to wait for a legislative hearing.</p>
Other Payroll Expenses (OPE)	Expenses other than salaries paid for state employees. These include retirement payments, Social Security taxes, and health insurance costs.
ORBITS	ORegon's Budget Information Tracking System (ORBITS) is a system used to prepare budget requests. It compiles, maintains, and reports revenue, expenditure, and position data for budget preparation and execution.
Other Funds	Money received by state agencies that does not come from the General Fund or from the federal government. Other Funds come from sources such as gasoline taxes, driver licenses fees, and fishing license fees. Other Funds may be dedicated, requiring the revenue to be spent for specific purposes. Examples of dedicated funds are park user fees dedicated to park programs and gasoline taxes dedicated to highway programs.

Appendix B. Glossary

Package	A component of a program unit that presents proposed budget, policy, and program changes for an agency. The two types are essential and policy packages.
Pass-through Expenditures	Expenditures that are not directly for state use. While an agency has an appropriation or limitation for a particular program, the funds may be “passed through” to non-state entities. Some examples include funding for education programs such as the State School Fund, Community Colleges, and Higher Education, as well as many social programs that provide cash and food assistance.
Personal Services	Employee gross compensation (salary, pay differentials, other payroll expenses). Includes state temporary personnel services.
Position Information Control System (PICS)	A computerized statewide database of authorized position details for budget preparation and execution.
Planning Study (<i>in capital budgeting</i>)	Provides enough data for full project development. Normally includes siting, feasibility, and preliminary design studies. Includes cost estimates and all else that is needed to do a capital project budget request.
Policy Package	A package that presents policy and program changes above or below the agency’s current service level budget. An agency’s total budget is the sum of its base budget, essential packages, and policy packages.
Price List of Goods and Services	Identifies projected state assessments and user fees. Compiled for budgeting by the Department of Administrative Services (DAS). Includes assessments and fees of DAS, Department of Justice, Correction Industries, Secretary of State, Treasurer of State, and Central Government Services (certain costs of the legislative assembly, Legislative Fiscal Office, Legislative Council, and Governor’s Office). Also allocates other shared statewide costs for services of the PEBB Employee Assistance Program, State Library, Law Library, Government Ethics Commission, and Capitol Mall security functions.
Program Unit	A budget structure containing similar services or functions for deliberation of major policy issues and budget information. Agency activities may be grouped into one or more program units.
Project Costs (<i>in capital budgeting</i>)	The total of all necessary costs to construct the complete facility. Includes site acquisition, direct construction costs, furnishings, equipment, and contingencies allowance. Includes all indirect costs, such as design consultants, material testing services, special inspection services, project management, One Percent for Art, and others.
Real Property Improvements	Property that is fixed, immovable, and permanent. Real property includes land, structures affixed to the land, property affixed to the structures, and in some cases, trees etc., growing on the land. Includes sidewalks, landscaping, drives, tunnels, drains and sewers.
Rebalance	Sometimes it becomes necessary to realign budgets during the biennium. Because appropriations and limitations are specified in statute, legislative action is needed to rebalance the budget. A rebalance can be done on a statewide basis (usually when revenues are below forecast) or can be done at the agency level. In either case, the

Appendix B. Glossary

term generally refers to the increases and decreases necessary to better align the budget with the expected needs.

Reclassification

A change in position classification because duties, authority, and responsibilities are significantly changed, but the required knowledge and skills remain similar.

Revenues

Cash receipts and receivables of a governmental unit derived from taxes and other sources.

Repairs

Work done to restore worn or damaged property to normal operating condition. Repairs are usually Services and Supplies expenditures.

Replacement (*in capital budgeting*)

Putting one facility component in place of another to gain equal or greater performance or economy or to comply with codes. It performs the same function. Usually required by wear or by accidental damage.

Roll-up Costs

The full costs associated with expenditures that were not fully charged in the previous biennium. Typically, these are personal services and debt service costs that are implemented as the biennium progresses. Increases in salary and/or benefits are usually phased-in during the biennium as part of a collective bargaining agreement. Debt is usually issued during the biennium. Many times it is issued late in the biennium to minimize the costs for that period.

During the following biennium, the full 24-month costs for both categories need to be accounted for. The additional amount is considered the roll-up cost. While roll-up costs are usually associated with personal services and debt service costs, they also apply to any program costs that were implemented in the middle of the biennium.

Salary Adjustment Allocations

Money or limitation allocated by the Emergency Board to fund approved compensation plan increases.

Services and Supplies

Expenditures for business operations. Examples include personal service contracts, consumable materials, publishing, office supplies, travel, utilities, rent, and maintenance and repair of equipment and buildings.

Space Planning

Analyzing workflow, space, and equipment needs of work units to plan efficient equipment, furnishings, and support systems.

Special Payments

Budgeted transfers and payments where goods and services are not received in return. Paying out contributions, loans, deposits, or collections. Also, paying federal or state funds to eligible people, cities, counties, quasi-public agencies, and others.

Special Purpose Appropriation

A General Fund appropriation to the Emergency Board for a specific purpose. When the appropriation is established, it states the agency and specific purpose for the funds. The Emergency Board can only allocate funds to that agency and for that purpose. There is also an expiration date for the appropriation. After that date, any remaining funds become available for any purpose for which the Emergency Board may lawfully allocate funds.

Special Session

Meeting of the Legislature between regularly scheduled sessions. May be called by the Governor or the Legislature.

Appendix B. Glossary

State Agency or Agency	Various defined in state statutes. Commonly, a department, office, board, or commission created by state law to carry out duties assigned by law. Agencies range in size from thousands of employees with billion dollar budgets to one employee with a tiny budget. They are funded by license and user fees, state and federal taxes, fines, and fees for service. Some agencies report to a board or commission.
Tentative Budget	A document that is used to estimate the state's relative fiscal position for the coming two-year budget period, assuming the continuation of all current law programs and services. For a complete explanation, see https://www.oregonlegislature.gov/lfo/Documents/2010-3TentativeBudgetandCSL.pdf
Unfunded Mandate	A requirement that a lower level of government provides a program or performs an activity within existing resources. Under a federal mandate, the federal government may require a state or local government to provide a service and not provide additional federal funding to pay for it. Under a state mandate, the state may require a local government to provide a service. However, under the Oregon Constitution, a local government is not required to comply with certain new state mandates unless the state pays the costs of the new services. The Constitution provides exceptions.
Vacancy Factor	A calculation to project budget savings expected from staff turnover during the biennium.

**State Government Service Charges
2017 - 2019 Price List of Goods and Services**

Please note: This online model does not include any service charges for volume or activity-based usage.

This report only reflects fixed State Government Service Charges.

STATE GOVERNMENT SERVICE CHARGES Dentistry, Board of -- 83400	
Description	ARB Amount
Central Government Service Charge	\$8,216
COBID - Certification Office for Business Inclusion and Diversity	\$401
DAS - Chief Financial Office	\$5,000
DAS - Chief Financial Office-Capitol Planning Comm.	\$0
DAS - Chief Human Resources Office	\$4,040
DAS - Chief Human Resources Office - HRIS	\$3,829
DAS - Chief Operating Office	\$1,771
DAS - Chief Operating Office-Bill Tracker	\$167
DAS - Enterprise Asset Management-Real Estate Services	\$138
DAS - Enterprise Asset Management-State Surplus Property Base	\$0
DAS - Enterprise Asset Management-Surplus Personal Property Transactions	\$0
DAS - Enterprise Goods & Services-Procurement Services	\$866
DAS - Enterprise Goods & Services-Risk (Liability)	\$48,054
DAS - Enterprise Goods & Services-Risk (Property)	\$152
DAS - Enterprise Goods & Services-Risk (Workers Compensation)	\$17,223
DAS - Enterprise Goods & Services-Risk Administration	\$3,585
DAS - OSCIO - Oregon State Chief Information Office	\$12,459
DAS - OSCIO - State Data Center	\$6,374
Oregon Government Ethics Commission	\$161
Oregon State Library	\$845
Oregon State Treasury-Article XI-Q Bonds	\$0
Oregon State Treasury-Certificates of Participation (COP)	\$0
Oregon State Treasury-Lottery Revenue Bonds	\$0
Oregon State Treasury-Revenue Bonds	\$0
Oregon State Treasury-Treasury Obligation Bonds	\$0
Secretary of State-Archives Administrative Rules	\$4,442
Secretary of State-Archives Compact Shelving	\$100
Secretary of State-Archives Record Center	\$3,548
Secretary of State-Archives Records Management	\$1,268
Secretary of State-Archives Security Depository	\$0
Secretary of State-Audits	\$2,970
State of Oregon Law Library	\$511
State Police- Capital Mall Security	\$0
Total	\$126,120

Select Legislation from Short Legislative Session

House Bill 4016- Signed by Governor Brown

Permits Oregon Board of Dentistry, Oregon Medical Board, Oregon State Board of Nursing and State Board of Pharmacy to contract to establish impaired health professional program for licensees of boards. Requires program to meet requirements for impaired health professional program contracted for established by Oregon Health Authority.

House Bill 4095- Signed by Governor Brown

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

House Bill 4106- Signed by Governor Brown

Prohibits state agency from relying only upon expediency, convenience, best interest of public, general public need or speculation as basis for finding of prejudice that authorizes temporary adoption, amendment or suspension of rule.

Senate Bill 1504 – Signed by Governor Brown

Enacts interstate Physical Therapy Licensure Compact.

Enrolled
House Bill 4016

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

CHAPTER

AN ACT

Relating to impaired health professional programs; creating new provisions; amending ORS 676.190; and declaring an emergency.

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

SECTION 1. ORS 676.190 is amended to read:

676.190. (1) The [*Oregon Health Authority shall*] **health profession licensing boards may** establish or contract to establish an impaired health professional program.

(2) A program established or contracted for under this section [*The program*] must:

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

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

(c) Enter into diversion agreements with enrolled licensees;

(d) If the enrolled licensee has a direct supervisor, assess the ability of the direct supervisor to supervise the licensee, including an assessment of any documentation of the direct supervisor's completion of specialized training;

(e) Report substantial noncompliance with a diversion agreement to a noncompliant licensee's board within one business day after the program learns of the substantial noncompliance; and

(f) At least weekly, submit to licensees' boards:

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

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

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

[(3)] **(4)** When the program reports substantial noncompliance under subsection [(1)(e)] **(2)(e)** of this section to a licensee's board, the report must include:

(a) A description of the substantial noncompliance;

(b) A copy of a report from the independent third party who diagnosed the licensee under ORS 676.200 (2)(a) or subsection [(6)(a)] **(7)(a)** of this section stating the licensee's diagnosis;

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

(d) The licensee's employment status.

[(4)] **(5)** The program may not diagnose or treat licensees enrolled in the program.

[(5)] (6) The diversion agreement required by subsection [(1)] (2) of this section must:

(a) Require the licensee to consent to disclosure and exchange of information between the program, the licensee's board, the licensee's employer, evaluators and treatment programs or providers, in compliance with ORS 179.505 and 42 C.F.R. part 2;

(b) Require that the licensee comply continuously with the agreement for at least two years to successfully complete the program;

(c) Require that the licensee abstain from mind-altering or intoxicating substances or potentially addictive drugs, unless the drug is:

(A) Prescribed for a documented medical condition by a person authorized by law to prescribe the drug to the licensee; and

(B) Approved by the program if the licensee's board has granted the program that authority;

(d) Require the licensee to report use of mind-altering or intoxicating substances or potentially addictive drugs within 24 hours;

(e) Require the licensee to agree to participate in a recommended treatment plan;

(f) Contain limits on the licensee's practice of the licensee's health profession;

(g) Require the licensee to submit to random drug or alcohol testing in accordance with federal regulations, unless the licensee is diagnosed with solely a mental health disorder and the licensee's board does not otherwise require the licensee to submit to random drug or alcohol testing;

(h) Require the licensee to report to the program regarding the licensee's compliance with the agreement;

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

(j) Require the licensee to report applications for licensure in other states, changes in employment and changes in practice setting; and

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

[(6)(a)] (7)(a) *[If a health profession licensing board participating in the program establishes by rule an option for self-referral to the program, a licensee of the health profession licensing board may self-refer to the program.] A health profession licensing board may establish by rule an option to permit licensees of the health profession licensing board to self-refer to the program.*

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

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

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

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

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

[(7) *The authority shall adopt rules establishing a fee to be paid by the health profession licensing boards participating in the program for administration of the program.*]

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

(8) The health profession licensing boards shall arrange for an independent third party to conduct an audit every four years of an impaired health professional program for the licensees of those health profession licensing boards to ensure compliance with program guidelines. The health profession licensing boards shall report the results of the audit to the

Legislative Assembly in the manner provided by ORS 192.245 and to the Governor. The report may not contain individually identifiable information about licensees.

(9) The [authority] health profession licensing boards, in consultation with one another, may adopt rules to carry out this section.

SECTION 2. Section 3 of this 2016 Act is added to and made a part of ORS 676.185 to 676.200.

SECTION 3. (1) The Impaired Health Professional Program Work Group is established.

(2) The work group consists of the designees of any health profession licensing boards that elect to establish or contract for an impaired health professional program as described in ORS 676.190.

(3) The work group shall facilitate the establishment and continuation of the impaired health professional program described in ORS 676.190.

(4) A majority of the members of the work group constitutes a quorum for the transaction of business.

(5) Official action by the work group requires the approval of a majority of the members of the work group.

(6) The work group shall elect one of its members to serve as chairperson.

(7) The work group shall meet at times and places specified by the call of the chairperson or of a majority of the members of the work group.

(8) The work group may adopt rules necessary for the operation of the work group.

(9) The Oregon Medical Board shall provide staff support to the work group.

(10) Members of the work group are not entitled to compensation, but may be reimbursed for actual and necessary travel and other expenses incurred by them in the performance of their official duties in the manner and amounts provided for in ORS 292.495. Claims for expenses shall be paid out of funds appropriated to the health professional licensing board that the member represents for purposes of the work group.

(11) All agencies of state government, as defined in ORS 174.111, are directed to assist the work group in the performance of duties of the work group and, to the extent permitted by laws relating to confidentiality, to furnish information and advice the members of the work group consider necessary to perform their duties.

SECTION 4. The amendments to ORS 676.190 by section 1 of this 2016 Act become operative on July 1, 2017.

SECTION 5. This 2016 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2016 Act takes effect on its passage.

Passed by House February 9, 2016

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Timothy G. Sekerak, Chief Clerk of House

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Tina Kotek, Speaker of House

Passed by Senate February 19, 2016

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Peter Courtney, President of Senate

Received by Governor:

.....M,....., 2016

Approved:

.....M,....., 2016

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Kate Brown, Governor

Filed in Office of Secretary of State:

.....M,....., 2016

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Jeanne P. Atkins, Secretary of State

Enrolled House Bill 4095

Sponsored by Representative GILLIAM; Representatives CLEM, KENNEMER, LIVELY, Senator GIROD (Pre-session filed.)

CHAPTER

AN ACT

Relating to dentistry; and declaring an emergency.

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

Whereas collaboration between the Oregon Board of Dentistry and other medical professional boards in this state fosters productive and equitable discipline procedures among all medical professions; and

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

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

SECTION 1. Section 2 of this 2016 Act is added to and made a part of ORS chapter 679.

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

- (a) The request is made 10 years or more after the date on which any disciplinary sanction ended;**
 - (b) The individual was not disciplined for financially or physically harming a patient;**
 - (c) The individual informed the board of the matter for which the individual was disciplined before the board received information about the matter or otherwise had knowledge of the matter;**
 - (d) The individual making the request, if the individual is or was a licensee, has not been subjected to other disciplinary action by the board following the imposition of the disciplinary sanction; and**
 - (e) The individual fully complied with all disciplinary sanctions imposed by the board.**
- (2) The board shall adopt by rule a process for making a request under this section.**

SECTION 3. As soon as practicable after the effective date of this 2016 Act, the Oregon Board of Dentistry shall:

- (1) Provide notice to each individual licensed by the board under ORS chapter 679 of the process for making a request described in section 2 of this 2016 Act; and**
- (2) Provide public notice of the process for making a request under section 2 of this 2016 Act.**

SECTION 4. This 2016 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2016 Act takes effect on its passage.

Passed by House February 8, 2016

Received by Governor:

Repassed by House February 25, 2016

.....M,....., 2016

Approved:

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Timothy G. Sekerak, Chief Clerk of House

.....M,....., 2016

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Tina Kotek, Speaker of House

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Kate Brown, Governor

Passed by Senate February 24, 2016

Filed in Office of Secretary of State:

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Peter Courtney, President of Senate

.....M,....., 2016

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Jeanne P. Atkins, Secretary of State

Enrolled
House Bill 4106

Sponsored by Representatives KENNEMER, GOMBERG, Senator JOHNSON; Representatives DAVIS, DOHERTY, EVANS, HOYLE, HUFFMAN, KENY-GUYER, KOMP, MCLANE, PILUSO, SPRENGER, STARK, WEIDNER, WILSON, WITT, Senators BEYER, BOQUIST, KNOPP, THATCHER (Presession filed.)

CHAPTER

AN ACT

Relating to state agency adoption of temporary rules.

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

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

- (a) "Agency" has the meaning given that term in ORS 183.310.
- (b) "Rule" has the meaning given that term in ORS 183.310.
- (c) "Statement of need" means the statement described in ORS 183.335 (5)(c).

(2) No later than February 1 of each year, an agency that is subject to ORS 183.335 shall provide a report to the Legislative Assembly, in the manner provided in ORS 192.245, regarding all rules that the agency adopted, amended, repealed or suspended during the preceding 12-month period. The report must include:

- (a) The number of rules adopted, amended or repealed in accordance with ORS 183.335 (2) and (3); and
- (b) With respect to rules adopted, amended or suspended using the procedure described in ORS 183.335 (5):
 - (A) The number of rules;
 - (B) A list of the rules;
 - (C) A statement of need for each rule and all of the agency's findings that a failure to act promptly would result in serious prejudice to the public interest or the interest of parties concerned; and
 - (D) For each rule, an explanation of why proceeding under ORS 183.335 (5) was the most appropriate method for adopting, amending or suspending the rule and why it was not appropriate to proceed in accordance with ORS 183.335 (2) and (3).

Passed by House February 17, 2016

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Timothy G. Sekerak, Chief Clerk of House

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Tina Kotek, Speaker of House

Passed by Senate February 26, 2016

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Peter Courtney, President of Senate

Received by Governor:

.....M,....., 2016

Approved:

.....M,....., 2016

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Kate Brown, Governor

Filed in Office of Secretary of State:

.....M,....., 2016

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Jeanne P. Atkins, Secretary of State

Enrolled Senate Bill 1504

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 Senate Interim Committee on Health Care)

CHAPTER

AN ACT

Relating to physical therapy; creating new provisions; amending ORS 676.177, 688.020, 688.110, 688.160 and 688.201; and declaring an emergency.

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

SECTION 1. The provisions of the Physical Therapy Licensure Compact are as follows:

PHYSICAL THERAPY LICENSURE COMPACT

SECTION 1. PURPOSE

The purpose of this Compact is to facilitate interstate practice of physical therapy with the goal of improving public access to physical therapy services. The practice of physical therapy occurs in the state where the patient/client is located at the time of the patient/client encounter. The Compact preserves the regulatory authority of states to protect public health and safety through the current system of state licensure.

This Compact is designed to achieve the following objectives:

1. Increase public access to physical therapy services by providing for the mutual recognition of other member state licenses;
2. Enhance the states' ability to protect the public's health and safety;
3. Encourage the cooperation of member states in regulating multi-state physical therapy practice;
4. Support spouses of relocating military members;
5. Enhance the exchange of licensure, investigative, and disciplinary information between member states; and
6. Allow a remote state to hold a provider of services with a compact privilege in that state accountable to that state's practice standards.

SECTION 2. DEFINITIONS

As used in this Compact, and except as otherwise provided, the following definitions shall apply:

1. "Active Duty Military" means full-time duty status in the active uniformed service of the United States, including members of the National Guard and Reserve on active duty orders pursuant to 10 U.S.C. Section 1209 and 1211.

2. "Adverse Action" means disciplinary action taken by a physical therapy licensing board based upon misconduct, unacceptable performance, or a combination of both.

3. "Alternative Program" means a non-disciplinary monitoring or practice remediation process approved by a physical therapy licensing board. This includes, but is not limited to, substance abuse issues.

4. "Compact privilege" means the authorization granted by a remote state to allow a licensee from another member state to practice as a physical therapist or work as a physical therapist assistant in the remote state under its laws and rules. The practice of physical therapy occurs in the member state where the patient/client is located at the time of the patient/client encounter.

5. "Continuing competence" means a requirement, as a condition of license renewal, to provide evidence of participation in, and/or completion of, educational and professional activities relevant to practice or area of work.

6. "Data system" means a repository of information about licensees, including examination, licensure, investigative, compact privilege, and adverse action.

7. "Encumbered license" means a license that a physical therapy licensing board has limited in any way.

8. "Executive Board" means a group of directors elected or appointed to act on behalf of, and within the powers granted to them by, the Commission.

9. "Home state" means the member state that is the licensee's primary state of residence.

10. "Investigative information" means information, records, and documents received or generated by a physical therapy licensing board pursuant to an investigation.

11. "Jurisprudence Requirement" means the assessment of an individual's knowledge of the laws and rules governing the practice of physical therapy in a state.

12. "Licensee" means an individual who currently holds an authorization from the state to practice as a physical therapist or to work as a physical therapist assistant.

13. "Member state" means a state that has enacted the Compact.

14. "Party state" means any member state in which a licensee holds a current license or compact privilege or is applying for a license or compact privilege.

15. "Physical therapist" means an individual who is licensed by a state to practice physical therapy.

16. "Physical therapist assistant" means an individual who is licensed/certified by a state and who assists the physical therapist in selected components of physical therapy.

17. "Physical therapy," "physical therapy practice," and "the practice of physical therapy" mean the care and services provided by or under the direction and supervision of a licensed physical therapist. The "practice of physical therapy" also has the meaning given that term in ORS 688.010.

18. "Physical Therapy Compact Commission" or "Commission" means the national administrative body whose membership consists of all states that have enacted the Compact.

19. "Physical therapy licensing board" or "licensing board" means the agency of a state that is responsible for the licensing and regulation of physical therapists and physical therapist assistants.

20. "Remote State" means a member state other than the home state, where a licensee is exercising or seeking to exercise the compact privilege.

21. "Rule" means a regulation, principle, or directive promulgated by the Commission that has the force of law.

22. "State" means any state, commonwealth, district, or territory of the United States of America that regulates the practice of physical therapy.

SECTION 3. STATE PARTICIPATION IN THE COMPACT

A. To participate in the Compact, a state must:

1. Participate fully in the Commission's data system, including using the Commission's unique identifier as defined in rules;

2. Have a mechanism in place for receiving and investigating complaints about licensees;

3. Notify the Commission, in compliance with the terms of the Compact and rules, of any adverse action or the availability of investigative information regarding a licensee;

4. Fully implement a criminal background check requirement, within a time frame established by rule, by receiving the results of the Federal Bureau of Investigation record search on criminal background checks and use the results in making licensure decisions in accordance with Section 3.B.4.;

5. Comply with the rules of the Commission;

6. Utilize a recognized national examination as a requirement for licensure pursuant to the rules of the Commission; and

7. Have continuing competence requirements as a condition for license renewal.

B. Upon adoption of this statute, the member state shall have the authority to obtain biometric-based information from each physical therapy licensure applicant and submit this information to the Federal Bureau of Investigation for a criminal background check in accordance with 28 U.S.C. §534 and 42 U.S.C. §14616.

C. A member state shall grant the compact privilege to a licensee holding a valid unnumbered license in another member state in accordance with the terms of the Compact and rules.

D. Member states may charge a fee for granting a compact privilege.

SECTION 4. COMPACT PRIVILEGE

A. To exercise the compact privilege under the terms and provisions of the Compact, the licensee shall:

1. Hold a license in the home state;

2. Have no encumbrance on any state license;

3. Be eligible for a compact privilege in any member state in accordance with Section 4D, G and H;

4. Have not had any adverse action against any license or compact privilege within the previous 2 years;

5. Notify the Commission that the licensee is seeking the compact privilege within a remote state(s);

6. Pay any applicable fees, including any state fee, for the compact privilege;

7. Meet any jurisprudence requirements established by the remote state(s) in which the licensee is seeking a compact privilege; and

8. Report to the Commission adverse action taken by any non-member state within 30 days from the date the adverse action is taken.

B. The compact privilege is valid until the expiration date of the home license. The licensee must comply with the requirements of Section 4A to maintain the compact privilege in the remote state.

C. A licensee providing physical therapy in a remote state under the compact privilege shall function within the laws and regulations of the remote state.

D. A licensee providing physical therapy in a remote state is subject to that state's regulatory authority. A remote state may, in accordance with due process and that state's laws, remove a licensee's compact privilege in the remote state for a specific period of time, impose fines, and/or take any other necessary actions to protect the health and safety of its citizens. The licensee is not eligible for a compact privilege in any state until the specific time for removal has passed and all fines are paid.

E. If a home state license is encumbered, the licensee shall lose the compact privilege in any remote state until the following occur:

1. The home state license is no longer encumbered; and

2. Two years have elapsed from the date of the adverse action.

F. Once an encumbered license in the home state is restored to good standing, the licensee must meet the requirements of Section 4A to obtain a compact privilege in any remote state.

G. If a licensee's compact privilege in any remote state is removed, the individual shall lose the compact privilege in any remote state until the following occur:

1. The specific period of time for which the compact privilege was removed has ended;
2. All fines have been paid; and
3. Two years have elapsed from the date of the adverse action.

H. Once the requirements of Section 4G have been met, the license must meet the requirements in Section 4A to obtain a compact privilege in a remote state.

SECTION 5. ACTIVE DUTY MILITARY PERSONNEL OR THEIR SPOUSES

A licensee who is active duty military or is the spouse of an individual who is active duty military may designate one of the following as the home state:

- A. Home of record;
- B. Permanent Change of Station (PCS); or
- C. State of current residence if it is different than the PCS state or home of record.

SECTION 6. ADVERSE ACTIONS

A. A home state shall have exclusive power to impose adverse action against a license issued by the home state.

B. A home state may take adverse action based on the investigative information of a remote state, so long as the home state follows its own procedures for imposing adverse action.

C. Nothing in this Compact shall override a member state's decision that participation in an alternative program may be used in lieu of adverse action and that such participation shall remain non-public if required by the member state's laws. Member states must require licensees who enter any alternative programs in lieu of discipline to agree not to practice in any other member state during the term of the alternative program without prior authorization from such other member state.

D. Any member state may investigate actual or alleged violations of the statutes and rules authorizing the practice of physical therapy in any other member state in which a physical therapist or physical therapist assistant holds a license or compact privilege.

E. A remote state shall have the authority to:

1. Take adverse actions as set forth in Section 4D against a licensee's compact privilege in the state;

2. Issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses, and the production of evidence. Subpoenas issued by a physical therapy licensing board in a party state for the attendance and testimony of witnesses, and/or the production of evidence from another party state, shall be enforced in the latter state by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage, and other fees required by the service statutes of the state where the witnesses and/or evidence are located; and

3. If otherwise permitted by state law, recover from the licensee the costs of investigations and disposition of cases resulting from any adverse action taken against that licensee.

F. Joint Investigations

1. In addition to the authority granted to a member state by its respective physical therapy practice act or other applicable state law, a member state may participate with other member states in joint investigations of licensees.

2. Member states shall share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the Compact.

SECTION 7. ESTABLISHMENT OF THE PHYSICAL THERAPY COMPACT COMMISSION

A. The Compact member states hereby create and establish a joint public agency known as the Physical Therapy Compact Commission:

1. The Commission is an instrumentality of the Compact states.

2. Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

3. Nothing in this Compact shall be construed to be a waiver of sovereign immunity.

B. Membership, Voting, and Meetings

1. Each member state shall have and be limited to one (1) delegate selected by that member state's licensing board.

2. The delegate shall be a current member of the licensing board, who is a physical therapist, physical therapist assistant, public member, or the board administrator.

3. Any delegate may be removed or suspended from office as provided by the law of the state from which the delegate is appointed.

4. The member state board shall fill any vacancy occurring in the Commission.

5. Each delegate shall be entitled to one (1) vote with regard to the promulgation of rules and creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs of the Commission.

6. A delegate shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for delegates' participation in meetings by telephone or other means of communication.

7. The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the bylaws.

C. The Commission shall have the following powers and duties:

1. Establish the fiscal year of the Commission;

2. Establish bylaws;

3. Maintain its financial records in accordance with the bylaws;

4. Meet and take such actions as are consistent with the provisions of this Compact and the bylaws;

5. Promulgate uniform rules to facilitate and coordinate implementation and administration of this Compact. The rules shall have the force and effect of law and shall be binding in all member states;

6. Bring and prosecute legal proceedings or actions in the name of the Commission, provided that the standing of any state physical therapy licensing board to sue or be sued under applicable law shall not be affected;

7. Purchase and maintain insurance and bonds;

8. Borrow, accept, or contract for services of personnel, including, but not limited to, employees of a member state;

9. Hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of the Compact, and to establish the Commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters;

10. Accept any and all appropriate donations and grants of money, equipment, supplies, materials and services, and to receive, utilize and dispose of the same; provided that at all times the Commission shall avoid any appearance of impropriety and/or conflict of interest;

11. Lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve or use, any property, real, personal or mixed; provided that at all times the Commission shall avoid any appearance of impropriety;

12. Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property real, personal, or mixed;

13. Establish a budget and make expenditures;
14. Borrow money;
15. Appoint committees, including standing committees comprised of members, state regulators, state legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in this Compact and the bylaws;
16. Provide and receive information from, and cooperate with, law enforcement agencies;
17. Establish and elect an Executive Board; and
18. Perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of physical therapy licensure and practice.

D. The Executive Board

The Executive Board shall have the power to act on behalf of the Commission according to the terms of this Compact.

1. The Executive Board shall be comprised of nine members:
 - a. Seven voting members who are elected by the Commission from the current membership of the Commission;
 - b. One ex-officio, nonvoting member from the recognized national physical therapy professional association; and
 - c. One ex-officio, nonvoting member from the recognized membership organization of the physical therapy licensing boards.
2. The ex-officio members will be selected by their respective organizations.
3. The Commission may remove any member of the Executive Board as provided in by-laws.
4. The Executive Board shall meet at least annually.
5. The Executive Board shall have the following Duties and responsibilities:
 - a. Recommend to the entire Commission changes to the rules or bylaws, changes to this Compact legislation, fees paid by Compact member states such as annual dues, and any commission Compact fee charged to licensees for the compact privilege;
 - b. Ensure Compact administration services are appropriately provided, contractual or otherwise;
 - c. Prepare and recommend the budget;
 - d. Maintain financial records on behalf of the Commission;
 - e. Monitor Compact compliance of member states and provide compliance reports to the Commission;
 - f. Establish additional committees as necessary; and
 - g. Other duties as provided in rules or bylaws.

E. Meetings of the Commission

1. All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rulemaking provisions in Section 9.
2. The Commission or the Executive Board or other committees of the Commission may convene in a closed, non-public meeting if the Commission or Executive Board or other committees of the Commission must discuss:
 - a. Non-compliance of a member state with its obligations under the Compact;
 - b. The employment, compensation, discipline or other matters, practices or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures;
 - c. Current, threatened, or reasonably anticipated litigation;
 - d. Negotiation of contracts for the purchase, lease, or sale of goods, services, or real estate;
 - e. Accusing any person of a crime or formally censuring any person;
 - f. Disclosure of trade secrets or commercial or financial information that is privileged or confidential;

g. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

h. Disclosure of investigative records compiled for law enforcement purposes;

i. Disclosure of information related to any investigative reports prepared by or on behalf of or for use of the Commission or other committee charged with responsibility of investigation or determination of compliance issues pursuant to the Compact; or

j. Matters specifically exempted from disclosure by federal or member state statute.

3. If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision.

4. The Commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the reasons therefore, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release by a majority vote of the Commission or order of a court of competent jurisdiction.

F. Financing of the Commission

1. The Commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization, and ongoing activities.

2. The Commission may accept any and all appropriate revenue sources, donations, and grants of money, equipment, supplies, materials, and services.

3. The Commission may levy on and collect an annual assessment from each member state or impose fees on other parties to cover the cost of the operations and activities of the Commission and its staff, which must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated based upon a formula to be determined by the Commission, which shall promulgate a rule binding upon all member states.

4. The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same; nor shall the Commission pledge the credit of any of the member states, except by and with the authority of the member state.

5. The Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the audit and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the Commission shall be audited yearly by a certified or licensed public accountant, and the report of the audit shall be included in and become part of the annual report of the Commission.

6. An assessment levied, or any other financial obligation imposed, under this Compact is effective against the State of Oregon only to the extent that moneys necessary to pay the assessment or meet the financial obligations have been deposited in an account established under ORS 182.470 by the Physical Therapist Licensing Board pursuant to ORS 688.201.

G. Qualified Immunity, Defense, and Indemnification

1. The members, officers, executive director, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided that nothing in this paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of that person.

2. The Commission shall defend any member, officer, executive director, employee or representative of the Commission in any civil action seeking to impose liability arising out

of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities; provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further, that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

3. The Commission shall indemnify and hold harmless any member, officer, executive director, employee, or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

SECTION 8. DATA SYSTEM

A. 1. The Commission shall provide for the development, maintenance, and utilization of a coordinated database and reporting system containing licensure, adverse action, and investigative information on all licensed individuals in member states.

2. Notwithstanding Section 9.A.1., the Physical Therapist Licensing Board shall review the rules of the Commission. The licensing board may approve and adopt the rules of the Commission as rules of the licensing board. The State of Oregon is subject to a rule of the Commission only if the rule of the Commission is adopted by the licensing board.

B. Notwithstanding any other provision of state law to the contrary, a member state shall submit a uniform data set to the data system on all individuals to whom this Compact is applicable as required by the rules of the Commission, including:

1. Identifying information;
2. Licensure data;
3. Adverse actions against a license or compact privilege;
4. Non-confidential information related to alternative program participation;
5. Any denial of application for licensure, and the reason(s) for such denial; and
6. Other information that may facilitate the administration of this Compact, as determined by the rules of the Commission.

C. Investigative information pertaining to a licensee in any member state will only be available to other party states.

D. The Commission shall promptly notify all member states of any adverse action taken against a licensee or an individual applying for a license. Adverse action information pertaining to a licensee in any member state will be available to any other member state.

E. Member states contributing information to the data system may designate information that may not be shared with the public without the express permission of the contributing state.

F. Any information submitted to the data system that is subsequently required to be expunged by the laws of the member state contributing the information shall be removed from the data system.

SECTION 9. RULEMAKING

A. 1. The Commission shall exercise its rulemaking powers pursuant to the criteria set forth in this Section and the rules adopted thereunder. Rules and amendments shall become binding as of the date specified in each rule or amendment.

2. Notwithstanding Section 9.A.1., the Physical Therapist Licensing Board shall review the rules of the Commission. The licensing board may approve and adopt the rules of the Commission as rules of the licensing board. The State of Oregon is subject to a rule of the Commission only if the rule of the Commission is adopted by the licensing board.

B. If a majority of the legislatures of the member states rejects a rule, by enactment of a statute or resolution in the same manner used to adopt the Compact within 4 years of the date of adoption of the rule, then such rule shall have no further force and effect in any member state.

C. Rules or amendments to the rules shall be adopted at a regular or special meeting of the Commission.

D. Prior to promulgation and adoption of a final rule or rules by the Commission, and at least thirty (30) days in advance of the meeting at which the rule will be considered and voted upon, the Commission shall file a Notice of Proposed Rulemaking:

- 1. On the website of the Commission or other publicly accessible platform; and**
- 2. On the website of each member state physical therapy licensing board or other publicly accessible platform or the publication in which each state would otherwise publish proposed rules.**

E. The Notice of Proposed Rulemaking shall include:

- 1. The proposed time, date, and location of the meeting in which the rule will be considered and voted upon;**
- 2. The text of the proposed rule or amendment and the reason for the proposed rule;**
- 3. A request for comments on the proposed rule from any interested person; and**
- 4. The manner in which interested persons may submit notice to the Commission of their intention to attend the public hearing and any written comments.**

F. Prior to adoption of a proposed rule, the Commission shall allow persons to submit written data, facts, opinions, and arguments, which shall be made available to the public.

G. The Commission shall grant an opportunity for a public hearing before it adopts a rule or amendment if a hearing is requested by:

- 1. At least twenty-five (25) persons;**
- 2. A state or federal governmental subdivision or agency; or**
- 3. An association having at least twenty-five (25) members.**

H. If a hearing is held on the proposed rule or amendment, the Commission shall publish the place, time, and date of the scheduled public hearing. If the hearing is held via electronic means, the Commission shall publish the mechanism for access to the electronic hearing.

1. All persons wishing to be heard at the hearing shall notify the executive director of the Commission or other designated member in writing of their desire to appear and testify at the hearing not less than five (5) business days before the scheduled date of the hearing.

2. Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

3. All hearings will be recorded. A copy of the recording will be made available on request.

4. Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.

I. Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the Commission shall consider all written and oral comments received.

J. If no written notice of intent to attend the public hearing by interested parties is received, the Commission may proceed with promulgation of the proposed rule without a public hearing.

K. The Commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

L. Upon determination that an emergency exists, the Commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rulemaking procedures provided in the Compact and in this section shall be

retroactively applied to the rule as soon as reasonably possible, in no event later than ninety (90) days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

1. Meet an imminent threat to public health, safety, or welfare;
2. Prevent a loss of Commission or member state funds;
3. Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule; or
4. Protect public health and safety.

M. The Commission or an authorized committee of the Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the website of the Commission. The revision shall be subject to challenge by any person for a period of thirty (30) days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing, and delivered to the chair of the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

SECTION 10. OVERSIGHT, DISPUTE RESOLUTION, AND ENFORCEMENT

A. Oversight

1. The executive, legislative, and judicial branches of state government in each member state shall enforce this Compact and take all actions necessary and appropriate to effectuate the Compact's purposes and intent. The provisions of this Compact and the rules promulgated hereunder and adopted by the Physical Therapist Licensing Board shall have standing as statutory law.

2. All courts shall take judicial notice of the Compact and the rules in any judicial or administrative proceeding in a member state pertaining to the subject matter of this Compact which may affect the powers, responsibilities or actions of the Commission.

3. The Commission shall be entitled to receive service of process in any such proceeding, and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the Commission shall render a judgment or order void as to the Commission, this Compact, or promulgated rules.

B. Default, Technical Assistance, and Termination

1. If the Commission determines that a member state has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated rules, the Commission shall:

a. Provide written notice to the defaulting state and other member states of the nature of the default, the proposed means of curing the default and/or any other action to be taken by the Commission; and

b. Provide remedial training and specific technical assistance regarding the default.

2. If a state in default fails to cure the default, the defaulting state may be terminated from the Compact upon an affirmative vote of a majority of the member states, and all rights, privileges and benefits conferred by this Compact may be terminated on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

3. Termination of membership in the Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be given by the Commission to the governor, the majority and minority leaders of the defaulting state's legislature, and each of the member states.

4. A state that has been terminated is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.

5. The Commission shall not bear any costs related to a state that is found to be in default or that has been terminated from the Compact, unless agreed upon in writing between the Commission and the defaulting state.

6. The defaulting state may appeal the action of the Commission by petitioning the U.S. District Court for the District of Columbia or the federal district where the Commission has its principal offices. The prevailing member shall be awarded all costs of such litigation, including reasonable attorney's fees.

C. Dispute Resolution

1. Upon request by a member state, the Commission shall attempt to resolve disputes related to the Compact that arise among member states and between member and non-member states.

2. The Commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes as appropriate.

D. Enforcement

1. The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of this Compact.

2. By majority vote, the Commission may initiate legal action in the United States District Court for the District of Columbia or the federal district where the Commission has its principal offices against a member state in default to enforce compliance with the provisions of the Compact and its promulgated rules and bylaws. The relief sought may include injunctive relief. In the event judicial enforcement is necessary, the prevailing member shall be awarded all costs of such litigation, including reasonable attorney's fees.

3. The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or state law.

SECTION 11. DATE OF IMPLEMENTATION OF THE INTERSTATE COMMISSION FOR PHYSICAL THERAPY PRACTICE AND ASSOCIATED RULES, WITHDRAWAL, AND AMENDMENT

A. The Compact shall come into effect on the date on which the Compact statute is enacted into law in the tenth member state. The provisions, which become effective at that time, shall be limited to the powers granted to the Commission relating to assembly and the promulgation of rules. Thereafter, the Commission shall meet and exercise rulemaking powers necessary to the implementation and administration of the Compact.

B. Any state that joins the Compact subsequent to the Commission's initial adoption of the rules shall be subject to the rules as they exist on the date on which the Compact becomes law in that state. Any rule that has been previously adopted by the Commission shall have the full force and effect of law on the day the Compact becomes law in that state.

C. Any member state may withdraw from this Compact by enacting a statute repealing the same.

1. A member state's withdrawal shall not take effect until six (6) months after enactment of the repealing statute.

2. Withdrawal shall not affect the continuing requirement of the withdrawing state's physical therapy licensing board to comply with the investigative and adverse action reporting requirements of this act prior to the effective date of withdrawal.

D. Nothing contained in this Compact shall be construed to invalidate or prevent any physical therapy licensure agreement or other cooperative arrangement between a member state and a non-member state that does not conflict with the provisions of this Compact.

E. This Compact may be amended by the member states. No amendment to this Compact shall become effective and binding upon any member state until it is enacted into the laws of all member states.

SECTION 12. CONSTRUCTION AND SEVERABILITY

This Compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this Compact shall be severable and if any phrase, clause, sentence or provision

of this Compact is declared to be contrary to the constitution of any party state or of the United States or the applicability thereof to any government, agency, person or circumstance is held invalid, the validity of the remainder of this Compact and the applicability thereof to any government, agency, person or circumstance shall not be affected thereby. If this Compact shall be held contrary to the constitution of any party state, the Compact shall remain in full force and effect as to the remaining party states and in full force and effect as to the party state affected as to all severable matters.

SECTION 2. The Legislative Assembly of the State of Oregon hereby ratifies the Physical Therapy Licensure Compact set forth in section 1 of this 2016 Act.

SECTION 3. ORS 676.177 is amended to read:

676.177. (1) Notwithstanding any other provision of ORS 676.165 to 676.180, a health professional regulatory board, upon a determination by the board that it possesses otherwise confidential information that reasonably relates to the regulatory or enforcement function of another public entity, may disclose that information to the other public entity.

(2) Any public entity that receives information pursuant to subsection (1) of this section shall agree to take all reasonable steps to maintain the confidentiality of the information, except that the public entity may use or disclose the information to the extent necessary to carry out the regulatory or enforcement functions of the public entity.

(3) For purposes of this section, "public entity" means:

(a) A board or agency of this state, or a board or agency of another state with regulatory or enforcement functions similar to the functions of a health professional regulatory board of this state;

(b) A district attorney;

(c) The Department of Justice;

(d) A state or local public body of this state that licenses, franchises or provides emergency medical services; or

(e) A law enforcement agency of this state, another state or the federal government.

(4) Notwithstanding subsections (1) to (3) of this section, the Physical Therapist Licensing Board may disclose information described in subsection (1) of this section to the Physical Therapy Compact Commission established in section 1 of this 2016 Act.

SECTION 4. ORS 688.020 is amended to read:

688.020. (1) Unless a person is a licensed physical therapist or holds a permit issued under ORS 688.110, a person shall not:

(a) Practice physical therapy; or

(b) Use in connection with the name of the person the words or letters, "P.T.", "R.P.T.", "L.P.T.", "physical therapist", "physiotherapist" or any other letters, words, abbreviations or insignia indicating that the person is a physical therapist, or purports to be a physical therapist.

(2) Unless a person holds a license as a physical therapist assistant, a person shall not:

(a) Practice as a physical therapist assistant; or

(b) Use in connection with the name of the person the words or letters, "L.P.T.A.", "P.T.A.", "physical therapist assistant", "licensed physical therapist assistant", or any other letters, words, abbreviations or insignia indicating that the person is a physical therapist assistant or purports to be a physical therapist assistant.

(3) Subsections (1) and (2) of this section do not apply to an individual who is authorized to practice as a physical therapist, or work as a physical therapist assistant, by compact privilege as defined in section 1 of this 2016 Act.

SECTION 5. ORS 688.110 is amended to read:

688.110. (1) The Physical Therapist Licensing Board, in its discretion, may issue without examination a temporary permit to a person to practice as a physical therapist or to work as a physical therapist assistant in this state if the person files an application for license as provided in ORS

688.040 or 688.080, and pays to the board at the time of filing the application the temporary permit fee.

(2) A person holding a temporary permit may practice physical therapy only under the direction of a physical therapist licensed under ORS 688.010 to 688.201.

(3) The temporary permit shall be granted for a period not to exceed three months. The board may renew the temporary permit at its discretion for [*an additional three months, but no longer*] **no more than 90 days**.

SECTION 6. ORS 688.160 is amended to read:

688.160. (1) The Physical Therapist Licensing Board operates as a semi-independent state agency subject to ORS 182.456 to 182.472, for purposes of carrying out the provisions of ORS 688.010 to 688.201 and 688.990. The Physical Therapist Licensing Board consists of eight members appointed by the Governor and subject to confirmation by the Senate in the manner provided in ORS 171.562 and 171.565. All members of the board must be residents of this state. Of the members of the board:

(a) Five must be physical therapists who are Oregon residents, possess unrestricted licenses to practice physical therapy in this state, have been practicing in this state for at least two years immediately preceding their appointments and have been practicing in the field of physical therapy for at least five years.

(b) One must be a licensed physical therapist assistant.

(c) Two must be public members who have an interest in consumer rights and who are not:

(A) Otherwise eligible for appointment to the board; or

(B) The spouse, domestic partner, child, parent or sibling of a physical therapist or physical therapist assistant.

(2)(a) Board members required to be physical therapists or physical therapist assistants may be selected by the Governor from a list of three to five nominees for each vacancy, submitted by the Oregon Physical Therapy Association.

(b) In selecting the members of the board, the Governor shall strive to balance the representation on the board according to:

(A) Geographic areas of this state; and

(B) Ethnic group.

(3)(a) The term of office of each member is four years, but a member serves at the pleasure of the Governor. The terms must be staggered so that no more than three terms end each year. A member is eligible for reappointment.

(b) In the event of a vacancy in the office of a member of the board other than by reason of the expiration of a term, the Governor, not later than 90 days after the occurrence of the vacancy, shall appoint a person to fill the vacancy for the unexpired term.

(c) A board member shall be removed immediately from the board if, during the member's term, the member:

(A) Is not a resident of this state;

(B) Has been absent from three consecutive board meetings, unless at least one absence is excused;

(C) Is not a licensed physical therapist or a retired physical therapist who was a licensed physical therapist in good standing at the time of retirement, if the board member was appointed to serve on the board as a physical therapist; or

(D) Is not a licensed physical therapist assistant or a retired physical therapist assistant who was a licensed physical therapist assistant in good standing at the time of retirement, if the board member was appointed to serve on the board as a retired physical therapist assistant.

(4) Each member of the board is entitled to compensation and expenses as provided in ORS 292.495. The board may provide by rule for compensation to board members for the performance of official duties at a rate that is greater than the rate provided in ORS 292.495.

(5) A board member who acts within the scope of board duties, without malice and in reasonable belief that the member's action is warranted by law, is immune from civil liability.

(6) The board shall have power to:

- (a) Establish matters of policy affecting administration of ORS 688.010 to 688.201;
 - (b) Provide for examinations for physical therapists and physical therapist assistants and adopt passing scores for the examinations;
 - (c) Adopt rules necessary to carry out and enforce the provisions of ORS 688.010 to 688.201;
 - (d) Establish standards and tests to determine the qualifications of applicants for licenses to practice physical therapy in this state;
 - (e) Issue licenses to persons who meet the requirements of ORS 688.010 to 688.201;
 - (f) Adopt rules relating to the supervision and the duties of physical therapist aides who assist in performing routine work under supervision;
 - (g) Adopt rules establishing minimum continuing [education] **competency** requirements for all licensees;
 - (h) Exercise general supervision over the practice of physical therapy within this state;
 - (i) Establish and collect fees for the application or examination for, or the renewal, reinstatement or duplication of, a license under ORS 688.040, 688.080 or 688.100 or for the issuance of a temporary permit under ORS 688.110; and
 - (j) Establish and collect fees to carry out and enforce the provisions of ORS 688.010 to 688.201.
- (7) The board shall meet as determined by the board and at any other time at the call of the board chairperson, who shall be elected by the members of the board. All members have equal voting privileges.
- (8) The board may appoint and fix the compensation of staff as necessary to carry out the operations of the board.
- (9) The board shall:
- (a) Maintain a current list of all persons regulated under ORS 688.010 to 688.201, including the persons' names, current business and residential addresses, telephone numbers, electronic mail addresses and license numbers.
 - (b) Provide information to the public regarding the procedure for filing a complaint against a physical therapist or physical therapist assistant.
 - (c) Publish at least annually, and in a format or place determined by the board, final disciplinary actions taken against physical therapists and physical therapist assistants and other information, including rules, in order to guide physical therapists and physical therapist assistants regulated pursuant to ORS 688.010 to 688.201.

SECTION 7. ORS 688.201 is amended to read:

688.201. (1) All moneys received under ORS 688.010 to 688.201 shall be paid into [the] **an** account established by the Physical Therapist Licensing Board under ORS 182.470. **The board may establish an additional account under ORS 182.470 for the purpose of meeting financial obligations imposed on the State of Oregon as a result of this state's participation in the Physical Therapy Licensure Compact established under section 1 of this 2016 Act.**

(2) [Those moneys hereby are appropriated continuously] **The moneys paid into the accounts established by the board under ORS 182.470 are continuously appropriated** to the board and [shall] **may** be used only for the administration and enforcement of ORS 688.010 to 688.201 **and for the purpose of meeting financial obligations imposed on the State of Oregon as a result of this state's participation in the Physical Therapy Licensure Compact established under section 1 of this 2016 Act.**

SECTION 8. ORS 688.201, as amended by section 16, chapter 240, Oregon Laws 2013, is amended to read:

688.201. (1) All moneys received under ORS 688.010 to 688.201 shall be paid into [the] **an** account established by the Physical Therapist Licensing Board under ORS 182.470. **The board may establish an additional account under ORS 182.470 for the purpose of meeting financial obligations imposed on the State of Oregon as a result of this state's participation in the Physical Therapy Licensure Compact established under section 1 of this 2016 Act.**

(2) [Those moneys hereby are appropriated continuously] **The moneys paid into the accounts established by the board under ORS 182.470 are continuously appropriated** to the board and

[shall] may be used only for the administration and enforcement of ORS 676.850 and 688.010 to 688.201 and for the purpose of meeting financial obligations imposed on the State of Oregon as a result of this state's participation in the Physical Therapy Licensure Compact established under section 1 of this 2016 Act.

SECTION 9. (1) The amendments to ORS 676.177 by section 3 of this 2016 Act apply to information disclosed on or after the effective date of this 2016 Act.

(2) The amendments to ORS 688.020 by section 4 of this 2016 Act apply to individuals authorized to practice as a physical therapist, or work as a physical therapist assistant, by compact privilege on or after the effective date of this 2016 Act.

(3) The amendments to ORS 688.110 and 688.160 by sections 5 and 6 of this 2016 Act apply to licenses and permits issued or renewed by the Physical Therapist Licensing Board on or after the effective date of this 2016 Act.

(4) The amendments to ORS 688.201 by sections 7 and 8 of this 2016 Act apply to moneys received by the board on or after the effective date of this 2016 Act.

SECTION 10. This 2016 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2016 Act takes effect on its passage.

Passed by Senate February 18, 2016

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

.....
Peter Courtney, President of Senate

Passed by House February 24, 2016

.....
Tina Kotek, Speaker of House

Received by Governor:

.....M.,....., 2016

Approved:

.....M.,....., 2016

.....
Kate Brown, Governor

Filed in Office of Secretary of State:

.....M.,....., 2016

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



Survey Reports

OBD

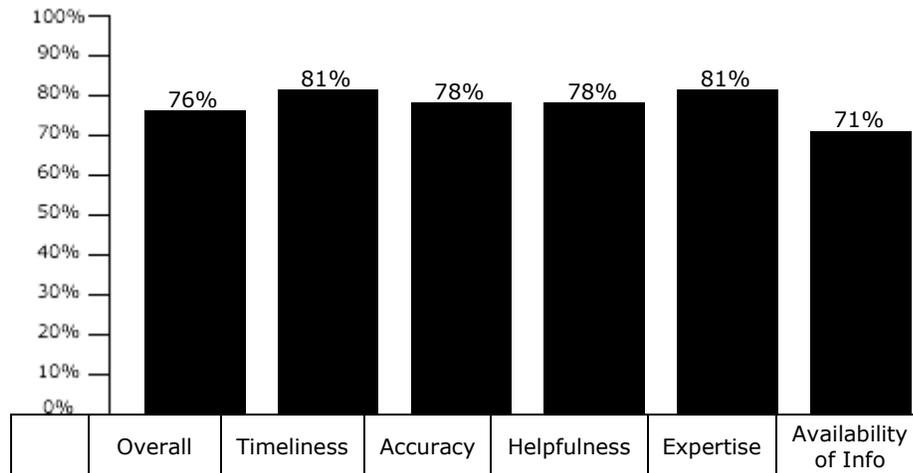
Showing Data for: OBD

Time Period: All Surveys

[Change View](#)

Number of Responses: 73

Percent Rating Service Good or Excellent



Rating Totals By Question

Question	Don't Know	Poor	Fair	Good	Excellent
Q1	6	6	7	19	35
Q2	6	10	5	16	36
Q3	10	6	8	14	35
Q4	10	8	4	16	35
Q5	7	12	7	12	35
Q6	6	9	7	17	34

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

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

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

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

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

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

Comments Received

Posted	Comment
3/30/2016 7:28:54 AM	Thank you for all your hard work.
3/15/2016 8:01:48 AM	I realize paying an exorbitant amount of money to fund more and more regulation, pay salaries of bureaucrats is.... The fees continue to climb....
3/15/2016 8:01:35 AM	I realize paying an exorbitant amount of money to fund more and more regulation, pay salaries of bureaucrats is.... The fees continue to climb....
2/23/2016 4:31:18 PM	Ms. Theresa Haynes does an excellent job of communicating with the renewal process.
2/11/2016 11:33:07 AM	Very prompt response to my email. Thank you!
2/11/2016 11:32:55 AM	Very prompt response to my email. Thank you!
1/11/2016 9:05:02 PM	After 3 attempts to discuss the questions that I have to transfer my dental hygiene license, I have had no success in contacting the professional that has the knowledge to help me.
1/10/2016 4:22:23 PM	I seem to get into the 15% random audit a lot
1/10/2016 4:22:17 PM	I seem to get into the 15% random audit a lot
12/22/2015 7:52:45 PM	I cannot open the newsletter. Also, I feel it was important see which professionals had violated the rules. I cannot possibly look up every individual, so it is not helpful or informative any more.
12/22/2015 6:18:02 PM	The mission statement of this agency has been to protect the public. Making it a challenge to find the names of licensees that have been disciplined protects the licensee, not the public.
12/22/2015 1:55:25 PM	Other than license renewals, I have never had any dealings with the Board.
12/22/2015 1:14:42 PM	If the audits are random and only 15% than why am I being audited for 2 consecutive renewals? Maybe they are alphabetically. You should change this to be more fair.
11/11/2015 9:03:10 PM	I appreciate all your help making this move easier Thank you Wendy
10/21/2015 7:09:40 AM	She just had to look I me up to see where my license renewal was due.
10/21/2015 7:09:34 AM	She just had to look I me up to see where my license renewal was due.
10/9/2015 11:53:53 AM	It took 3 phone calls to get the retirement form I needed. Ms Haynes quickly sent me an email form, the previous office help apparently couldn't get the request taken care of at all
9/10/2015 7:03:31 PM	Teresa was very prompt about sending my receipt for my license. Thank you, Barb
9/9/2015 7:47:23 PM	The board is not staffed sufficiently for investigators. Some cases take a year to resolve just due to sheer case load. The data provided is not a clear data visual representation. It would be great i
9/9/2015 4:00:35 PM	I would appreciate knowing what the mandatory five dollar workforce survey fee covers. A survey, in my experience, should be a voluntary experience to receive the best results.
9/9/2015 3:59:04 PM	why is a notary involved? that step will inhibit many providers from signing up. I don't have to have a notary for basically anything else these days.
9/9/2015 2:35:55 PM	I would like to see a response given when a provider gets their CE courses audited. A Pass for all courses accepted or a Fail if they aren't-some type of follow up for all the info we send in.
9/9/2015 12:12:54 PM	I have tried to use the Prescription Drug Monitoring website a few times and find it Very Difficult to Access patient information. Can you make more User Friendly?
9/1/2015 8:16:34 AM	I have called several times for licensing information. Each call, I received a warm, friendly correct answer instantly. Refreshing that this caliber of service does exist somewhere in the world.
8/7/2015 8:21:03 AM	You efficiently let us know of the meeting for rule changes, but what ARE the rule changes you are considering? Please email us of the summary of the issues with links of information on each issue.
8/5/2015 9:07:36 PM	Keep up the good work!
8/5/2015 5:22:46 PM	I am retired and won't be renewing my license. Coralie
8/4/2015 5:28:59 PM	End Tidal CO2 monitoring is unnecessary for enteral moderate sedation due to the fact that patients do not enter into significant respiratory depression.
8/4/2015 11:57:17 AM	it is ridiculous you are charging hygienist a mandatory 5.00 to take a survey. When I told the dentist I work for that, he laughed. That is extortion!!

8/4/2015 9:46:22 AM	Keep up the great work!
8/4/2015 7:22:27 AM	It would be nice if the Board of Dentistry would actually hire an Exceutive Director that had a clue about dentistry!
8/4/2015 7:14:06 AM	Happy with obd services.
7/24/2015 2:57:17 PM	Teresa gave excellent service and helped me immediately. She went over an above the expectation of service. She is knowledgeable, efficient and helpful. She helped me navigate the Web site.



Oregon

Kate Brown, Governor

Department of Administrative Services

Chief Financial Office

155 Cottage St NE

Salem, OR 97301-3963

Phone: 503-378-3106

Fax: 503-373-7643

RECEIVED

MAR 1 2016

Oregon Board
of Dentistry

Date: February 2, 2016

To: Stephen Prisby, Executive Director
Oregon Board of Dentistry
1500 SW 1st Ave, #770
Portland, OR 97201

Re: **FY 2015 GOLD STAR CERTIFICATE**

It is a great pleasure to inform you that your agency has earned the Chief Financial Office's Gold Star Certificate for fiscal year 2015.

The Chief Financial Office's Gold Star Certificate is awarded to state agencies that provide accurate and complete fiscal year end information in a timely manner. Clearly, the Gold Star is a challenge to earn, and its achievement is due primarily to your agency's diligent efforts to maintain accurate and complete accounting records throughout the year.

Your agency's participation in the Gold Star Certificate program is important in meeting statewide fiscal performance goals and key to the timely preparation of Oregon's Comprehensive Annual Financial Report (CAFR) and the statewide Schedule of Expenditures of Federal Awards. Your agency's success in accounting and financial reporting is also critical to Oregon's success in receiving a favorable audit opinion on both statewide documents.

The Chief Financial Office's Gold Star Certificate is Oregon's equivalent to the nationally recognized GFOA Certificate of Achievement for Excellence in Financial Reporting. Through the collaborative team effort of state agencies and the Chief Financial Office, Oregon has earned the GFOA Certificate every year since 1992. *Gold Star agencies* are key to making this possible.

The Gold Star Certificate was delivered to your agency's lead CAFR accountant, **Joan Stieger**. Congratulations to your agency and your fiscal team for this outstanding work!

Sincerely,

George Naughton, Chief Financial Officer
Chief Financial Office

Robert W. Hamilton, Manager
Statewide Accounting and Reporting Services



2017 Calendar

January						
Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

February						
Su	Mo	Tu	We	Th	Fr	Sa
			1	2	3	4
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12	13	14	15	16	17	18
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26	27	28				

March						
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			1	2	3	4
5	6	7	8	9	10	11
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19	20	21	22	23	24	25
26	27	28	29	30	31	

April						
Su	Mo	Tu	We	Th	Fr	Sa
						1
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16	17	18	19	20	21	22
23	24	25	26	27	28	29
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Holidays

- Jan 1** New Year's Day
- Jan 2** New Year's Day (Observed)
- Jan 16** Martin Luther King Day
- Feb 20** Presidents' Day
- April 16** Easter Sunday
- May 29** Memorial Day
- Jul 4** Independence Day
- Sep 4** Labor Day
- Sep 21-22** Rosh Hashanah
- Sep 30** Yom Kippur
- Nov 10** Veterans Day (Observed)
- Nov 11** Veterans Day
- Nov 23** Thanksgiving Day
- Nov 24** OBD Staff Holiday
- Dec 13-20** Chanukah
- Dec 25** Christmas Day

Important OBD Dates

- Evaluator's Meeting
- Board Meeting
- TBD CDCA Annual Conference
- TBD ODC Conference
- TBD AADA & AADB Mid Year Meeting
- TBD Strategic Planning Session
- TBD ADEX House Meeting
- TBD AADA & AADB Annual Meeting

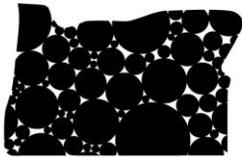
Other Significant Events

- TBD ODA House of Delegates
- TBD Mission of Mercy

2015 Charitable Fund Drive

Campaign Report

Submitted by:
Campaign Management Team
The Children's Trust Fund of Oregon
EarthShare Oregon
Deb Furry
2-19-2016



OREGON
EMPLOYEES
CHARITABLE
FUND DRIVE

2015 Charitable Fund Drive Campaign Report

Total raised \$ 835,022.52
4.7% of state employees participated

The Charitable Fund Drive (CFD) Committee goal for the 2015 campaign:

- Increase awareness of the Charitable Fund Drive

It was a mixed year for the Charitable Fund Drive. A group of agency coordinators who brought with them energy, enthusiasm, and workplace campaign experience saw their campaigns grow significantly. Other agencies couldn't quite find their momentum as internal transitions caused them to get off to a late start resulting in campaigns that didn't do as well as the year before. After two years of positive overall growth in the campaign, 2015 saw a decline. This year the state agencies saw 125 fewer donors than last year and a 1.64% decrease over 2014 pledges.

It was a mixed year for the universities. Western Oregon University and Eastern Oregon University both with a 7 % increase. Oregon State University also saw an increase this year of 5% and Oregon Institute of Technology was up 3%. The University of Oregon campaign, always the largest donor by agency to the campaign, was again down this year by 8%.

The number of events declined after 2014 high of 172 to 109. There were about the same number of opportunities this year (10 in 2014) for tabling and presentations by charity representatives, either as part of an event or presentation at a staff meeting. The campaign did lose the benefit of the Kickoff which was canceled due to weather. The lesson learned is that it has become the visual recognition of the launch of the campaign and an opportunity for coordinator's to meet groups that they would like to invite in for presentations.

The committee continued activities from the previous year to help increase awareness of the Charitable Fund Drive:

1. Two state wide emails from the Director of DAS
2. Donors had the ability online to easily renew their gift from the previous year

Many Agency and Site Coordinators did an absolutely fabulous job in creating visibility and awareness of the campaign and encouraging their co-workers to take a look at the Charitable Fund Drive. Because of their outstanding efforts, there are a number of agencies that met or significantly increased their prior year pledges.

Agency Highlights:

1. The Agencies shown below had a **REVENUE** increase over 2014. (A full listing of results by department is included in the appendices of this report).

State Police	415%
Veteran's Affairs	253%
Public Defense Services	189%
Parks & Recreation Dept.	158%
Legislative Administration	153%
Revenue	109%
Dentistry Board	100%
Legislative Fiscal Office	99%

Education Department	80%
Marine, Board	47%
Agriculture	37%
Nursing, Board	35%
Public Safety Standards & Training	30%
Oregon Medical Board	27%
Energy Office	25%
Pharmacy, Board	24%
Justice Dept.	20%
Governor's Office	19%
Library	16%
Corrections	14%
ODOT	13%
Aviation	4%
Oregon Business Development	4%
Legislative Counsel	4%
Public Utilities Commission	2%

There were also increases in the university system.

Western Oregon University	7 %
Eastern Oregon University	7 %
Oregon State University	5%
Oregon Institute of Technology	3%

2. Agencies listed below had an increase in **the number of donors** in 2015 over 2014. The agencies with significant increases are noted. *Please note the report on pages 9-10 indicate the percentage of employees participating within each department.*

Department Of Agriculture	Nursing Board
Commission for the Blind	Oregon Department of Transportation
Consumer & Business Services	Oregon Institute of Technology 141%
Department of Corrections	Parks & Recreation
Department of Education 209%	Public Defense Services 240%
Department of Energy 60%	Public Utility Commission
Department of Environmental Quality	Department of Revenue 128%
Department of Human Services	Secretary of State
Legislative Admin Office	State Police
Lottery	Veteran's Affairs 128%
Marine Board	Western Oregon University

3. **Award of Distinction Winners** for 2015: *This award started in 2010 and is given to the agency with the highest per capita giving by employee category.*

This year the awards were again presented to the winning department, at a time and place of their choosing, to create broader visibility and appreciation for employee generosity in support of the campaign and the great work of the coordinators.

1000 + employees: **Department of Justice** (third year in a row)

500 – 999 employees: **Department of Environmental Quality** (sixth year in a row)

100 – 499 employees: **Department of Housing & Community Services** (third year in a row)

99 or fewer employees: **Legislative Fiscal Office**

Universities: **University of Oregon** (sixth year in a row)

4. A new award was introduced this year, **The Award of Excellence** presented to the Agency with the highest total dollars raised within their employee category. A category was added for agencies of 4000+ employees and we did not include the universities.

4000+ employees: **Oregon Department of Transportation**

1000 -3999 employees: **Department of Justice**

500 – 999 employees: **Department of Environmental Quality**

100 – 499 employees: **Public Employees Retirement System**

99 or fewer employees: **Department of Energy**

Donor Highlights

1. Donors continue to average 2.6 designations to charities when they used the online pledging. Paper pledges had an average of 1.85 designations.
2. The average gift per donor for all gifts through the campaign was \$327. This was a slight decrease from last year's average of \$332.
3. There were a total of 109 fundraising events, which raised \$29,051. This represents 67 fewer events and \$6,547 less than the \$35,598 raised in 2014. Closer to the number of events and dollars (\$25,706) raised in 2013.
4. 88% of all giving was done on-line when events are taken out of the number (these are always entered as paper pledges). Paper pledges counted for 12% of gifts through the state agencies just slightly higher than the universities.
5. 36% of donors requested to have their contact information passed along to their designated charities. This is just 2% less than last year.
6. New last year, donors could select to be contacted year-round by the CMO Team. This year 268 chose this option, 30 more than last year. They will receive the CFD Newsletter **Your Gifts at Work**.
7. Range and median of all gifts
 - a. Range is \$1 to \$7200 an increase of \$1200 over the previous year
 - b. Median gift is \$180 same as last year

- c. More than 77% of all gifts are at the level of \$360 or below (same as last year)
- d. 7.6% of the gifts are at the level of \$1000 or above and account for 37% of the total dollars pledged (very similar to last year)

8. Method for giving

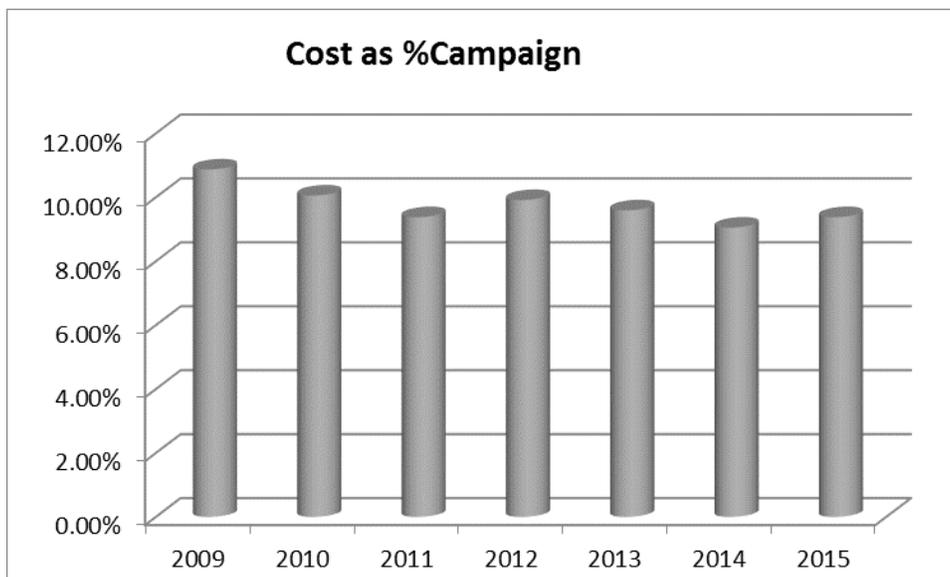
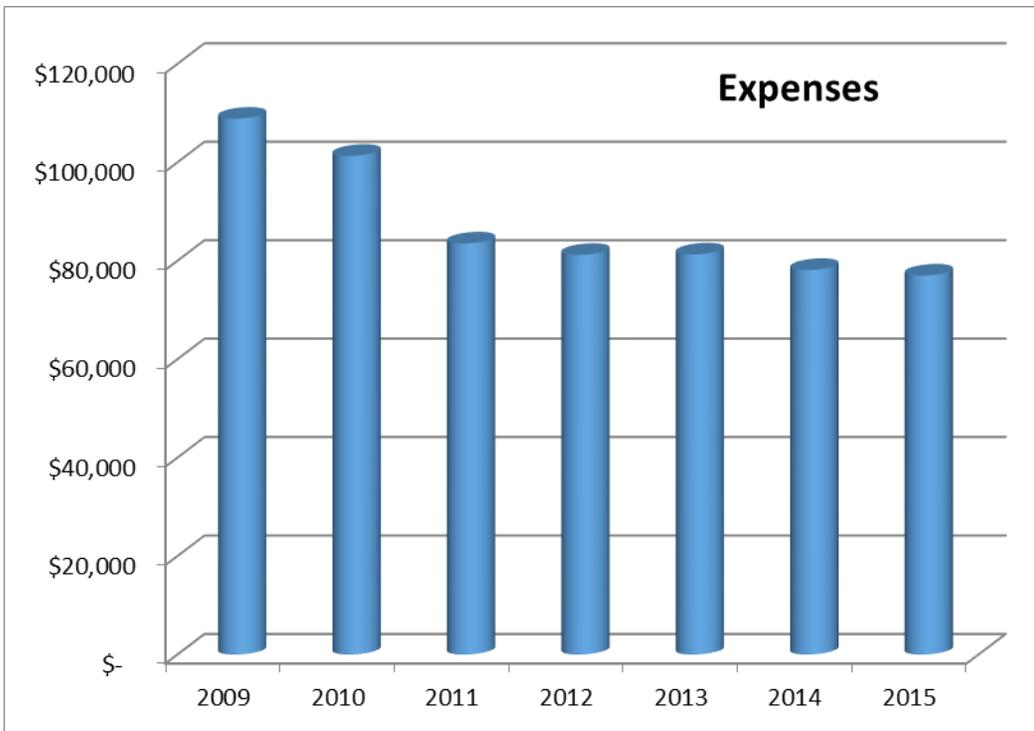
	# donors	Total \$\$	% donors	% dollars	Avg. Gift
Events	-----	\$ 29,051	0%	4%	-----
Cash	29	\$ 821	1%	0%	\$ 28.30
Check	76	\$ 12,393	3%	2%	\$ 163.07
Credit card	218	\$ 55,134	9%	7%	\$ 252.91
Recurring CC	13	\$ 9,000	1%	1%	\$ 692.31
Recurring E-check	5	\$ 430	0%	0%	\$ 86.00
Payroll	2013	\$ 711,743	86%	87%	\$ 353.57

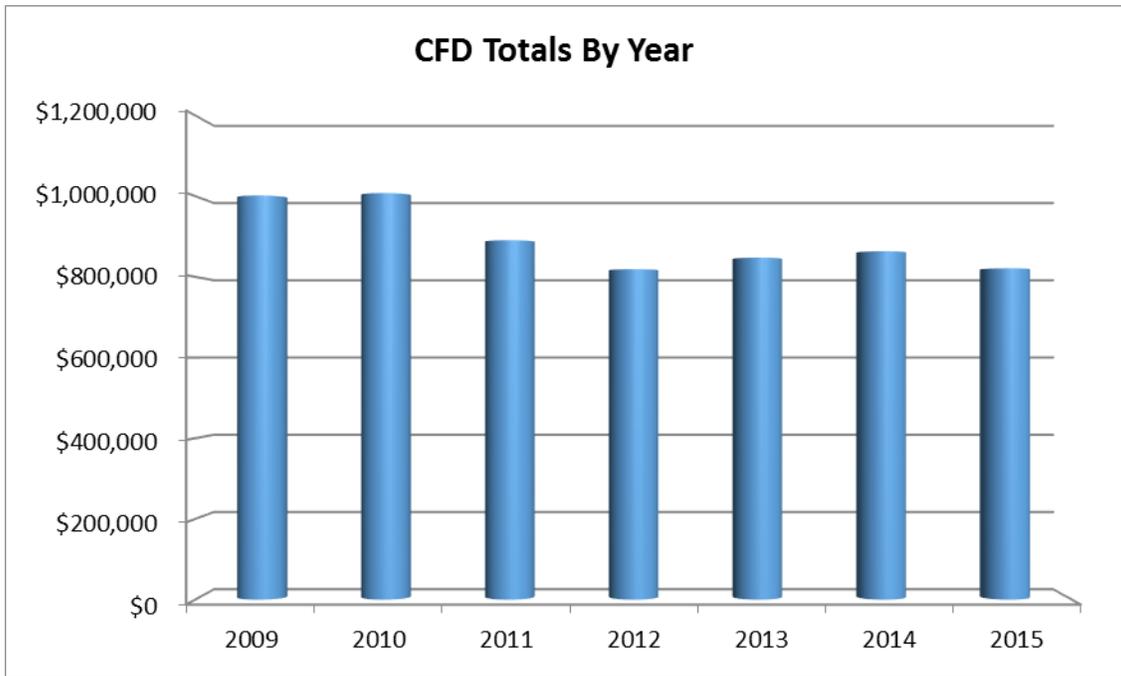
CFD EXPENSES

The CMO Team continues to work diligently to reduce expenses where possible. At this point, we have reduced expenses everywhere possible.

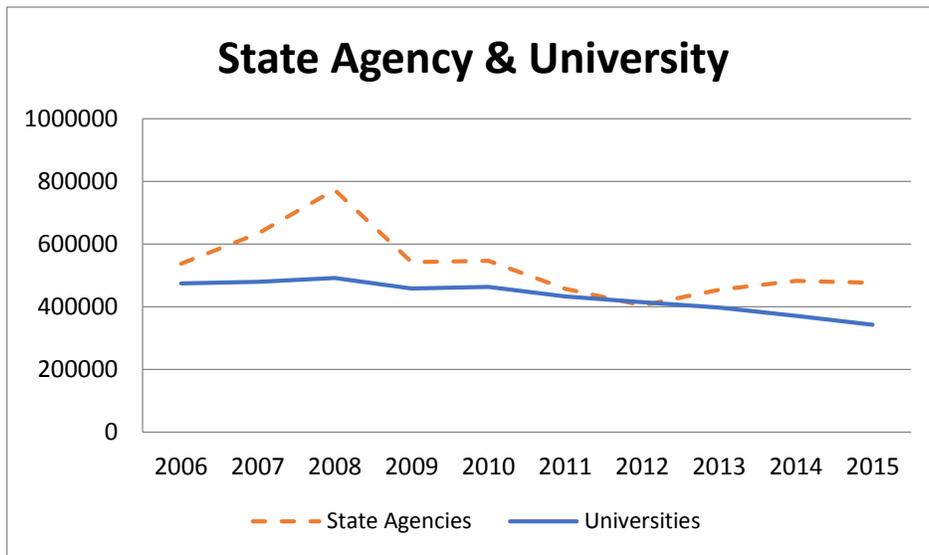
While the campaign's fiscal year goes through the end of March, we estimate that expenses should fall close to \$77,000. This would keep expenses at 9.4 percent of pledges.

The graphs that follow show the downward trend of total campaign expenses, how that varies as a percentage of campaign, and how that correlates to the campaign results.





Trends in giving by State Agency and University



Preliminary plan for the 2015 Charitable Fund Drive

Many are continuations of efforts already underway:

2016 Goal – 100% awareness of the Charitable Fund Drive.

1. Increase engagement.
 - a) Continue to work with DAS Director to engage support and leadership for the CFD.
 - b) Engage more support among Agency Directors and department leadership for the CFD and the role of the Agency Coordinator in implementing the campaign.
 - c) Continue to position the Agency Coordinators in a leadership role within the campaign.
 - d) Invite key Agency Coordinators to share their success stories with the CFD Committee so we better understand what contributes to success and look to replicate.
 - e) Better understand how to use the unique culture of each agency as a component of their campaign success.
 - f) Engage people's minds and hearts through more direct involvement in organizations supported by the CFD and stories.
 - g) Equip Agency and Site Coordinators to be more effective in their outreach through personal stories.
2. Increase visibility of the campaign.
 - a) Distribute ***Your Gifts at Work***, the CFD newsletter produced 8 times per year to past donors to keep them informed about the difference their Charitable Fund Drive dollars make.
 - b) Assess current materials – printed and online – do we have the right materials?
 - c) Develop new tools to help coordinators promote the campaign visually and electronically.
 - d) Continue to improve quality and availability of information for coordinators and donors on the CFD website (ecfd.oregon.gov) and publicize campaign events on the website.
 - e) Explore the use of department intranet sites as opportunities to promote the CFD and link to the online pledge site.
 - f) Use the CFD Facebook site as another means to publicize the campaign and connect coordinators.
 - g) Work proactively with Statesman Journal's state government reporter.
 - h) Plan a weather backup for the Kickoff.
3. Increase awareness of the opportunity and benefit of payroll contributions and re-position events as promoting the campaign, rather than *being* the campaign.
 - a) Develop promotional materials about the power of payroll contributions.
 - b) Encourage more speaking and tabling events, as a part of the event activity, where employees have the opportunity to meet with representatives from the charitable organizations.
4. Provide more educational opportunities.
 - a) Provide more information about the various organizations and the work that they are doing and the impact they are making.
 - b) Increase awareness of the resources and services available to State employees and their families.



News & Views

Citizen Advocacy Center

Fourth Quarter, 2015 – Health Care Public Policy Forum – Volume 27 Number 4

Announcement

Our 2016 annual meeting will be held in Portland Oregon on Saturday afternoon and all day Sunday, September 17 and 18, 2016. The meeting will be co-sponsored by CLEAR. The theme will be “Modernizing the Regulatory Framework for Telehealthcare Delivery.” It will take place immediately following the CLEAR meeting, which ends at noon on Saturday.

Proceedings of Citizen Advocacy Center’s Annual Meeting November 12-13, 2015, in Washington, DC.

Demonstrating Current Competence: How Far Have We Come? Where Are We Headed?

Editorial Note: The following proceedings are not a verbatim transcript, but they are faithful to the speaker’s remarks. Please visit www.cacenter.org to find copies of the speakers’ PowerPoint presentations, which you may want to consult as you read these proceedings.

Opening Remarks: Rebecca LeBuhn, Board Chair Citizen Advocacy Center

The call to this meeting said we are returning to a familiar theme. We do this because we think it is time to assess where we are in terms of assuring and demonstrating continuing competence and to take a look at some promising ideas and trends that will influence how healthcare professions will measure and demonstrate competence in the near future.

This truly is a familiar theme for CAC. We've been researching and advocating on this topic almost since the creation of the organization. I looked back at just a few of our publications. In 1995, we published a resource guide entitled *The Role of Licensing in Assuring the Continuing Competence of Health Care Professionals*. In it, we quoted CAC's first Board Chair, Ben Shimberg:

It's amazing how little board members know about their licensees once that precious piece of paper has been mailed out.... Has the licensee kept up with the field? Does he or she practice at the state-of-the-art level? Do the services he or she delivers to the public meet the minimum standards of competence set by the board?

We quoted NOCA, then the National Organization for Competency Assurance (now the Institute for Credentialing Excellence). Several of our speakers today and tomorrow are affiliated with that organization. Their 1981 *Guidelines on Continuing Competence* said:

Continuing competence assurance is necessary ... health care technology is advancing too fast for a certificate of competence earned at the beginning of one's career to constitute proof of competence many years later. Demonstrations of continuing competence are as reasonable and necessary as are required demonstrations of entry-level competence.

We quoted the Pew Health Professions Commission:

Assessing the continuing competence of practitioners, a much more difficult task at which many professional licensing bodies have done very little, other than requiring attendance at continuing education courses. There should be more attention to assessing the actual practice performance of licensees using quality assurance techniques and evaluation of consumer and professional criticisms about licensees.

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We quoted Virginia's Department of Health Professions, which wrote in 1985:

Continuing competence is one of the dominant issues in professional regulation. Regulatory boards are careful to ensure that candidates for licensure are competent, but it is possible to practice for a lifetime without being required to demonstrate continuing competency... the community of regulators acknowledges the need for prevention and agrees that some system for monitoring the continuous acquisition of knowledge, skills, and ability by health practitioners is a warranted use of State regulatory powers.

In 1997, CAC published proceedings from a conference we called *Continuing Professional Competence: Can We Assure it?* At that conference, we posed the same question we pose here today: Where have we been and where are we going? Ben Shimberg opened the conference by identifying several challenges:

- When we evaluate competence, are we concerned with cognitive knowledge or with functioning and judgment?
- Which is a better indicator of continuing competence: general, entry-level knowledge or the knowledge and skills needed in the professional's current setting?
- Is it important to evaluate the continuing competence of everyone in the profession, or only those who give reason to suspect there may be a need for evaluation and remediation?
- When it comes to assuring continuing competence, what is the appropriate division of responsibility between the regulatory system and private credentialing bodies?

Another set of conference proceedings published by CAC in 2001 explored barriers to advancing continuing competence requirements and suggested strategies for overcoming them. The barriers had to do with

- a need for common terms and definitions
- a need for research and information to validate methodologies and approaches, including what to measure and how to relate competence assessment to patient outcomes, and
- a need for collaboration and cooperation among agencies, and between public and private sectors.

In 2004, CAC published a *Roadmap to Continuing Competence Assurance*. The route included research, legislative and regulatory mandates, utilization of evidence-based methods to demonstrate competence, and reforming continuing education.

In 2006, CAC joined with AARP's Public Policy Institute in a publication entitled, *Implementing Continuing Competency Requirements for Health Care Practitioners* (<http://www.cacenter.org/files/ImplementingContinuingCompetencyRequirements.pdf>). We convened another meeting conference on continuing competence in 2011 (<http://www.cacenter.org/files/ContinuingCompetenceProceedings2011.pdf>). And now, here we are again.

This brief recollection makes it clear that regulators, certifiers, and organizations like CAC have long recognized the need for demonstrating current competence. We have known what questions need answers. But the will to act and the science for assessing and demonstrating competence in practice have been slow to emerge.

At CAC, we think we are slowly turning the corner. The Institute for Credentialing Excellence held its annual meeting two weeks ago. There were no fewer than six sessions on continuing competence, recertification, or reflective practice. The American Board of Medical Specialties is moving along a bumpy road toward implementing Maintenance of Certification programs within its member boards. Many health care professions are talking seriously about ways they might require demonstrations of competence as a condition of re-licensure. CE is changing – with assessment based courses and CE in the work setting. Advancements in psychometrics make it possible to assess reasoning power as well as book learning. Organizations are making a serious effort to overcome resistance among licensees and credential holders to new requirements around re-licensure and re-certification. A clarification in terminology enables us to distinguish between *competence*, meaning a potential ability or capability to function in a given situation, and *competency*, which focuses on actual performance in a given situation.

In the next day and a half, we will hear about public expectations regarding the current competence of licensees and credential holders. They think licensing boards and certifying bodies are taking care of the situation. Should we strive harder to meet those public expectations? Or, do we need to disappoint them the news that their confidence is misplaced?

We will hear about innovations in CE and psychometrics and performance testing. We'll hear about how some organizations have tried to overcome resistance within the profession to continuing competence and competency requirements.

Many of these innovations come from certifying organizations. They encounter the same challenges as licensure boards, but since they are private, voluntary organizations, they can be more nimble about experimenting with new approaches and changing the rules of the game.

The concluding panel is comprised of representatives from the world of licensing. We'll hear from them about what their professions are doing to assess continuing competence and, significantly, how their professions might integrate some of the innovations described during the conference into their approach to licensure renewal.

At lunch today, we are pleased to honor Lisa McGiffert with the Ben Shimberg public service award and to hear her speak.

Part I – What Do Consumers Expect?

AARP Survey - Ed Susank, Public Member, National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA)

I am going to tell you about a study of consumer opinion in Virginia conducted by AARP a little over eight years ago. Let me speak first about the context in which the study came about.

The dictionary definitions of “competence” run the gamut from the legal aspects to the reproductive aspects. For our purposes, the key definition is “capable of performing an allotted function.” As a consumer, it is not enough for me to be assured that my healthcare provider *knows* how to do something. That is certainly a prerequisite. I want to know that they can *perform*. It is the doing that counts.

The Commission on Medical Education was formed during the Hoover administration at the suggestion of the American Association of Medical Colleges. In 1932, the Commission predicted that at some point every physician might be required to take courses to ensure that his or her practice would be kept up to date. Fifteen years later, the American Academy of General Practice was the first group to require continuing education as a condition for membership. Twenty years later, the Department of Health Education and Welfare went a step further by recommending that physicians undergo periodic reexamination over the course of a career. As many of you know, the Citizen Advocacy began looking at this issue in the early 1990’s and joined a few other voices to question whether coursework alone is enough to assure competence over the course of a career. In 1995, CAC published a resource guide on how licensing boards could assure continuing competence of the healthcare professionals they regulate and their entire annual meeting in 1996 was devoted to this topic.

In 1995, the Pew Commission issued its seminal report, *Reforming Healthcare Workforce Regulation*. That report focused on how the approximately ten and half million healthcare workers in the United States were affecting the cost, quality and accessibility of healthcare. One of the ten policy objectives the Commission suggested was that states should require licensing boards to develop, implement, and evaluate requirements that would assure the continuing competence of their healthcare professionals.

In March 1998, the American Board of Medical Specialties (ABMS) commissioned a task force on competence. One of its stated goals was to improve the quality of healthcare. The ABMS leadership knew it was not enough to simply maintain quality – there had to be continuous improvement. They noted that a written examination alone was probably not enough to document competence in real world clinical practice. The ABMS task force developed a list of six general competencies that physicians in training would have to demonstrate - the *doing*, not just the *knowing*. That was a clarion call to the twenty-four ABMS member boards for maintenance of certification (MOC) built around the six general competencies.

In April 2003, the Institute of Medicine (IOM) issued a report recommending that all licensed professionals be required to periodically demonstrate their competence. It challenged licensing and certification boards to start moving toward such a requirement. It also recommended that these boards simultaneously evaluate the various assessment techniques they were using and modify them as necessary, incorporating the feedback loop that is so important to any ongoing process improvement.

As things were progressing at a national level, related activities were taking place in the Commonwealth of Virginia. Concerns were raised in the 1996 session of the Virginia General Assembly that some healthcare professionals might not be maintaining current knowledge of practice modalities and ethical issues. The Joint Legislative and Review Commission introduced two study resolutions. One of the studies found that the Virginia Board of Medicine was not adequately protecting the public from substandard care by physicians. This prompted the legislature to study the entire Bureau of Health Professions, which oversees and provides staff for thirteen different health professional licensing boards. There had also been some collaboration between AARP's Public Policy Institute and CAC on a document called *Implementing Continuing Competency Requirements for Healthcare Practitioners*. Also, AARP's State Director strongly supported the concept and decided to focus on Virginia as a place to explore legislation to require periodic measurements of competence as a condition of license renewal.

AARP is a data-driven organization. It was clear that the experts had weighed in on the importance of re-testing. AARP recognized that what was missing was solid data from consumers themselves. In 2006, AARP commissioned a research organization to gather the views of Virginia residents aged 50 and older.

The statisticians tell us that the survey had a sampling error of plus or minus 3.78%. AARP staff developed most of the questions, drawing upon questions used in other surveys, including the Kaiser Family Foundation and the American Board of Internal Medicine Foundation. In April 2007, AARP released the survey results in a report entitled *Strategies to Improve Healthcare Quality in Virginia: A Survey of Residents 50 and Over*. That report is available on the AARP website.

The survey focused on consumer impressions and included questions that probed the respondent's understanding of what it means to be licensed as a healthcare professional in the Commonwealth of Virginia. What did they know about the requirements for licensing? How do respondents assess the qualifications of a particular professional? How might they compare one professional with another? Respondents were asked how effective various techniques would be in controlling healthcare cost and reducing medical errors. They were asked whether they or a family member had experienced a medical error. Three of ten said yes. Despite that finding, 87% of respondents indicated at least some level of satisfaction with the quality of their healthcare. Thirty-nine percent were very satisfied, 33% were somewhat satisfied, and 15% were extremely satisfied. Only 13% expressed some level of dissatisfaction.

The survey asked people what they thought was required to practice medicine in Virginia. Nearly everyone correctly answered that practitioners had to be licensed and thought they must have completed some specified level of training and passed a written examination of their medical knowledge. More than two out of three respondents (68%) incorrectly thought that healthcare professionals are required to periodically demonstrate that they have up-to-date knowledge and deliver quality care. In fact, the Commonwealth of Virginia, like most other states, has no such requirements. People don't have to demonstrate their knowledge and skills. All that most states require is that people sit through some minimum hours of continuing education. If you go back to some of the earlier questions, it is probably not unreasonable to suggest that the disconnect we saw regarding satisfaction with healthcare may be based on these incorrect assumptions as to what standards were in place.

Respondents were asked their opinion about whether certain actions would ensure quality healthcare. Ninety percent of respondents said it is either extremely or very important for healthcare professionals to be periodically reevaluated to show they are currently competent to practice. But, regular ongoing assessments are *not* required to renew the licenses of healthcare professionals today, although as you are going to hear in this meeting, that is gradually changing. Eighty-eight percent of respondents thought it was very important that practitioners have high success rates for the diseases and conditions that they treat most often. Eighty-one percent wanted healthcare practitioners to pass written tests of their medical knowledge. Seventy-three percent wanted them to get high ratings from their patients. Seventy percent thought it important to get high ratings from other professionals.

Respondents were eager for information that would help them compare physicians. Nine out of ten said they'd like information on whether a physician communicates well with patients. Almost as many said it would be useful to know whether a doctor (or other healthcare professional) is board certified. Despite this finding, only 35% had investigated whether their own physician was board-certified. (On this point, we have often thought licensing boards should set standards for how professionals are allowed to advertise themselves.)

Respondents were asked to evaluate actions that might help reduce medical errors. Considered most important was having adequate numbers of nurses. Other items that ranked very high were better reporting of serious medical errors, quality control systems in hospitals, and requiring healthcare professionals to periodically demonstrate their current competence.

The findings of the AARP Virginia study closely parallel other studies done at about the same time by the Kaiser Family Foundation and the American Board of Internal Medicine. More recent surveys reflect changes in the healthcare environment – the Affordable Care Act, the increasing use of electronic media -- which have changed people's expectations.

NBCRNA / CAC Survey - Karen Plaus, Executive Director, National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA)

NBCRNA's mission is to promote patient safety through credentialing programs that support lifelong learning. We want to be recognized as one of the leaders in credentialing in the anesthesia community.

The first national certification examination was introduced in 1945 as a requirement for membership in the national organization. In 1969, the professional association began awarding certificates of professional excellence to members who completed a certain number of CE requirements every five years. In 1975, the responsibility for certification of nurse anesthetists was transferred to the council for certification. This was in response to recommendations from the Pew Commission and others that credentialing should be separate from the member organization. Continuing education became a requirement for recertification of nurse anesthetists in 1976 – 40 credits every two years with no examination. In 1978 the responsibility was transferred to an autonomous council on recertification. Between 2005 and 2007, the two councils merged to become NBCRNA.

We conducted a national benchmark study of what other organizations were doing in relation to continuing competency. We consulted the AARP study and Institute of Medicine reports on redesigning continuing education and multiple articles and reports on continuing competency. We held focus sessions with students, practitioners, educators, and other leaders. We did a recertification practice analysis to establish the knowledge and skills to be assessed in a practice examination. We wanted an examination that was different from entry to practice and demonstrated continued learning and growth.

In August 2011, we introduced an ideal continued professional recertification program, including a test every eight years, no grandfathering, completion of continuing education, and the opportunity to earn CE credit for involvement in professional activities. But, nurse anesthetists, like many other professions, had concerns about taking a test and prohibiting grandfathering. It was clear we couldn't adopt the ideal program.

We wanted to create parity with other providers, including anesthesiologists and anesthesia assistants, who are our competitors and our colleagues. They both required some type of examination and ongoing continuing education. The American Society of Anesthesiologists compared anesthesiology assistants and nurse anesthetists and faulted us for having a less rigorous program. Our certificants faced challenges with reimbursement, scope of practice, and other issues because of the differences in our recertification programs.

In 2011-12, we realized it would be valuable to get the public perspective, and patient expectations. So, NBCRNA embarked on a public opinion poll about continuing competence and recertification. We partnered with a leading national polling firm and with CAC to add credibility to the survey results.

We asked whether individuals should be examined on their profession-specific knowledge. Did they need to attend educational programs throughout their careers? Should there be an independent body to evaluate their knowledge and skills v. self-evaluation?

The survey started with an explanation of the purpose and functioning of professional certification programs. Then we asked a series of questions to assess consumer expectations about periodic examinations, CE, etc. We asked if consumers thought professionals should be excused from certain education and evaluation requirements, including passing an exam, periodically demonstrating qualifications, and attending CE programs. We asked what kind of training and / or evaluation consumers thought professionals should be expected to complete related to their current practice.

Ninety-one percent of the 2,000 respondents think it is important for clinicians to pass periodic examinations. Seventy-four percent think healthcare providers should not be excused from lifelong learning, regardless of their years of practice. Eighty-nine percent think healthcare providers should attend educational programs throughout their careers. The majority disagrees with the concept of grandfathering.

Our media release was picked up by many publications, including the Wall Street Journal, the Boston Globe, the Miami Herald, Minneapolis St Paul Tribune, Sacramento Bee, Columbus Dispatch, and more. We had more than 113 million media hits as a result of the press release.

We found that the public's perspective is aligned with many of the best practices in certification and recertification. In addition, we concluded that our recertification program aligns with patient expectations.

We made four major program modifications in the recertification program initially introduced in 2011. The program that will launch August 2016 is an eight-year program consisting of two four-year cycles. Individuals will take 60 Class-A assessed CE requirements in the first cycle. We award Class-B activities, such as teaching. We introduced the concept of voluntary core modules – evidence-based review of content related to four areas identified in our practice analysis that every nurse anesthetist has to know. In the second four-year cycle, the same Class-A and Class-B activities are required in addition to an examination based on the practice analysis. Individuals from 2020-2024 will be required to meet a performance standard, or complete additional activities. Starting with the 2028-2032 cycle, the examination will have a passing standard.

We know continuing competence requires a commitment to lifelong learning. We know we need to educate nurse anesthetists and other stakeholders about continuing competence and the need to represent competence to the patients and public we serve. We created a discovery series to educate stakeholders, dispel the misperceptions associated with the program and reach those stakeholders who have not familiarized themselves with the coming requirements.

I would like to thank the Citizen Advocacy Center for its assistance in gathering the public perspective and helping to message the importance of the public perspective in evaluating and changing continuing competence requirements for certification organizations.

Question – What happened after AARP’s survey results were released?

Susank - AARP recognized the importance of legislation to require some type of ongoing competency testing as a condition of licensure renewal. The boards of medicine and nursing supported the legislation that was introduced, but some of the smaller boards were concerned because they didn’t have the resources to implement continuing competency requirements. The smaller boards were able to convince legislators that this was too complicated for Virginia to take on. But, the survey is still cited by many organizations as an indicator of consumer expectations.

Comment – Consumers Union has done several national polls that include questions related to physician oversight.

Question – In my experience as a high school teacher, continuing education offerings are varied. Are you going to direct your certificants to certain subject areas? How do you assess vendors and their offerings?

Plaus - Some CE vendors already include an assessment as part of their courses. Our national membership organization is helping us try to effect this change in CE offerings.

Question - Will the modules you described as voluntary eventually become mandatory?

Plaus - The modules are developed by external CE vendors and then evaluated by us against the domain areas in our professional practice analysis and recognized by us. Certificants are concerned about the additional cost of recertification if these modules were made mandatory. We will be studying the value of the core modules before making a decision about whether they should be required for the second four-year cycle.

Question - Do you require individuals to take general modules, or modules related to their actual practice?

Plaus – The four modules are the same as the content modules on our exam. They take general modules, no matter what their area of practice.

Comment - My comment is about requirements imposed in response to a disciplinary matter involving problems that come up in practice. I don’t think we always specify closely enough exactly what remedial CE is appropriate in a given case.

Comment - In the dental field, disciplined practitioners may be referred to educational opportunities and examinations to improve their performance.

Question – Did publicizing the results of your survey help overcome certificants’ resistance to the new recertification requirements?

Plaus - Yes for those who bought into the need for change. No for those who opposed change no matter what information we sent to them.

Question - Do you have plans in place to periodically monitor consumer expectations and adjust to any changes that occur?

Plaus – We expect to adapt to changes in consumer expectations, to attitudes within the profession, and to changes in the state-of-the art in assessing continuing competence. Evaluation is a critical piece of the effort.

Part II – Innovative Programs to Meet Consumer Expectations

Innovations in Continuing Education – Graham McMahon, President and Executive Director, Accreditation Council for Continuing Medical Education (ACCME)

I come to this topic as a physician and an educator. I have worked hard at thinking about teaching and learning and how we generate meaningful engagement, health awareness, performance improvements and change. ACCME’s role as an accreditor is to bring the various elements of the CME provider community to play advancing best practices in improving patient outcomes and care. We are fortunate to be in a system where health professionals are intrinsically motivated to do the right thing. Our job is to provide them the nourishment to continue to grow and improve in ways they know are right for them. Our job is to steer the entire profession in a positive direction and support the growth and improvement of the profession as we serve our patients.

We are committed to providing the infrastructure to deliver education to clinicians. Our role is to give the clinicians the confidence that the activities we accredit provide unbiased, independent information that is evaluated appropriately and is relevant to their needs, not the needs of a marketing or commercial interest.

Unlike our colleagues in Europe we do provider-based accreditation. We accredit 2,000 organizations nationally – hospitals, healthcare systems, medical schools, and the like – to provide high quality education to learners of all types. Because we develop a relationship with those providers, and encourage, sustain, and regulate them, we are able to develop systems that are able to flexibly meet the needs of the learners they interact with.

Europe has an activity-based accreditation system, where every time a provider wants to put on a program, give a lecture, bring a group of people together to learn, it needs to get permission from the accreditor by sending them materials in advance and weeks later getting approval. That is obviously a chaotic, inflexible and problematic system.

CME is a lot more than a series of lectures. The new model is to attend to the individual and personalized needs of learners. This is challenging because unlike in medical school, individual practice is incredibly diverse in a residency. Mandatory education for everyone on specified topics doesn't meet individual needs and results in box-checking behavior that results in almost no behavior change. We have to be very careful about the balance between regulation and mandatory requirements and the carrots and incentives that bolster professional self-confidence and self-determination and respects diversity of our practicing audience.

Even in that context, all activities need to be relevant to individual's needs, independent of commercial influence, evidence-based, and evaluated for outcomes. In some respects, we've been pretty successful. We have a uniform system of provider accreditation. We have systems for activity management. We have a working system of disclosure of conflict management, which many organizations we work with have adopted. There is an expectation that activities are based on needs and appropriately chosen for pedagogy. Whether it is a course, a performance assessment, or a skill-based program, it is evaluated and integrated into a longitudinal program of performance improvements where participation is tracked and managed appropriately.

But, we have major challenges above and beyond the diversity of our learners and the difficulty of leveraging a relatively small number of providers to meet that broad need. We have challenges related to funding CME providers because our health system leaders often consider continuing education to be about points and credits and not about the actual behaviors and performance improvement that really drive educational quality. It makes me furious when I ask a group, "What is CME?" and they say it is credit. It is not about credit. It is about performance improvement, learning, knowledge, skills, and attitude.

Traditionally, some clinicians chose programs based on convenience and ease and sometimes many of these activities are promotional marketing masquerading as high quality continuing education. Two additional problems are worth mentioning. One is the tradition of relatively constant educational approaches –a speaker on stage, a dark room, people reading newspapers in the back, searching their iPads, whatever it is. This is an ineffective approach to actually generating change. The reason it has stayed this way is that many of our clinicians are acculturated and accustomed to learning that way. Often, learning isn't happening. It is difficult for the community to adapt to different techniques, such as collective problem solving. Shifting the culture toward active, participatory, effective, and efficient education is difficult.

Our work as accreditors is to encourage providers to adopt educational approaches that actually work. This means approaches that engage people, make them more self-aware, able to evaluate themselves against their peers, and so on. Clinicians have to actually participate to learn and grow; it doesn't work to be passive.

We also have to accommodate our learners' evolving expectation. Our younger learners expect a very different educational environment than our more senior and seasoned learners do. This challenges educational providers because producing apps and technologically sophisticated adaptive solutions is expensive. We are working to address

confusing and diverse systems for awarding credit. When learners provide feedback to the CE providers, the providers can deliver better value to the health system by investing in a system that supports the competency improvement that we are all looking for.

Our 2,000 providers offer about 150,000 activities annually resulting in about 25 million interactions with the healthcare community. Our growth is not with physician learners. Our high quality educational activities draw learners from multiple professions to in-person and Internet based education across the country.

The vast majority of providers are eager to demonstrate their ability to use best practices and do the right thing. Providers are required to engage in continuous quality improvement and their activities are required to evolve and adapt to the changing needs of learners. We like to think of ourselves as coaches rather than cops, so we work with providers to hold them account, and help them to improve. We try to move the community forward by commending CME providers who demonstrate their ability to engage in educational best practices.

The area of greatest difficulty is managing and resolving conflicts of interest. Many of the best speakers and teachers have completely appropriate and necessary relationships with the industries in which they work. You want to have those people be able to present and engage audiences at events. But, they have to do so without any promotional marketing and they have to disclose their relationships so learners can make their own judgments about any bias. Most of the problems involve errors in interpretation and what appear to be honest mistakes.

In our evaluations, we look for evidence that providers are doing exactly what we know works best for educational quality and for generating those types of behavior modification we know are important. About half of our providers achieve accreditation commendation. We do sometimes have to put providers on probation when they make meaningful errors in the way in which they manage their educational activities, or even eject them from the system.

In addition to courses and Internet-based activities, CME providers offer a wide variety of other types of learning and improvement activities. This speaks to the evolution of the educational system. We have learned to adapt to time constraints. Gone is the day when we can access hours of a clinician's time for education. We have to meet learners where they are – with apps, in small conferences, in their clinics, via problem-solving cases that engage them in active learning, and multiple other ways.

One of the common misconceptions about the CME system is that it has been corrupted by commercial investment. To the contrary, the reassuring news is that only about 11% of activities are funded in any way by a commercial organization like a pharmaceutical company. Eighty-nine percent are funded either by a professional society meeting or by a health system putting on grand rounds or an educational activity.

The vast majority of activities are designed for knowledge improvement, but over half are designed to change actual skills. About one-third of activities are designed to change patient level outcomes. About 89 percent are measuring knowledge outcomes; just under

half are measuring for performance outcomes; 13 percent are measuring patient outcomes. This may seem small, but consider the difficulty of what they are measuring. Accreditation standards are encouraging providers to move in this direction and design activities to meet community needs.

We promote additional research to evaluate how to be more effective in communicating the message to healthcare systems that accredited CME can be a powerful resource to generate performance improvement. There is evidence that several organizations that have made meaningful investments in educational activities for their health systems can demonstrate meaningful improvement in quality and efficiencies.

ACCME is evolving in response to the changing needs and expectations of the community, such as engagement of patients and patient representatives in the planning and delivery of continuing education for physicians. Organizations will now be rewarded for appointing patient representatives to communicate patient perspectives and values to healthcare providers. Other expectations drive creativity and innovation, research, engaging leadership, working collaboratively with other community based organizations, measuring actual skill and ability, measuring and demonstrating the effect on patient outcomes, engaging students in the planning and delivery of educational activity, doing more inter-professional work, team based activities and measuring outcomes based on team performance, engaging health informatics and using data to improve performance.

We are also working with other organizations, such as the American Board of Internal Medicine. ABIM's diplomates have been frustrated over the years over the mismatch between expectations of the board and the availability of educational activities that meet those expectations. We told ABIM that our providers are able to reach learners where they work, where they practice, and where they live and deliver a high quality diverse array of educational resources to meet their needs. ABIM has agreed to let accredited CME providers issue Maintenance of Certification points based on a much broader view of what counts for high quality education. They are willing to trust our educational providers without requiring activity review, which they traditionally have done.

We are working with colleagues in pharmacy and nursing to offer something called joint accreditation, where interdisciplinary credits are issued appropriately. We can work together and can create alignment because our values are similar. This is an affirmative sign of the growth of true appreciation for teamwork.

We have an infrastructure that is trustworthy and reliable and is doing remarkable work. The accreditation system is evolving to meet the expectations of the community and increase the engagement between CME providers and the healthcare community in planning and delivering continuing education.

Question - How do you recognize targeted learning as opposed to seat time?

McMahon - We worry that mandating CME in certain areas will just create box-checking behavior, cynicism and lack of engagement. Individualizing the target is much

more likely to be effective. Providing data that is interesting and useful to an individual provider, such as comparing his or her performance with that of peers, is compelling information that they value.

Question - Is there any way of evaluating the comparative effectiveness of the variety of activities that are different from course work?

McMahon - The challenge is that it depends on what you are trying to achieve. If you are trying to develop skills, the type of educational intervention you need is very different than if you are trying to improve a clinician's receptivity to patients of a different racial or ethnic group. It is true that people can learn. Our job is to determine which intervention is more effective and more efficient to achieve the outcome you are looking for.

Innovations in Demonstrating Competence in Practice – Jim Henderson, Executive Vice President, Castle Worldwide

As other speakers have noted, not much has changed in the way we talk about continuing competence. But, things are beginning to happen. We have a sense of traction and progress being made. Medicine led the way with the research done in connection with Maintenance of Certification programs adopted by the American Board of Medical Specialties. Progress is apparent in many other certification and licensure areas.

The traction is in response to the ever-accelerating pace of change in healthcare practice, new technologies, and enhanced expectations. Consumers have access to more information about their conditions and the services they need. Much of that information is of high quality. This puts the onus on credentialed providers to stay ahead of the curve and be prepared.

Most credentialing bodies have no idea about the proficiency of the people they have credentialed after they award the initial credential. Yet, consumers assume that current competence has been verified in one way or another through recertification or re-licensure. That's a faulty assumption. In many cases, state laws don't provide the regulatory body with the authority to require it. So, in order for a state to verify that a person has maintained proficiency, they have to open up their practice acts and there is a lot of resistance to doing that. When certifications augment licenses, regulatory bodies often look to the national certification process as a means of getting at continuing competence through endorsement.

How do we go about assessing continuing competence? The first thing is to articulate the organization's beliefs about continuing competence. Think about the stakes that are associated with the profession or the practice of the discipline. Determine what implications those stakes have for public safety. Consider the pace of change in the profession. These are variables in the creation of a framework for assessing continuing competence.

You also need to think about specialization that occurs. The examination that qualifies an individual to achieve the initial credential is broad ranging across the entire discipline.

But with the very first job, practitioners begin to specialize in the kinds of patients they see and the kinds of problems they work with. That specialization creates an opportunity for deep on-the-job learning in that area and an opportunity to forget those things relevant to other settings. You need to consider to what degree natural specialization occurs and how you are going to deal with the problem that surfaces if a person working in a subspecialty wants to change jobs and work in a different specialized area. They may have lost some of the core competence they need to draw on to work in the new area. To what degree does natural specialization occur and how will the continuing competence program address that. Then, you can develop a consensus statement that provides clear direction for assessing continuing competence.

This is one of the points that the Institute for Credentialing Excellence has addressed so well in two really good documents. *Methods for Ensuring Continuing Competence Part I, and Part II*. The second one in particular talks about defining the construct of what continuing competence means in the discipline a credential is focused on. It is only after defining the construct that you can design a meaningful assessment of competence.

Assessment should be the bedrock at the beginning, middle, and end of a renewal cycle to verify that the requirements for proficiency have been met. At the beginning of the cycle, self-assessment to define career objectives can be accomplished online or through a structured process where the practitioner considers areas of current practice where he or she may want to enhance proficiency. One method of self-assessment is self-report based on reflection. The problem with this method is that self-assessment is unreliable.

Assessments are important in the middle of the renewal cycle. Continuing education without an assessment has little value. When there is an assessment component, people aren't as likely to read the newspaper during a CE activity. End of activity assessments don't need to have the same degree of reliability as a high stakes assessment needs to have. Their value is not so much in the score report as it is in motivating the person to pay attention and learn.

Assessments at the end of the renewal cycle may be higher stakes and therefore require higher reliability. These assessments must cover some core competencies and allow the individual to select components relevant to his or her own current practice and anticipated future practice.

There are a variety of commonly used measures, many of which were identified in a 2009 ICE publication on benchmarking the renewal activities of certification and licensure bodies around the country. These include guided reflection on practice. This occurs when an individual encounters a new situation or problem that resembles something similar encountered in the past and instantly makes that connection and grows professionally. We want to teach people to do this better and also guide them through a process they can use to set goals for their renewal cycle.

Self-assessments can be informal or formal. Academic course work is often used as a measure that a person is maintaining or building competence. Engaging in research leading to publication or presentations often earns continuing professional development credit. Participation in professional meetings and activities could include writing

questions for an examination. Active employment indicates that the individual is performing well enough to satisfy his or her employer. It also indicates that the individual is keeping up with technological developments via on-the-job training.

Periodic examination is not necessarily required, depending on the nature of the profession and the public's expectations. Continuing education is much better with an assessment at the end. Most of what I have talked about has to do with assessing a level of knowledge. However, peer review gets at performance in a way that other assessments don't do. Portfolios, where an individual submits documentation of elements of his or her practice can provide standardized review.

The best programs involve a multi-step approach, the utilization of a variety of tools, and an iterative process. It isn't enough to do it once or to use only one tool.

Larry Fabrey, Senior Vice President, Applied Measurement Professionals (AMP)

We psychometricians live by the standards of the American Educational Research Association, the American Psychological Association and the National Council on Measurement Education. There has been no mention of recertification in any of the versions of those standards since 1966. The National Commission for Health Certifying Agencies made no mention of recertification or continuing competence in 1977. In the 2002 standards adopted by the National Commission on Certifying Agencies (NCCA), there were for the first time two standards related to recertification. They essentially said there has to be a requirement for periodic recertification, a statement of basis and purpose (basically to measure or enhance competence), and a rationale for the time interval. These standards weren't very vigorously enforced. International standard ISO 17024 also mentions recertification. It requires documentation that the credential confirms continued competence and there have to be adequate activities to ensure an impartial assessment to confirm continued competence.

The current version of NCCA's accreditation standards effective in January 2016 has more definition about what maintaining certification has to involve. This could apply also to licensing. The essential elements are:

- statement of purpose,
- definition of continuing competence,
- time-limited ...supported by a rationale,
- periodic recertification,
- mechanism to verify that certificants have met the requirements,
- publicly available policies and procedures.

I suspect that these new standards will result in a little more rigid adherence to compliance. The commentary related to standards identifies different mechanisms that could be used to conform to the standard. There is guidance for what various tools should include. For example, if an organization uses a test for recertification, the test has to have the same properties of validity and reliability that any other test should have. If

an organization uses continuing education, it has to make sure it is as meaningful as possible. Since the concept of recertification standards was introduced in 2002, the momentum has grown. Now we are well past the tipping point.

I want to ask questions today rather than provide answers. For example, is there a difference between *competence* and *continuing competence* in practice? If your answer is no, it seems to me that if the test you give to new applicants is what your organization requires to provide evidence of competence, then the same test would measure continuing competence. Suppose a person gets certified or licensed today as an xyz professional, what assurance does the public have about the meaning of that credential five years hence? What is the meaning of your credential over time? If it is okay with you that the meaning of the credential can change, that's fine. The idea is to set the goal, identify what the goal is, and don't concentrate on the tools.

That said, here are some innovative assessment tools in alphabetical order:

- Audio
- Branching simulations
- Case studies
- Drag and drop
- Essay
- Fill-in-the-blank
- Graphics
- Hotspot ...

Many of these are not new techniques, although they have been enhanced by technology. There is new flexibility in administration. For example, there are ways to do a superficial computer-based evaluation of an essay exam. Written simulation is a tool that used to be administered in paper format, using invisible ink. Now it is possible to incorporate all sorts of audio and video in a computer-based environment.

The bottom line is that there are tools. But, don't start with the tools. Think first about what you want to convey to members of the public about the meaning of the credential. Identify the goal. Then develop the tool that will meet the goal you have set for your continuing competency program. If an organization asserts that the credential holder has demonstrated knowledge and skills, the assessment must show both. If the organization mentions only knowledge of a defined content area, the assessment is less complex. In a similar vein, what does the organization want assert about credential holders five, ten or fifteen years after initial certification or licensure? Start with the goal, not the tool.

Question - Licensing boards are complaint-driven. So, we often don't get feedback about competence until someone has been harmed. Is there any way to develop a system that would bring hospital peer review into the system so they can review competence on a regular basis?

Fabrey - Most of you are familiar with 360-degree evaluations, which include patient feedback. You can go online now and get patient opinion. The issue I have from a psychometric perspective is that this is a self-selected group of people choosing to

participate, which raises questions about reliability. As to peer review, it is human nature to not want to report about one's colleagues.

Question - Dentistry has a three-part definition of competency: skill, knowledge and values. You have to be able to do the right thing, know why you are doing it, and value doing well. We have a hard time measuring values.

Fabrey - Simulated patients is one way to get at values, although at one point in time. The answer may lie in some kind of continuous evaluation with patients involved.

Henderson – Peer review is a great tool for assessing things like values. Like Larry, I value reliability, but when it comes to certain things, I am willing to live with a less formal process. Peer review consisting of observation followed by a discussion with the individual to get at nuances can be a valuable way to learn and to get at the values that undergird professionalism.

Fabrey - Going back to my question about whether continued competence is different from initial competence, I think the answer probably should be yes. If you are thinking yes, what we are talking about now may be a good part of the meaning of continued competence.

Comment - Some places in the country send questionnaires to their patients, whose responses are made publicly available.

Question - As a public member, I have an expectation that every healthcare provider is competent today. As a regulator, my dilemma is how do I meet that expectation? Today, you could be a pediatric nurse and tomorrow you could be a geriatric nurse and next year someone else. How do we assess 150,000 licensees with a small budget?

Fabrey - Solve your dilemma by changing your expectation. People aren't perfect. There will be errors. There will be disciplinary actions. The solution may be to get multiple sources of input involved.

Question - Most of us are licensure based. I see private sector practices that do data analysis, evaluate their practitioners and improve performance.

Fabrey - That is a good point. Licensing boards can imitate successful models from other sectors.

Kim Edward LeBlanc, Executive Director, Clinical Skills Evaluation Collaboration (CSEC)

The Clinical Skills Evaluation Collaboration (CSEC) is an endeavor of the Educational Commission for Foreign Medical Graduates (ECFMG), which credentials foreign medical graduates to allow them to come to the US for training, and the National Board

of Medical Examiners (NBME), which administers many different examinations to assess the competency of physicians and other professionals. CSEC was begun to administer the clinical skills exam. The collaboration began in 2003.

The mission of the two organizations is to be sure that anyone practicing medicine in the US has a minimal level of competency required to enter training programs. It doesn't mean they are ready to practice medicine, per se, but it allows them to train to practice medicine. It is really a licensing exam. Medical boards use the USMLE program to assess someone's qualifications to be granted a license.

There are more than 900,000 licensed physicians in the US. Slightly fewer than 23% are foreign medical graduates. In any given year, about .51 % will be sanctioned by a licensing board, or about 4,500 individuals.

There are three steps in the USMLE process. Step one is weighted toward foundational science. Step two has two parts: clinical knowledge assessment and clinical skills assessment and is usually taken during a student's senior year. Step three is an assessment of clinical skills after one year of residency.

Prior to 2004, there was no assessment of clinical skills in the US. The precursor to the current exam was only for foreign graduates and was heavily weighted toward English proficiency. When the collaboration was formed in 2003, everyone wanting to practice medicine in the US was required to take the clinical skills evaluation. Shockingly, prior to that, nearly a third of medical students completed medical school without ever having been witnessed examining a patient. Since then, every medical school in the US has a clinical skills program.

Are the assessment results predictive? Canadian research shows that failing the clinical skills exam was a predictor for getting in trouble with medical boards, particularly with patient-physician communication and clinical decision-making. Many other studies confirm this. The three most common reasons physicians get in trouble with licensing boards are communication, communication, communication.

We know what is good and what is bad professional behavior. We know what is safe and what is not safe. The problem is that it is not always obvious when a clinician crosses the line.

We have tested over 380,000 examinees as of the end of last month. We have more than 4.5 million standardized patient encounters.

The clinical skills exam takes a whole day. There are twelve encounters with standardized patients, which is enough to have a valid and reliable exam. During the encounters, the examinees have 15 minutes with a patient. They are given a fairly common clinical scenario developed in collaboration with subject matter experts. They take a history and do an appropriate physical examination. They have to communicate and show empathy. After the encounter, examinees have a maximum of ten minutes to type patient notes.

This year we will test more than 35,500 examinees. About 21,000 will be US graduates and the remainder foreign graduates. How well do these students perform? Prior to 2013, the fail rate was around 2%. The exam has changed significantly so the failure rates went up to 4.9% for US graduates. The fail rate is now declining again.

The exam has three components: interpersonal skills; spoken English proficiency; and the Integrated Clinical Encounter, which includes history taking, physical, diagnosis and treatment plan.

What happens if someone fails? They take remedial studies and try again. The USMLE limits individuals to six attempts for any one exam. Many state medical boards' limit is 3 or 4 re-takes.

Question – Medicine has residencies. Do you think a skills assessment would be appropriate in other professions that don't have residencies?

LeBlanc – In my opinion, no licensed professional should have qualms about being tested. We can teach all we like, but we also need to assess someone's ability.

Question – Do you really need 12 encounters??

LeBlanc - For scoring purposes, we have 12 encounters and at least 11 are scored. We have ad hoc stations where we pre-test items.

Question - Can you visualize a clinical skills test being used as part an assessment of current competence for license renewal purposes?

LeBlanc - Yes. We have been asked by an organization to do this for them, particularly for individuals who want to re-enter practice. I don't know that we could do it for every physician seeking licensure renewal. It would overwhelm our system. But, licensing boards need to decide whether they would like to see that happen.

Question – My board sees nurses fired when the problem is really a team problem. I hear a lot about assessment for individuals, but how about assessing the team and the environment and the system?

LeBlanc - I agree. We are looking at adopting a team-based approach in the future. Clearly, there is always a scapegoat, but is that the right person?

Question - Please talk about how students responded to the requirement that they take this assessment.

LeBlanc - The resistance continues. Some of it is cultural. We survey everyone who completes the exam and they often comment that the exam is unnecessary because they have been assessed at school. True, but CSEC is standardized.

Comment – A system is only as strong as its weakest link. So, improving individuals contributes to improving teams.

Performance Testing – Tom Granatir, Senior Vice President, Policy and External Relations, American Board of Medical Specialties (ABMS)

I will talk about the political backlash ABMS is experiencing in opposition to Maintenance of Competence MOC requirements. There is also a sad story on the science because our ambition to measure performance exceeds our ability to do it. It is a reality we have to face.

When physicians say MOC didn't make me a better doctor, didn't have any effect on patient care, and it's invalid and never been proven, they may be right. We heard Dr. McMahon say a person can attend an educational event and get nothing out of it. In the minds of doctors and hospitals, both CME and the certification process are all about checking boxes and not about meaningful engagement to make things better.

Both of us would like to try to create a system that is innovative about assessing and improving. Dr. Fabrey asked earlier what a credentialing organization wants to assert about its credential. This is actually a tough question. It is probably not what was suggested earlier that everybody is able to perform competently in a given domain. That is not something that any certifying body can actually attest.

ABMS has 24 independent member boards that certify physicians to practice in a specialty. We are a strange kind of trade organization because we don't get to choose our members and our members don't get to choose us. The boards emerged from a joint initiative by AMA and ABMS. They decide whether it is appropriate to create a new specialty. When they do, residency programs have to be in place to provide training in that specialty. ABMS certification is very intimately linked to the creation of training programs. There are many other certification programs, many of which have strong tests, but they may not have the direct involvement in creating training in specialties.

Part of what ABMS boards do is create the standards for training and part of what they do is create an assessment at the end of training to make sure people have learned from the training and are confident they can practice in the specialty. This is not a judgment about whether they do practice well, but a judgment about whether they are capable of practicing well. That is a big distinction.

The first board (ophthalmology) was created in 1917 amidst a movement to look at the quality of medical care. The American College of Surgeons adopted the first standards for hospitals in 1917. This was part of the progressive movement in the early 20th century, which included standardizing training and evaluation of medical practice. The profession decided to separate the assessment function from the guild function. The AMA did not control the boards; they were independent from the very beginning. Four more boards were created during the next 15 years and ABMS was created as the umbrella in 1943. Now there are 24 boards. The boards set standards for themselves in the sense of establishing expectations.

Initial certification follows residency training. About 800,000 physicians are certified in a specialty. Maintenance of Certification (MOC) was approved in 2000, implemented in 2006 and revised in 2009 and 2014. About 500,000 physicians are participating in MOC. That number increases by about 50,000 a year.

At the time MOC was introduced, a decision was made for legal and political reasons to “grandfather” physicians who had been issued lifetime certifications. Research shows that skills decline over time, so two boards created in the 1960’s (Family Medicine and Emergency Medicine) decided to have no grandfathering. During the next twenty years, all the other boards moved toward the recertification requirement. Still, in the backlash we are now experiencing toward MOC, there are physicians who say they don’t want to take an MOC examination.

There isn’t any evidence that medical specialists are better doctors, but there is science to show that skills decline. There is also evidence that people can’t assess themselves. They tend to ignore what they are bad at and overestimate what they are good at.

In 1999, the boards adopted a competency framework for medical training along with the Accreditation Council for Graduate Medical Education (ACGME), which sets standards for training. There are six core competencies: professionalism, knowledge, practice and procedural skill, lifelong learning and improvement, interpersonal communication, and system-based practice. These competencies can be observed during training, but once people are out in practice it is more difficult to observe. MOC implies a philosophical shift from “Are you ready to practice?” to “How are you practicing?” This is a much harder question to answer. Interested parties all over the world are researching what it means to make care better and what at the qualities it takes to do so.

Because MOC affects people already in practice, it is not only about knowing, it is also about learning and doing and improving. There are four elements: professionalism and professional standing; lifelong learning and self-assessment; external assessment of knowledge, judgment and skills; and improvement in medical practice. There were few models for assessing improvement in medical practice so we have been developing measures – multiple measures for some specialties and sub-specialties.

The boards have taken various approaches to what the improvement in medical practice element is. Is it about measuring actual performance? A lot of the backlash we are hearing is that this is tedious work that physicians don’t feel they ought to be doing. Some of the boards (pediatrics, for example) are emphasizing participating in learning collaboratives and learning how to use data to become a better doctor. The surgeons and anesthesiologists tend to focus on more technical matters, so they have simulations and patient outcomes in terms of functional results. Other boards (obstetrics and gynecology) are focusing on making sure people are practicing according to the latest evidence. Some boards are developing registries to collect data. We don’t have a good understanding of what practice-based learning means. If physicians have to stop practice to assess themselves, that probably does not qualify as practice-based learning. The ultimate idea of an integrated system of assessment and learning that happens in practice is something we would like to see happen, but don’t know how to do it.

Meanwhile there have been some papers on the topic, including *Achieving the Potential of Health Care Performance Measures* by Robert A. Berenson, Peter J. Pronovost, and Harland M. Krumholz. These authors evaluated the kind of measures we use – process measures, outcome measures. There are limitations to both. Are outcomes attributable to

a particular physician or to a system? When we look for something, we find more of it. On the process side, was the care appropriate? Was the diagnosis right? We measure whether a physician is doing something well, but we aren't measuring whether it was the right thing to do. We don't have a way to measure that.

Their recommendations at the end of the paper are to

- Move to outcomes
- Use other QI approaches
- Measure at the organization level, not the clinician level
- Measure patient experience of care and patient-reported outcomes as ends in themselves
- Promote a rapid-learning health system
- Invest in measurement science
- Create an entity to set standards for measuring and reporting quality and cost data.

One of their recommendations is to measure at the organization level, not the individual level. But under the ACA, physicians are now going to be held accountable for a quality score computed on their participation in quality activities, quality measures, resource use metrics, and so on. The payment system is entirely dependent on being able to measure something that I'm pretty sure we can't measure.

Meanwhile, one of the things the board has been concerned about is the 10-year exam interval. We also think that studying for a test is not the best way to retain knowledge. So the boards are looking for different approaches. One option is more frequent tests with feedback; remote testing at the test-takers convenience; a more practice-relevant system; and using new technologies such as videos and simulations.

The Board of Internal Medicine, the largest board, convened its own group of experts to look at the science and make recommendations about what it is important for an internist to be able to do and whether there is a way of assessing it. They concluded the ten-year cycle should be replaced by more frequent assessments focusing on cognitive knowledge because we don't have reliable tools to assess the other competencies.

So, the science isn't great. We don't have the tools to measure all the things we think are important. Physicians are purists and are pushing back ferociously against us. They are forming alternative boards that will confuse the public about what certification actually means. We are spending a lot more of our time dealing with that than figuring out how to upgrade the science.

Simulation is attracting a lot of interest among medical educators. Family Medicine is looking at how to use data from electronic medical records to create a profile of physician performance.

One question is whether we actually need to assess every doctor. Are there ways to figure out how to look at the population and have more interventions with the people who need it the most? Computer assisted testing and predictive modeling can help us figure out where to target interventions and individualize testing requirements and their

frequency. Other boards are looking at reporting on certain “tracer” conditions, registries of variables such as certain kinds of imaging, and physician engagement in safety programs and organizational quality improvement.

Do we need different ways of evaluating physicians? What are the qualities that can be assessed locally – in context? How can we engage physicians in a positive way? We need the support of the patient community to keep pushing us to improve our tools. We need consumers to tell us what they expect.

We confront practical challenges:

- How can we reduce the data collection burden?
- Can we develop relevant measure for everybody?
- How do we capture the “non-technical” competencies?
- What qualities are best assessed locally?
- Do we need different approaches for different specialties?
- What is the best way to help physicians improve care?

There are additional philosophical challenges:

- Should we focus more on improvement science than measurement science?
- How do we focus on organizational improvement and still meaningfully assess the performance of individuals?
- How do we reconcile our focus on capabilities in a world that wants measures of actual performance?
- Should MOC assess general competence in the specialty or focus on what physicians do in practice?

Question - Do you see any concepts that licensing boards use for risk-based assessment not tied to the disciplinary process? Licensing boards have access to data about prescribing patterns, for example, but no outright authority unless there is a disciplinary complaint and investigation.

Granatir – The ABMS boards have a close relationship with state medical boards and get data about actions that have been taken. They rely heavily on state boards to do their job of identifying professional issues. A risk-based assessment that could be used as a screener is a very good idea.

Question - Please speak more about portfolio improvement. Do the doctors choose the cases to include in their portfolios?

Granatir - The intention is to get physicians meaningfully engaged in an improvement process inside their hospital. There are also community collaboratives and group practices participating in this. We are looking for organizations that have strong safety and quality enforcement and have demonstrated they can do quality improvement. They apply to sponsor the program and choose the things they want to work on inside the hospital. It started at Mayo and now there are fifty-five sponsors. We are looking for an infrastructure of quality improvement support that physicians can become engaged in.

Grady Barnhill, Director of Examination Programs, National Commission on Certification of Physician Assistants (NCCPA)

This is an exciting time to be at a conference on this topic. I agree with other speakers that we are finally getting some traction in things we have been talking about for a long time. There are lots of reasons why continuing competence is important. For example, a 2015 study of anesthesiologists found that 124 out of 277 operations included a medication error or adverse drug event.

In the mid-90's, CAC came up with the five-step model for a continuing competence program: 1) routine periodic assessment; 2) personal improvement plan; 3) implement improvement plan; 4) documentation; 5) demonstration of competence. My talk will focus on two of those steps: routine periodic assessment and demonstration of competence. Some of us feel these two might be merged, one occurs at the beginning of a renewal cycle and the other at the end. Those two points in time are not very far apart.

Looking at trends in continuing competence, we see advances around the globe. We are seeing more emphasis on reflection and on targeted assessment. The physicians and surgeons of Ontario, for example, mandate practice audits for practitioners who are 70 and older. More attention is being paid to non-technical skills, such as communication. Communication was found in one survey to be a primary factor in 43% of errors made during surgery.

Competency includes skills and attitudes, but because of push back from members of the profession and because skills and attitudes and other non-technical skills are more difficult to assess than knowledge, there is a tendency to rely heavily on multiple-choice tests of knowledge. Self-assessment, we seem to agree, is unreliable. More of an effort is being directed at approaches that are evidence-based and supported by data. The New Zealand pharmacists have a four-step program with the fourth step being evaluation and documentation of the outcomes of learning.

Some organizations are giving more points for higher quality CE. The Royal College of Physicians and Surgeons in Toronto, for example, rewards such high quality activities as accredited self-assessment and practice review and appraisal. Pharmacists in New Zealand earn a different number of points per activity depending on its quality. For example, demonstrating practice improvement earns five times more points than attending CE with no assessment.

What kinds of assessments are in use? The Pharmacy Examining Boards of Canada have for some years used objective structured clinical exams (OSCE), or standardized patients. The American Board of Anesthesiology is using a novel online assessment called the MOCA Minute. A single question is sent to every certificant's home every week with one minute to respond. The system gives feedback and direction to resources to promote learning. Answering a certain number of questions over a year is the equivalent of taking a test.

Practice reviews are increasingly in use. The National Board for Certification in Occupational Therapy (NBCOT) incorporates virtual reality in its new assessments. Some of us are using practice exams, which provide detailed feedback to the test-takers.

Should self-assessment be voluntary or mandatory? Voluntary assessments tend to be under-utilized and may work best for those who need them least.

What about length of time in practice? Research shows that knowledge is not permanent. Those in practice for longer times tend to perform less well on examinations and have poorer outcomes. A study based on a literature search published in 2005 in the Annals of Internal Medicine documented many studies showing poorer outcomes over time.

Another study implies that one reason for declining performance may be that practitioners focus on a narrow specialty while the exams they are taking are general in nature.

What is new in assessments? One example is the anesthesia crisis resource management simulator. Another is the virtual standardized patient, which can be used to take blood pressure, perform a physical, and more. The Standard Patient Hospital used in the University of Southern California assesses communication. The system can create a variety of personalities, including “average, sullen, loquacious, uncertain, reserved, and erratic.” Medical sonographers can use simulators to improve the quality of their images. A test of virtual reality skills training of professionals in alcohol screening produced this conclusion: “The technology tested in this trial is the first virtual reality simulation to demonstrate an increase in the alcohol screening and brief intervention skills of health care professionals.” Simulations used for high stakes surgery, endoscopy, and other skills are also working pretty well. The Food and Drug Administration is requiring completion of simulation training for some procedures, such as carotid stenting. Data mining of E-pelvis simulator assessments with 41 expert and 41 novice practitioners found that 92% performed correctly.

Turning to my organization and physician assistants (PAs), this is traditionally a broad-based generalist credential. Yet, our numbers are changing and now over 70% of our practitioners are specialists. How should we address the generalist vs. specialist conundrum? PAs want practice mobility among specialties, but also want to be assessed by what they do.

Is it a waste of time for a specialist to study for and pass a broad-based exam? For public protection, you want to be testing people on what they are doing, which is an argument for focusing more on testing by specialty.

For our practice analysis, we looked at PA practice over time and by specialty. We found that practice doesn't change much over time. But, how different is specialized versus general primary care practice? We interviewed 72 different practitioners in eleven different specialty areas about knowledge, skills and abilities. We had seventeen come in to talk about the general credential. We designed a large survey of more than 93,000 PAs to address all these issues. We looked at what practitioners do and what diseases and disorders they encounter in practices. We had about a 17 % participation rate.

We compared practitioners with 6 or fewer years of practice with those having more than 6 years of experience. The younger ones are more inclined to use informatics. Those with more experience spend more time negotiating contracts. The new folks more frequently recognize professional and clinical limitations. All the practitioners tend to encounter the same diseases and disorders over time. Then we compared emergency medicine with primary care (family medicine, general internal medicine, and pediatrics) and found greater variations in knowledge and skills and in the frequency of encountering conditions. The bottom line is that specialty PA practice appears to be different from general primary care practice.

We are envisioning a general primary care assessment component as an online summative / formative assessment. We will also have practice-focused modules, probably in such fields as family medicine, pediatrics, more rigorous emergency medicine, orthopedic surgery, hospital medicine, cardiology, dermatology, and so on. We are probably five years out for implementation. The worst part is that we will put this out for public comment, but what we hope is that the practitioners who are complaining bitterly about having to take this test will be more amenable to a test that is more like real life. We will, for example, let them take the assessment at home and, for some questions, consult outside resources just as they would in practice.

Question – You commented that communication is a competence issue. There is a bridge between certification organizations and regulators. Typically, regulators see a lot of issues with communication. How can we bridge on this particular competency issue?

Barnhill - Our exam is used as a de facto licensing exam and 27 states require continued certification with us for continued licensure. So it is very high stakes. One thing we have found is that “if you test it, they will teach it.” I think the best thing a certifying body can do, which would in turn impact licensing bodies, is to test communications. This has to be done through patient questionnaires or 360 behavior- based interviews, or maybe in a virtual context.

Question – My dental school teaches students that they must practice only within their current level of competency. This makes self-assessment a serious matter.

Barnhill – Your point is well taken. It has been found that self-assessments improve when practitioners are given feedback. Perhaps by providing objective information, we can improve the capacity to self-assess more accurately.

Part III – Innovations in Overcoming Stakeholder Resistance

Making Continuing Competence Fun – Paul Grace, President and Executive Director, National Board for Certification in Occupational Therapy

We started looking at continuing competency three years ago. We had a very traditional certification renewal requirement where individuals had to satisfy a predetermined number of continuing education units during a three-year cycle. Most states have licensure renewal requirements of two to three years, so we adopted a three-year cycle to

be consistent. This has been beneficial for our certificants because many of the states allow the units that individuals submit to us to be credited towards their licensure renewals.

We are accredited by the National Commission for Certifying Agencies and conform to the ISO 17024 standard. ISO and NCCA have standards related to continuing competence. We held a series of focus groups throughout the U.S. composed of certificants, educators, employers, and state regulators. A consensus emerged that we didn't want another one-size-fits-all test. Unlike the entry-level people coming out of school or finishing a training program, older individuals don't like testing. Based on the focus groups, we developed our "vary audacious goal," and I think we have met it. Our goal was to provide a virtual platform for certificants to engage in continuing competency programs. We got the idea from a session at ATP about how games are used in education. We translated that into putting serious gaming into assessment. So, we created an innovative and dynamic delivery platform for games.

Many thought our program duplicated the state licensing requirements, but our accreditation requires a certification renewal program. Also health systems were becoming interstate or regional and they wanted their therapists to be held to a national standard. That is one of the reasons we reached out to employers to determine what kind of program would fit within their business model and also support our certificants and their assistants in their jobs.

The IOM's report on continuing competency of the 21st century workforce identified major areas where healthcare, particularly allied healthcare, workers should be able to: provide client-centered care, work in professional teams, employ evidence-based practice, apply quality management, utilize informatics, and demonstrate professional responsibility. We used these as the major domain areas of our practice analysis. Then we brought together regulators, academics, certificants, and employers and did a typical practice analysis for a high-stakes certification examination.

We wanted the program to have validity so every part of the game is linked back to some aspect of the practice analysis. We identified the knowledge associated with each of IOM's domains and those knowledge areas are assessed in the game at some level. Our study did not focus exclusively on OT because we hoped the tool would be useful for other professions if it focused on knowledge that is essential for practice. (Employers have been enthusiastic about the study because they may be able to use it for professional development scenarios for their staff.) Then we assembled subject matter experts and gaming company employees to develop the games.

We wanted the games to be accessible and engaging. We also wanted to make the games generational. Millennials learn differently than Gen-Xs and Baby Boomers. So, we wanted a gaming platform adaptable to all these populations. The sweet spot was 25 to 45-year-old therapists who comprise the bulk of our population. Those individuals like the more traditional multiple-choice way of assessment. As they get younger, gaming is more attractive.

We didn't want one-size-fits-all. We didn't want gaming to interfere with actual assessment. We wanted clear and consistent graphics. We paid attention to

incorporating appropriate sound. We wanted to provide needed instruction and meaningful feedback. In addition to games, we had to develop a platform to deliver the games. They can be played on a computer or a tablet.

We know that students have an abundance of evidence at their fingertips. When they graduate, the evidence is no longer accessible unless their workplace provides it. Our board adopted a policy to provide a free subscription to the ProQuest and Refworks evidence-based database to our certificants.

There is little research about using serious games in assessment. We are sponsoring a post-doctoral student at the University of Florida who will follow up with OTs and their patients to determine whether this program makes a difference in practice. So we hope over time we will have enough data to be able to report about the effectiveness of our games.

We called our program the Navigator because we hope it guides users to the place they want to be. The game begins with a self-reflective computer-based questionnaire. Individuals enter their current practice area and the computer selects the appropriate case simulations, multiple-choice quizzes, and match play games accordingly. It is possible to override the computer and select additional games if, for example, someone is considering transitioning to another specialty area. The multiple choice mini-practice quizzes are developed with references and reading lists to enable certificants to learn more about the topic areas. The match games include one developed by a group of organizational psychologists to teach people who have not attended graduate school how to locate and use evidence in practice. There are also common self-assessment tools. Certificants earn professional development units (PDUs) by completing the games. Seventeen states currently recognize the PDUs obtained this way. They also get feedback showing where they fall within the cohort of people who have played the same games.

Where are we today? We did a soft launch of the program in early June. As of two weeks ago, 16,341 games had been played by more than 6,000 occupational therapists. The feedback has been positive. Academics have asked to incorporate the program into their curriculums. Employers are interested because the games not only support a therapist's continuing education but also reveal the areas where continuing education is especially needed.

Editorial Note: Much of Mr. Grace's presentation was video taken from the recertification link on the NBCOT website, which can be found here:
<http://www.nbcot.org/certification-renewal>.

Question – Is it safe to say that as a therapist's scores improve, their patient outcomes improve?

Grace - The research initiative we are supporting will give us some insight into that. Based on the feedback we are getting we are fairly confident the program is improving patient care.

Question - Are the games required?

Grace – No, this is one option for earning PDUs.

Question - How do you plan to update the content?

Grace – We have a development team and an ongoing practice team. Some of the original games are already being reviewed for modification. We re-check the references annually to be sure they are up-to-date. It is very expensive. Other certifiers have asked if we can make the platform available. We haven't decided about that. We make the games available to certificants free of charge because we think it is a value proposition to our certificants. We wanted a product that meets our accreditation needs and is attractive to certificants.

Deeming to Avoid Duplicative Requirements – David Swankin, President and CEO, Citizen Advocacy Center, CAC

My remarks are derived from excerpts from a report that Becky LeBuhn, Richard Morrison and I wrote and AARP published in July 2006 entitled *Implementing Continuing Competency Requirements for Healthcare Practitioners*. (<http://www.cacenter.org/files/ImplementingContinuingCompetencyRequirements.pdf>).

The report contained a number of recommendations, including:

Licensing boards should grant deemed status to continuing competence programs administered by voluntary credentialing and specialty boards or by hospitals and other healthcare delivery institutions when the private programs meet board-established standards. Boards must require organizations to meet or exceed the standards applicable to licensees who choose to demonstrate their continuing competence through board-administered continuing competence programs.

This recommendation assumes that boards have programs that can serve as benchmarks and that they can measure the effectiveness of credentialing organization programs against the benchmarks. Most boards don't meet those assumptions, but they could evaluate outside private programs against a standard. This is how we explained our rationale for the recommendation.

We raised two questions: How should state legislatures take into account the relationship between continuing competence requirements of licensing boards and those of specialty certification boards? Should current board certification satisfy a licensing board when a licensee again demonstrated his or her competence? This was our answer:

State legislatures need to provide guidance to licensing boards on implementing a continuing competence mandate. Within certain parameters, legislatures should empower boards to issue rules and regulations specifying acceptable methods for assessing and demonstrating competence. Legislatures should also empower boards to recognize a variety of acceptable pathways by which licensees can demonstrate their continuing competence. For example, boards might be

authorized to recognize (deem) outside organizations as the boards' agents in enforcing continuing competency requirements because few if any licensing boards have the resources to implement universal competency requirements. Moreover, such an effort by boards could unnecessarily duplicate sound assessment and demonstration programs already administered by other organizations.

On that point, Ed spoke yesterday about our efforts in Virginia to get legislation passed and he mentioned that there was not overt opposition by the medical society or the nurse's association, but we don't know what went on behind the scenes because no one voted for the legislation. Since 90% of physicians in Virginia are board-certified, the board would have to concern itself with only 10% of the physicians licensed in the state. That stopped the conversation for a while. Medicine has the highest percentage of board-certified licensees, so this fix won't work as well for other professions. Back to the publication:

To be consistent with current regulatory practice, for a licensing board to recognize a credential awarded by a private entity, for example, a specialty certification board, a professional association, a hospital credentialing committee, as evidence that a licensee has demonstrated continuing competence. Many boards already deem that individuals meet education and examination requirements for initial licensure by successfully completing programs recognized by the board or accredited by an independent agency recognized by the board as well as CE programs, in which a mandated requirement they be satisfied by completing courses that meet the standards of an independent accrediting agency. Legislatures and boards would have to identify the criteria that outside organizations would be required to meet in order to earn deemed status. Several acceptable approaches are possible. Legislators could choose to legislate some or all of the criteria for granting deemed status to private organizations. They could direct licensing boards to establish the deeming criteria via rules and regulations. Or, the legislatures could establish the criteria in broad policy terms and allow the boards to fill in the specifics by rulemaking. Whatever the approach, it is essential that any program for evaluating current competence be equivalent in terms of public protection to the program a licensing board establishes on its own for periodically evaluating and verifying the continued competence of its licensees.

Private voluntary specialty certification boards will likely seek deemed status from their professional licensing boards. In some professions, states already accept board certification as evidence of qualification for initial licensure. In many professions, specialty certification indicates that the practitioner has met a higher standard, as opposed to maintaining minimum acceptable competence, which is the most that a regulatory body traditionally can require under their laws. Therefore, regulatory boards may not be empowered to require specialty certification as evidence of continuing competence, but they could offer it as an option for meeting the legal continuing competence requirement of those licensees who choose to earn a specialty certification. However, no licensee

should be put in danger of having their license taken away or legally restricted unless they fail to meet statutory minimum competency standards.

The number of specialty certification organizations varies widely by profession. Medical specialty boards are numerous and by some estimates about 90% of all licensed physicians are certified by specialty board. The American Board of Nursing Specialties has 26 member boards in the United States (as of 2006), one of which is the American Nurses Credentialing Center, an ANA-sponsored organization that certifies 135,000 nurses in more than 50 specialties. It is estimated that only about four percent of pharmacists are board certified. In other health professions, there are no specialty certification boards at all. Some specialty certification boards have recertification programs requiring maintenance of competence, ongoing lifelong learning based on assessment and demonstrations of continuing competence. The most developed of these is the American Board of Medical Specialties program.

In addition, all certification programs accredited by the National Commission on Certifying Agencies (NCCA) must require periodic recertification, although for many the requirement can be satisfied by documenting CE credits. In 2002, CAC surveyed certification bodies in a variety of health professions and found that at that time, 95% of the forty-four responding boards require practicing certificants to demonstrate their competence periodically, 86% of them allowed their certificants to meet their continued competence requirements by taking approved CE not based on assessment. This is changing rapidly.

Before granting deemed status, licensing boards need to evaluate and assess the specific requirements of each voluntary certification board against the licensing board's own requirements. Certification bodies that allow their certificants to fulfill recertification requirements simply by taking continuing education courses should be found inadequate. Likewise, portfolio requirements based solely on self-reflection and continuing professional development programs that contain only competence improvement steps also would not have the necessary rigor in our view.

AARP has articulated principles for according deemed status, including the following seven criteria:

- State boards retain full authority to enforce all regulatory requirements,
- Reliance on deemed status is subject to full and open public comment,
- The public has ready access to deemed status organization's standards and measures,
- Information about individuals, including their qualifications and affiliations, who conduct reviews on behalf of the deemed status organizations are made public,
- Surveys conducted by deemed status organizations are validated periodically,

- The results of deemed status organization’s review process are public, and
- Deemed status organizations have no conflicts of interest with, and are independent of those entities they approve or accredit.

Turning to another document from the Credentialing Resources Center Daily published in August 18, 2015 and entitled, *The Medical Staff’s Guide to Overcoming Competence Assessment Challenges*:

After a practitioner completes his or her initial focused professional practice evaluation, the (hospital) medical staff is responsible for monitoring his or her competence on an ongoing basis. The following excerpt from the Medical Staff Guide to Outcome Competence Assessment Challenges describes what data needs to be tracked to ensure a practitioner is currently competent.... Often, negligent credentialing claims are based on allegations that the organization failed to ensure that a practitioner was competent to provide specified care, treatment, or services. Organizations should ensure that they have done their due diligence to not only verify initial competence but to also establish a comprehensive process to monitor and review practitioners’ ongoing competence.

Monitoring a practitioner’s overall performance is a comprehensive, data-driven process. Most organizations collate these data into a central department for tracking and trending and/or use commercially available databases to help streamline the process. Performance data that should be monitored on an ongoing basis include but are not limited to the following:

- Department-specific quality metrics
- Quality metrics identified by the organization that can be tracked and measured for each practitioner (e.g., average length of patient stay as noted in the example above, unplanned returns to the emergency department or ICU, timely patient discharge, etc.)
- Compliance with medical record documentation requirements (e.g., countersignatures; appropriate documentation of verbal orders; thorough, accurate, and timely documentation; etc.)
- Medication reconciliation compliance (e.g., review any discrepancies noted by the pharmacy or error rates attributed to the practitioner)
- Complaints or grievances reported from patients/families
- Performance concerns documented by the department chair (e.g., collegiality, meeting attendance, feedback from medical students/residents, etc.)
- Peer review data (e.g., clinical or behavioral concerns, policy or compliance violations, etc.)
- Maintenance of current credentials (e.g., number of times practitioner allowed license, Drug Enforcement Administration, insurance, or other credentials to expire, resulting in automatic suspension)
- Ongoing monitoring of state medical board investigations/sanctions, National Practitioner Data Bank (NPDB) updates, and Office of Inspector

- General (OIG) queries to ensure the practitioner is not on the excluded parties list
- Complaints or concerns reported from employees, the compliance department, or peers
- Overall compliance with hospital policies, code of conduct, medical staff bylaws, and rules and regulations
- Data from patient/family satisfaction surveys
- Any other data identified by the organization as being meaningful and measurable performance data. (Source: <http://www.credentialingresourcecenter.com/news/assessing-ongoing-competence>)

CAC is aware of a study of peer review in California. The study showed that some hospitals used peer review as a vehicle for improving quality. Others didn't. If a licensing board set standards for peer review it would have to have the staff, the will and the resources to implement the standards. It is hard to see how a board in a large state with many hospitals would be able to evaluate them all. It is a wonderful idea, but it would be difficult to implement unless the board used third parties, such as accrediting organizations. Or, boards could rule that all magnet hospitals could have deemed status. If boards had their own program for requiring demonstrations of continuing competence as a condition of re-licensure, it would be easier to measure an outside program against the board's program.

Netia Miles, Licensing Manager, Oregon Medical Board

I am here to talk about how the Oregon Medical Board assesses current competence. The Oregon Board recognizes that continuing medical education credits and courses relevant to one's practice are just one important element used for competence assessment during a medical career. Given that, there are four competency assessment areas in which physicians earn continuing medical education (CME) credits: licensure renewal, re-entry to practice, license status change and investigative process resulting in board orders.

We license about 21,000 practitioners, the largest group being physicians and physician assistants. The average professional with no identified issues or problems may participate in maintenance of certification. For those who don't participate in maintenance of certification, we require 60 hours of CME every two years for physicians and physician assistants and 30 hours of CME every two years for acupuncturists. The CME credits must be relevant to the licensee's practice.

The board requires any licensed physician who has been out of practice for two years or more to design a re-entry plan. The re-entry plan is influenced by a number of factors, including the number of years of active practice before the hiatus, the number of years out of practice, and the number of years of specialization. A re-entry plan may include supplemental training or mentorship, CME, re-certification, or passing a national exam. In some circumstances, the board may require a licensee to pass a standardized and validated competency assessment. They also may be required to engage in computer-

bases simulations or undergo evaluation by third-party assessor or board-approved clinician.

The reason for documenting license status is that it enhances patient safety and allows the board to know who is practicing in our state and that they are practicing at the appropriate capacity. For the sake of time I will discuss only two categories: active and inactive. Active status means actively practicing in the state at a current Oregon practice address. A practitioner who changes to out-of-state practice is subject to being changed to inactive. Some licensees who remain in state but choose to cease practice still want to maintain a licensed status. They can have an inactive status.

Those who want to change from inactive to active status go through a reactivation process, which is an abridged version of the application process. It allows us to review what the individual has been doing while out of practice. If they have been practicing in another state, the board would initiate a license verification to establish that they are in good standing. If they have not been in practice for at least two or more years, the re-licensure process comes into play. We establish competency and ask for a background check.

The last situation in which continuing competency is assessed is when licensees go through the investigatory process. The investigatory committee interviews every licensee who has an open investigation. The committee has the power to evaluate competency and request an evaluation of the licensee's practice. The committee can send the licensee for targeted CME and/or call in a consultant for specialized case reviews.

In 2014, we closed 730 investigative cases. Approximately 9% (64 licensees) of those resulted in board orders. As a condition of these orders, a compliance officer travels around the state and makes random visits to do competency assessments, records reviews, and the like. We might send physicians to outside organizations, such as CPEP or substance abuse programs. The licensee also can be subject to random review and interview by the board and assignment to CME.

Question – I'm intrigued by deemed status. I think it opens up a lot of possibilities. My question is when there is a problem down the road related to an organization that has been approved for deemed status? Can the board view that organization's records?

Miles – If we start an investigation we look for any and all records, so I believe we would have access to the records of an organization with deemed status.

Swankin – If the board accepts a licensee's demonstration of competence through another organization's program, the licensee would waive any personal right to keep records confidential.

Question - You said there are two routes for licensure renewal. Approximately what percentage of licensees renews through the MOC program vs. the CME program? Do

you accept certifications from entities other than ABMS? Also, do you collect any data comparing outcomes for the two groups?

Miles - Currently, we are considering whether to accept other certification organizations in addition to ABMS. We audit 10% of licensees for compliance every renewal year. I can't give you percentages, but the number of people complying via MOC is definitely increasing.

Comment – In Washington State, the pharmacy commission recognizes CE approved by the American College of Pharmaceutical Education, which has a large CE approval mission. We also deem CE approved by other boards of pharmacy. We also have a process whereby the commission can approve a provider of CE for a two-year period. We can pre-approve programs or post-approve at the request of a pharmacist. We don't have deeming of hospitals. I don't know what the rules would look like if we did.

Comment – Washington State's Nursing Commission is overwhelmed with applications for CE because there are schools popping up everywhere, including remote and virtual CE sites and we have to review them all. Also, there is a term used in a previous law because we didn't have enough nurses. The law says "non-traditional" schools can apply to certify nurses to come into our state to practice. We could use some help from CAC to clarify the meaning of "non-traditional." To us, it means the students do not have to have clinical oversight by an RN or LPN. This is a huge gap, so we are trying to repeal the law.

Question – When the compliance officer does a site visit, does he or she interview anyone in addition to the licensee in question?

Miles – It depends on the circumstance. We can interview colleagues. The complainant and family members may also be interviewed.

Comment – The Maryland Board of Pharmacy enacted regulations allowing it to excuse a certified pharmacist from some of our mandates for CE or competency assessment. We will seek statutory authority next year.

Rewarding Good Marks in Self- Evaluation – Cyndi Miller Murphy, Executive Director, Oncology Nursing Certification Corporation (ONCC)

ONCC was founded in 1984. We now have eight certifications in various roles and subspecialties in oncology nursing. We are NCCA accredited. We currently have more than 37,000 certificants.

We have a four-year recertification cycle. For the first ten years we required re-testing, which was not popular. Our renewal rate was only about 59% for the basic exam and about 70% for the advanced exam. In 2000, we moved into something we call the "oncology nursing points renewal option" (ONPRO). This raised our recertification rate to about 75% for the basic exam. This benchmarks well against other nursing

certification organizations. All nurses need to get either 100 or 125 points, depending on whether they are at the basic or advanced level. In 2013, we began moving toward the “individual learning needs assessment (ILNA) approach. It will be phased in during 2016. In developing this approach, we sought input from oncology nurses, employers, educators, and the public. We looked closely at what other organizations are doing and what seems to be working. We patterned the ILNA program after NCC, but we are not as far along.

Let me say some more about the current system because I want to contrast it with the new system. ONPRO is used by about 95% of the candidates for renewal. Other options include taking the test, and several hundred candidates do. Eligibility criteria include an unencumbered RN or APRN license and active practice in nursing and a specialty. Nurses not in active practice take the test and meet the ONPRO requirements.

We have a four-year cycle. Holders of the basic credential must accrue 100 points during the four years. One point equals one hour of CE or CNE, presentations, publishing, or taking academic courses in an oncology specialty. Twenty percent of the points can be volunteer service or precepting students.

The ILNA is a better approach because it is individualized. Everyone has his or her own requirements based on their learning needs identified through assessment. It is not self-assessment, but one ONCC administers. We think this is better because it doesn't allow people to choose courses simply because they are convenient, free, fun, or about something they are already good at. We want to make sure certificants are closing gaps in knowledge rather than reinforcing their strengths.

ILNA is an option. The same eligibility criteria apply. The cycle remains four years. The main difference is the number and content of points, which are based on how an individual performs on the assessment. The assessment is based on our content outline, just like the examination is. We give them a diagnostic score report which tells them the categories in which they need to earn points. I think the majority of nurses continue to use CNE, but we still accept the other types of professional development we do for ONPRO, except volunteer service and precepting because that can't be categorized into specific content areas.

We decided to move forward with ILNA in 2011 and to phase it in over four years. People need to know what is coming and adjust to change. Our first cohort is people who certified or renewed in 2012. We did lots of communication. We have a video on our website fully explaining the process. We sent out emails and paper mail, did presentations at every opportunity.

The first cohort of candidates certifying for the first time in 2012 got their diagnostics when they took their test. Those renewing went online to take the assessment and get a diagnostic report to guide them for the next four years. So, in 2016, that first cohort will submit their points accrued under the new system.

Point accrual is tracked through the Learning Builder platform. We needed an online system to track the individual needs and development activities. The diagnostic report and corresponding learning plan is online, accessible by the certificant and ONCC. Certificants document their points in this personalized file.

The assessment itself begins with a survey where the candidate rates his or her knowledge. So far, the data shows people are not good at identifying their learning needs. The second part is a tutorial showing them how to use the assessment. It is similar to the exam, but in a low-key environment. They can take it online at home or at work.

The items are like items on the exam. It is weighted the same way. There are alternate items types that are not on the exam. There is no fee to take the assessment. We did not want cost to be a barrier.

Security measures include access only to those with a profile, randomized items, a required agreement not to share items, and so on. The assessment must be completed in two hours and no re-entry is allowed.

The diagnostic report indicates scores according to content areas. The points required for each area depend on the weighting of the category in the test blueprint. The minimum number of required points is 25, no matter how well the candidate does on the assessment.

So, the system is pretty simple and many nurses will need fewer points than before. We thought certificants would be happy about this, and many more than are. However, many perceive this as a test, which they don't see why they have to take. People resist change. We've received negative feedback, often based on a lack of understanding despite our efforts to communicate. I wish we could come up with a better term than "assessment."

We expected increased workload and costs for ONCC. We didn't anticipate the degree to which certificants would need help using the system. Many don't understand they must take the assessment before doing CE. Nor did we anticipate a lack of vendor understanding. We didn't expect to be accused of using this as a revenue stream for ONCC, since it doesn't cost the certificants anything and most end up paying less for CE. They are having difficulty matching continuing professional development activities with the needed learning content.

So far, 67% of the cohort renewing in 2016 have taken the assessment. Fifty-one percent of those renewing in 2017 and 41% of those renewing in 2018 have taken the assessment. The average number of points needed after the assessment is about a third of the 100 needed under ONPRO. Candidate feedback is improving gradually. In 2013, 72% found the assessment results useful in guiding professional development. That number was 84% in 2015. Similarly, 70% were satisfied with the process in 2013; 78% in 2015. We feel it will take 3 or 4 certification cycles for the necessary culture change and no more resistance.

Fran Byrd, Director Strategic Initiatives, National Certification Corporation (NCC)

The National Certification Corporation (NCC) is a private not-for-profit certification organization that has since 1975 awarded over 120,000 credentials to APRNs in the fields of inpatient obstetrics, neonatology, and women's health. All eight of our programs are NCCA accredited.

Our evolution into a continuing competency initiative has been a long process. The board followed the reports of the Pew Health Professions Commission, of the Institute of Medicine, and of CAC's wonderful resources and reports. In 2007 NCC did its own study with a group of certified women's health care nurses, letting them self-assess what they felt were their knowledge gaps and giving them a 100-item exam to see how well they assessed themselves. As you have heard multiple times, professionals do not appropriately self-assess their knowledge needs. So, the board decided it was time to move forward toward a third party process.

What do our certificants think they are gaining from this program? Notable benefits to them are that it does provide a third party mechanism to align their knowledge competency with their certification maintenance activities. It tailors their CE requirement for certification maintenance to their individual knowledge gaps based on their personal assessment results. The results are a personalized continuing education plan, which may well have fewer requirements than the prior one size fits all shotgun approach. The assessment approach does not threaten their certification status because it is just one available alternative.

There is no increase in the maximum number of CE hours required. Under the current program, 50 hours is the standard. We give them 5 hours of CE for taking the assessment. There is no mandate to take NCC CE modules. There are multiple acceptable accredited resources for CE. There is no increase in the recertification fee.

The major components of the specialty assessment process began with an orientation phase in which we encouraged certificants to just try it out. The second phase was a binding program beginning with the 2014 maintenance cycle. It involves a 125-item assessment with content and distribution reflective of the core certification exams. We recommend completion as early in the maintenance cycle as possible. We offer an early-taker option. The critical point is that no CE credits are acceptable before taking the assessment.

The assessment is available on demand from any computer, tablet or phone, except at locations that have maximum firewalls and spam filters. It does provide individual feedback using a customized education plan. Results for each competency area are tabulated in an index rating from one to ten. The board determined that for ratings of 7.5 or higher, NCC would not expect CE in that maintenance area. This gives them the option of being able to opt out of directed CE in a particular area. Individuals that have 7.5 ratings still have to do a baseline of fifteen hours of CE in categories of their choice

as long as they are obviously related to their specialty. They can earn baseline credits in some of the alternate ways, such as academic credits, presenting at an accredited CE conference, precepting, and so on.

Upon completion of the assessment, an individualized development plan populates the certificants personal online account. It tells them their index rating and the CE hours required. The report doesn't focus on items, but on those general areas within their core knowledge competency where they could use more work. This is to make it easier for those certificants who have doubts about the system or how it works. The individual codes and enters CE hours in their online account as they are accrued.

NCC's program began before ONCC's, so we are probably past the peak of the wave of alarm and opposition to change. During the orientation phase over 42,000 availed themselves of that opportunity. As a three weeks ago 54,369 of those who are due to renew in 2016 had completed their assessments or had locked in an alternative maintenance plan. This is 76% of the 71,147 who are due to take the assessment. This demonstrates that push back is gradually decreasing.

One of the best resources we provide is a CE coding catalogue for each one of our specialties. And, we are working with larger membership organizations to help them code their annual conferences.

I have been on the receiving end of emails from our certificants who are unhappy about this program, but I really feel the trend is getting more positive. In 2010 the general response was push back. Certificants were convinced we did this solely to make money. Now people are less hostile, even enthusiastic about it.

Looking back, what would we change? The orientation phase really threw people off. They thought they had already done it, so they didn't do it again when it went live. We probably should have let them use the orientation phase results for their first cycle. Looking forward, certificants will get different forms in different years. In the next cycle, individuals may get a repeat of the first form they received because we want to see if they are retaining anything.

Yesterday, I heard many speakers say we really don't have the scientific evidence we need. I think you sometimes have to go with your gut and we feel this is the right thing to do.

Question – Do other specialized certificates do this type of competency assessment?

Miller-Murphy – I don't know how many other similar programs there are.

Question – Is it a challenge to come up with enough items for multiple specialty areas?

Miller-Murphy - Yes, some of the categories are small and it is a challenge to come up with items. That is why we want to collapse some of the categories.

Question – I really like the idea of doing an assessment that drives professional development plans. It seems to me the success of the program is based on the quality of the assessment. Could you talk some more about how you develop the assessment tools? How different are they than the initial exam?

Byrd – Every specialty has its own assessment, which is developed by the same process that the certification exam was developed by the content team. They review every form of the assessment before it is posted. The distribution and weighting of the assessment is based on the content outline and distribution of the existing certification examination to keep it current.

Question – Do you take into account differences between what entry-level people are expected to know and what a seasoned practitioner should know?

Byrd - We have two advanced practice certifications. Our certification exams for advanced practice are at entry into practice level because many states use them as the qualification to practice. Our other six core exams are specialty, meaning certificants have approximately two years in the field and are voluntarily coming to take the exam. The assessment is more in line with the current certification exam, which is updated with current developments in the field.

Question - Do you have security in place to verify that the assessment takers are who they say they are?

Miller-Murphy – It is an honor system. I think the two-hour timing prohibits some security breaches.

Byrd – Certificants can only access the assessment through the link into their personal account. People who want to can find a way around it.

Part IV – Reactions from The Health Profession Regulators

Moderator: Rebecca LeBuhn

Panelists:

Marianne Alexander, National Council of State Boards of Nursing

David Jones, Maryland Board of Pharmacy

Mary Jo Monahan, Association of State Social Work Boards

Netia Miles, Oregon Board of Medicine

Kathy O'Dwyer-Armev, North Carolina Board of Physical Therapy Examiner

Carol Webb, Association of State and Provincial Psychology Boards

LeBuhn – This concluding panel is composed of representatives from six health care professional regulatory bodies. They will share their observations about what they have learned in the last day and a half and how they think is applicable to fulfilling their responsibilities as regulators. I will begin by asking each panelist to tell us who you represent, and how your professions approach continuing competence in the context of re-licensure.

Jones – I'm the long-term care commissioner for the Maryland State Board of Pharmacy. I will also have some comments from the Maryland Society of Pharmacists, which deals with long-term care and geriatric patients. The most complex competency scored by the board is the one around sterile compounding, where in legislation and regulation we reference USP 797 and we expect any pharmacy and pharmacist who is doing sterile compounding to be fully compliant. Our inspectors love what they are doing they look at procedures and cleanliness. We recently had a demonstration of what inspection can do. We inspected a pharmacy where the pharmacist had completed the required CE, but on inspection we found eleven deficiencies in compliance and competence. We are working with that practitioner to strengthen his competencies.

There are separate competencies around pharmacists who wish to do immunizations. Competencies get more complex as we add more and more things that those pharmacists can do. There are competencies about the techniques of administration, competencies about explaining the risks and benefits to patients. We can add competencies about patient privacy and cultural and education sensitivities.

Recent legislation in Maryland allows pharmacists to actually administer drugs as part of the teaching process for self-administering drugs. If a patient came in with an order for insulin, for example, that pharmacist could teach the patient how to self-administer. There we had to evaluate this competency, just as we did with immunization. If the pharmacy is doing immunizations as part of routine practice there are requirements for them to maintain competencies in their policy and procedure manual, which our inspectors will look at. We keep hearing more and more requests that pharmacists have provider status where they can do more in terms of education. As we get closer to that, we added some competencies. The board recently did a survey of pharmacists and pharmacy technicians, the schools of pharmacy and some public organizations. We found some issues with pharmacists understanding what was required for medication error risk management. There were some issues around communicating those risks to prescribers and to patients. We are working on an interactive module with which pharmacists so they can demonstrate those competencies on an ongoing basis around licensure.

Armey – I represent two perspectives. I am a member of the Federation of State Boards of Physical Therapy, where I currently chair the continuing competence committee. I am also a physical therapist licensee and staff deputy director of the physical therapy board in North Carolina.

The Federation's continuing competence committee started its work by looking at the Institute of Medicine and Pew Commission reports and other studies, looking for a basis for validating a continuing competency model that they hoped all the jurisdictions would adopt. To give you some flavor for what the model currently includes, it is sort of the triangulation model discussed by Dr. Henderson where practitioners can complete a variety of types of activities in order to demonstrate competencies every two years. The Federation has a rigorous tool called Procert through which activities can be certified. As a licensee, I took the orthopedics tool and I thought it was outstanding. It included case scenarios in a multiple-choice format. Because it is voluntary, not many people are taking it. I was nervous about taking the test, but I came out with a valuable gap analysis. It is based on both time and value-added activities. Conferences, continuing education, exams, residencies and fellowships fit under the certified category. Approved activities include study groups, research, and mentoring. I don't know that the Federation is yet utilizing the data to determine the extent to which practitioners are getting the education needed to fill the identified gaps. Certainly, today has emphasized the need for better data and data analysis.

North Carolina came late to requiring anything related to continuing competence for license renewal. In 2006, the legislature did authorize us to establish mechanisms for assessing continuing competence. That phrase "assessing continuing competence" did not require high stakes testing. The intent is that the practitioner engages in some analysis to inform the continuing development plan. Is that really happening in practice? I don't think so. I still see a lot of what's fast, what's cheap, what's convenient. Our model looks similar to the Federation's but everything is self-directed except one point has to be related to jurisprudence. I have felt the needle has to move and this conference has provided a lot of information about how to do periodic assessment and get closer to being able to really assure the public that we have a legitimate basis when we say a practitioner is competent.

Miles – The Oregon Health Authority took a bill to the legislature that will mandate cultural competency for our practitioners. This will apply to active practitioners under current renewal.

Alexander – I represent the National Council of State Boards of Nursing. We have explored this topic since the early 1980's, and our goal is to find a model that is evidence-based. We regulate three types of nurses: RN, LPNs and APRNs. For RNs and LPNs, continuing competence is handled at the state level, so requirements vary across the country. APRNs are required to be nationally certified, so they take the certifying organizations' exams and meet their recertification requirements. I commend the national certifying organizations for the work they are doing. They have made real progress. I think we have entered a new era of assessments that are focused toward individuals and will help them focus on their education and bring in an element of engagement.

Some nursing boards are experimenting continuing competency assessment. The Arizona Board of Nursing, for example, developed a structured simulation assessment to examine licensees who have been reported for competency issues. The nursing boards have been looking at continuing competence from a multi-dimensional standpoint.

One of the questions I would ask is, “Where are the employers in this process?” That is something we are looking at very closely because you can have great assessment tools, but as we all know, the bottom line is practice. People can pass tests and do CE, but it doesn’t mean they are ethical or careful or free of gaps in their knowledge. We have developed a tool called the adverse events decision pathway that helps employers analyze an adverse event using Just Culture principles. It helps them decide what type of remediation is needed and whether the individual needs to be reported to the board of nursing. We are hoping that working more closely with employers will help make nursing safer.

Monahan - I am the CEO at the Association of Social Work Boards (ASWB). We serve 64 jurisdictions throughout North America. Currently there are over 500,000 licensed social workers. Clinical social work is regulated in all 50 states. Masters level social work is regulated in 46 states. And Bachelors level in 40 states. Requirements for licensure are education, experience and an exam. We develop and administer the exam for all social workers.

All jurisdictions require some form of continuing education. This ranges from 50 credits every two years to ten credits. ASWB offers the Approved Continuing Education (ACE) program. We approve providers and our jurisdictions accept our approved providers. New Jersey requires a review of individual courses, and we provide that service for them. Some states specify certain CE courses that must be taken, for example ethics, medical errors, cultural competence, and domestic violence.

Some jurisdictions require social workers moving into the state to re-take the exam if they haven’t taken it in five years. Some states require retaking the test if the license has lapsed for more than two years. Retesting may be part of a discipline requirement.

In summary, I would say that we are concerned about the efficacy of continuing education to satisfy what the public wants. Are we really protecting the public if we are not recertifying in some manner? I have just hired a second full-time person in the continuing education department and we are taking a look at going beyond continuing education to continuing competency of social workers.

Webb - I am Carol Webb, the COO for the Association of State and Provincial Psychology Boards (ASPPB). Our members are the licensing boards in 50 states and ten Canadian provinces and four U.S. Territories. We develop the national licensing exam for psychology and offer a lot of other services to our member boards. I am a psychologist and served on the Georgia board for ten years.

Several years ago ASPPB appointed a task force to look at continuing competence and make recommendations to our member boards about how to assess continuing competence. Our website has links to Guidelines for Continuing Professional Development and a Maintenance of Competence for Licensure white paper. I chaired those committees.

The Continuing Professional Development Guidelines identify the areas of activities psychologists could use to demonstrate that they are continuing their professional development (CPD). Among the activities we feel the research supports include activities that have shown over time to improve outcomes and activities that have formal feedback.

Not all states require CE or CPD for renewal. We are encouraging all states to do so. Jurisdictions have begun to adopt our guidelines. Some have experienced no resistance from psychologists in the state, but others have withstood a huge backlash from licensees about the kinds of activities that are recommended. Mind you, this doesn't include any assessment. It just requires activities in addition to CE.

I've made many presentations to psychologists about this subject in recent years. I believe boards need to assure the public that licensees maintain their competence. Our boards are complaint-driven. What we are saying is that boards have a responsibility to do more than respond to complaints and more than just require CE to ensure in an evidence-based way that our licensees maintain their competence. We are working hard, making presentations, and trying to help the boards evolve.

LeBuhn – What have you learned in the last day and a half that you plan to take home and try to apply within your various professions? Let's revisit the various themes touched on in the agenda. We began yesterday talking about consumer expectations. Each of you has implied that consumer expectations have been the motivator for professions to take a more serious look at continuing competency requirements now than, say, five years ago.

Webb – In our discussions with our boards, the AARP data was one of the things they took most seriously. Now we have other data from the nurse anesthetists that we can present as well. Public expectation is a powerful argument and rationale for the need for a demonstration of continuing competence.

Monahan - Social workers pride themselves on starting where the client is, so I talk to social workers about licensure as a social justice issue. Providing competent, ethical and safe care is important and this needs to apply not just to initial licensure, but also throughout one's career. Everyone, including social workers, educators, students, and regulars, needs to be concerned about these topics.

Alexander – I think the presentation that hit home to me was about the use of gaming. It is saying is that we have a new generation of millennials who learn in different ways and

we have to recognize the ways they learn and determine the best way to assess their knowledge.

Miles – In terms of public feedback and public protection, we are looking at what we can do to improve public awareness of who we are and what we do. Back in 2012, we worked hard to revamp our website to make it more user friendly and simple to use.

Armey – As with so many things, perception is reality. If what the public really believes is that a current license means the practitioner is competent, even if that isn't the board's definition, we need to be reaching toward meeting the public's perception so we are meeting our public protection mission. The fact that they believe that periodic reassessment is happening as part of assuring continuing competence is something I will be taking home to the organizations I am a part of.

Jones – In follow-up to the AARP data we heard yesterday, our board of pharmacy is looking at stresses in the lives of pharmacists and pharmacy technicians that may lead to a risk of medication errors. Every pharmacy reports when a patient experiences a medication error. We did a survey and found that over the course of time 32% or respondents had experienced a medication error and almost a third of them had an adverse event secondary to that medication error. When we looked at other responses, we found that almost two-thirds of pharmacists did not consider an error found before the medication was dispensed to be a true medication error so there was no follow-up whatsoever. Most scary of all, sixty-one percent of the pharmacists who responded felt we have a punitive culture, so even errors that caused patient harm were not brought to the attention of the board. We are going to convene a task force representing all the stakeholders to look at how we can create interactive modules pharmacists and technicians can use to assess the risk of medication errors.

LeBuhn - All of you mentioned continuing education. Many of you said that you are trying to expand upon CE so it is just one of many tools used to assess and demonstrate continuing competence. What did you take away from the presentations yesterday about improving continuing education, such as focusing on active rather than passive learning, approving only accredited providers, requiring licensees to pass a pre-assessment so their choice of activities addresses gaps in their knowledge and skills?

Jones – With the growth in the number of competencies pharmacists are expected to have, continuing education needs to cover the multiple competencies expected of pharmacists. We are looking at cultural competence and we were asked to recommend that this be part of CE requirements. We put resources related to this competency on our website. For those pharmacists who do specialty care, such as geriatric cares, there are available modules teaching how to do a better job of monitoring patient care, reducing overall meds, and better stewardship to avoid placing those patients at risk.

Armey - Physical therapy jurisdictions have wide variation in re-licensure requirements. Some require only CE; some use the phrase continuing competence but include elements of continuing education. I think boards have huge variation in their resources, their structure, and their operations. So the things that I think may be possible to implement are a pre-assessment based on a practice analysis and targeted professional development

activities. The Federation is re-examining its model and the concept of best practices is attractive. The breadth of activities described at this conference is impressive and the deeming aspect is really important. I think we could explore some of these things. We need to take it beyond continuing education.

Alexander – I agree with what has been said. The concept of an assessment prior to continuing education allowing the individual to focus on their needs has not been new to us, but we are glad to see that others are using it. It certainly does seem to be the trend and something that will help individuals become more competent.

Monahan – I'm taking a lot back because I feel we have a lot of work to do. One of the easier things is to prepare a mission statement and define what continuing competence really is. We can develop that at ASWB and disseminate it to our members and then engage in a more informed dialogue. I also think we can make the CE providers appreciate how they are connected to regulation and how their offerings need to be higher quality and better related to competency in practice. I am also struck by new ways of learning. Most of the CE we currently approve is a little boring. It is not interactive engaging education that people can get excited about.

Webb - A lot of the information these two days is really important and will be used by ASPPB. Our various committees came up with a pretty clear conclusion that traditional CE without an evaluation component really doesn't demonstrate continuing competence. I like self-assessment assisted by some kind of peer review or formal feedback. I find that older practitioners really oppose any kind of assessment, but the younger ones are used to being evaluated over time and they don't push back so hard. We should be aiming our programs to this younger cohort.

Question – As several speakers have said the public perception is that this is happening. When I became a public member of the board of nursing, I was surprised to see that it is not happening. What is a public member to do? What is our best approach to persuade our boards to do what the public thinks we are doing? Should we go back and work on the state level? It seems to be a lot more efficient to get the national organizations to do something. They have more influence, more power, and more money to develop some of these things. What is the best use of the public members' time and energy?

Alexander – It is a challenge we have been working on it since the early 1980's. One obstacle is the huge investment, not only for the national association and the state boards and also the licensees. It is something that will potentially determine whether they renew their licenses. We want to get it right. We have been involved in a lot of research, data analysis and evaluation of various methods.

Once we decide on the right approach, we will do a national study to evaluate whether the method distinguishes among practitioners and is predictive. These are hard to measure when somebody's license and livelihood is on the line. We did a small-scale

pilot study where we looked at various types of continuing competence to see what is predictive, what might have an association with what the manager perceived as an individual competency level. We found out that there was no association. We did find that individuals told us they like being assessed and they want to learn what their learning needs are. We are building on that pilot study and looking at how regulators can use an assessment. It is a complicated process.

Miles – As a public member, you are a liaison to the public. We hold rulemakings all the time. We need to see members of the public come in to participate in our rulemaking process. I encourage public members to find ways to get citizens to come to board rulemaking proceedings.

Webb - You have a unique perspective and licensee board members should listen to that. I do think action has to occur at the national level because they have the resources and can help bring jurisdictions together.

Jones – Bring all the public muscle you can to board meetings. Have the public contact their legislators. Have the public show up en masse at hearings. Last year, a constituent complained about care, brought it to her legislator, who held a hearing at which the board of pharmacy was represented. The public speaks loudest of all because you vote.

LeBuhn – Having been a public member and having worked over the years with CAC, I know that change may take years and years of repetition. You have to keep the subject on the agenda. You've heard the litany of publications CAC has issued over the years and we honestly think we have had an impact. We know we are not the only people who influenced the progression of thought on the subject, but we have certainly contributed. We know how difficult it is to get the public to appear at board meetings. One idea CAC is promoting is that licensing boards assemble public advisory panels comprised of various stakeholders in the community to give the licensing board advice on various subjects including the need for more meaningful continuing competency requirements for re-licensure. Associations of licensing boards could write model acts. Consumer organizations can participate in the lobbying at the state level to get model acts enacted.

Jones – Speak to the boards about remote access for the public. The board of pharmacy in Maryland will soon begin interactive webinars to include people from all over the state.

Question – I am a public member. My question is addressed to the national association representatives. Have you reached out to national consumer organizations to get their input to find out their expectations relating to competency?

Alexander – NCSBN did a Gallup poll to ascertain consumer expectations. We got the same results at the AARP study. We know what the public wants. The challenge is to do it. Public members have an important role. Our data shows that 30% of the individuals we discipline have previously been disciplined by an employer. They are passed along from institution to institution and they do not come to the attention of the board of

nursing until some huge event occurs or somebody gets fed up. You should be actively working on getting people who are unsafe and unethical reported to the board so we can improve their competence before they continue their chain of unsafe practice.

Monahan – As the head of one of the national organizations, I appreciate the focus on the consumer. We have one consumer member on our board and plan to add another one. I really appreciate the suggestion about involving consumer organizations in our work.

Comment - This has been a wonderful learning experience. Every member of every licensure board is a public member. There are many who have a secondary role. Next year, I'd like to see a much bigger room and more attendance.

Comment - I am the executive director of a national certifying organization and am here representing the Institute for Credentialing Excellence (ICE). I heard someone ask, what is the public member to do. I think this is very important. ICE has a public member on its board and certifying bodies must have a public member to be accredited by NCCA. This has been a very informative meeting.

Comment - My board relies heavily on our public members and their input. We don't get involvement from the general public unless there is a problem. When we have a disciplinary case, we don't discipline on best practice. We discipline on basic practice. So, we have to have employers and professional organizations and all of us working together to make best practice a reality.

UNFINISHED
BUSINESS
&
RULES



Oregon

Kate Brown, Governor

Board of Dentistry
1500 SW 1st Ave. Ste 770
Portland, OR 97201-5837
(971) 673-3200
Fax: (971) 673-3202

Memorandum

DATE: April 13, 2016

TO: OBD Board Members & all interested parties

FROM: Stephen Prisby, Executive Director

SUBJECT: April Board Book Tab- 5 New and Proposed rule amendments in April Board Book

Due to the number of proposed rule changes to be considered by the Board, I have included a document with all the changes for the Board to consider.

Each rule is bookmarked, and if the bookmark indicates "For Board review" then the Board will consider moving it to a Committee for further review. If the bookmark indicates "For Committee review" then it has already been moved to a Committee, and will be placed on the appropriate Committee Agenda in the future.

There are also rules that have no proposed changes in the document because those rules will be discussed by the Board. There is also one statute referenced that will be discussed as well.

This document has all the proposed rules to consider at this time, but please be aware that more rule changes are still possible.

Division 1

818-001-0082

Access to Public Records

(1) Public records not exempt from disclosure may be inspected during office hours at the Board office upon reasonable notice.

(2) Copies of public records not exempt from disclosure may be purchased [upon receipt of a written request](#). The Board may withhold copies of public records until the requestor pays for the copies.

(3) The Board establishes the following fees:

(a) \$25 per hour for the time required to locate and remove non-public records or for filling special requests;

(b) Up to ten (10) pages at no cost; more than 10 pages, \$0.50 for each page plus postage necessary to mail the copies;

(c) \$0.10 per name and address for computer-generated lists on paper or labels; \$0.20 per name and address for computer-generated lists on paper or labels sorted by specific zip code;

(d) Data files on diskette or CD:

(A) All Licensed Dentists -- \$50;

(B) All Licensed Dental Hygienists -- \$50;

(C) All Licensees -- \$100.

(e) \$60 per year for copies of minutes of all Board and committee meetings;

(f) Written verification of licensure -- \$2.50 per name; and

(g) Certificate of Standing -- \$20.

Stat. Auth.: ORS 183, 192, 670 & 679

Stats. Implemented: ORS 192.420, 192.430 & 192.440

Hist.: DE 11-1984, f. & ef. 5-17-84; DE 1-1988, f. 12-28-88, cert. ef. 2-1-89, DE 1-1989, f. 1-27-89, cert. ef. 2-1-89; Renumbered from 818-001-0080; DE 1-1990, f. 3-19-90, cert. ef. 4-2-90; DE 1-1991(Temp), f. 8-5-91, cert. ef. 8-15-91; DE 2-1991, f. & cert. ef. 12-31-91; OBD 3-1999, f. 6-25-99, cert. ef. 7-1-99

OAR 818-001-XXXX

Relief from Public Disclosure

Upon the receipt of a written request of an individual who has been disciplined by the Oregon Board of Dentistry, the Board shall remove from its website, and other publicly accessible print and electronic publications under the Board's control, all information related to disciplining the individual under ORS 679.140 and any findings and conclusions made by the Board during the disciplinary proceeding, if:

(1) The request is made 10 years or more after the date on which any disciplinary sanction ended;

(2) The individual was not disciplined for financially or physically harming a patient as determined by the Board;

(3) The individual informed the Board of the matter for which the individual was disciplined before the Board received information about the matter or otherwise had knowledge of the matter;

(4) The individual making the request, if the individual is or was a licensee, has not been subjected to other disciplinary action by the Board following the imposition of the disciplinary sanction; and

(5) The individual fully complied with all disciplinary sanctions imposed by the Board.

A-Engrossed House Bill 4095

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

Sponsored by Representative GILLIAM; Representatives CLEM, KENNEMER, LIVELY, Senator GIROD (Pre-session filed.)

SUMMARY

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

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

Declares emergency, effective on passage.

A BILL FOR AN ACT

1 Relating to dentistry; and declaring an emergency.

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

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

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

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

11 **SECTION 1. Section 2 of this 2016 Act is added to and made a part of ORS chapter 679.**

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

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

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

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

23 **(d) The individual making the request, if the individual is or was a licensee, has not been
24 subjected to other disciplinary action by the board following the imposition of the disciplinary
25 sanction; and**

26 **(e) The individual fully complied with all disciplinary sanctions imposed 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.

818-001-0087

Fees

(1) The Board adopts the following fees:

(a) Biennial License Fees:

(A) Dental —\$390;

(B) Dental — retired — \$0;

(C) Dental Faculty — \$335;

(D) Volunteer Dentist — \$0;

(E) Dental Hygiene —\$230;

(F) Dental Hygiene — retired — \$0;

(G) Volunteer Dental Hygienist — \$0.

(b) Biennial Permits, Endorsements or Certificates:

(A) Nitrous Oxide Permit — \$40;

(B) Minimal Sedation Permit — \$75;

(C) Moderate Sedation Permit — \$75;

(D) Deep Sedation Permit — \$75;

(E) General Anesthesia Permit — \$140;

(F) Radiology — \$75;

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

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

(I) Instructor Permits — \$40;

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

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

(L) Anesthesia Dental Assistant — \$50;

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

(N) Non-Resident Dental **Permit** [Background Check](#) - \$100.00;

(c) Applications for Licensure:

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

(B) Dental Faculty — \$305;

(C) Dental Hygiene — \$180;

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

(d) Examinations:

(A) Jurisprudence — \$0;

(B) Dental Specialty:

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

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

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

(e) Duplicate Wall Certificates — \$50.

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

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

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

Stat. Auth.: ORS 679 & 680

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

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

1-2013, f. 5-15-13, cert. ef. 7-1-13; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14; OBD 2-2015(Temp),
f. & cert. ef. 6-26-15 thru 12-22-15; OBD 3-2015, f. 9-8-15, cert. ef. 10-1-15

DRAFT

Division 5

818-005-0015

Criminal Records Check Process

(1) Disclosure of Information by employee applicant/employee.

(a) Preliminary to a criminal records check, an employee applicant/employee shall complete and sign the Oregon Board of Dentistry Criminal Records Request form and, if requested by the Board, a fingerprint card within three business days of having received the card. The Oregon Board of Dentistry Criminal Records Request form shall require the following information: name, birth date, Social Security Number, driver's license or identification card number, prior residency in other states, and any other identifying information deemed necessary by the Board. The Oregon Board of Dentistry Criminal Records Request form may also require details concerning any circumstance listed in OAR 818-005-00201(1).

NOTE: The Board may extend the deadline for good cause.

(b) The Board may require additional information from the employee applicant/employee as necessary to complete the criminal records check and fitness determination, such as, but not limited to, proof of identity; or additional criminal, judicial, or other background information.

(2) When the Board determines under OAR 818-005-0005 that a criminal records check is required, the Board may request or conduct a LEDS Criminal Records Check, an Oregon Criminal Records Check, a Nationwide Criminal Records Check, or any combination thereof.

Stat. Auth.: ORS 181.534, 676.303 & 679.253

Stats. Implemented: ORS 676.303 & 181.534

Hist.: OBD 4-2011, f. & cert., ef. 11-15-11

Division 12

818-012-0005

Scope of Practice

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

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

(2) Unless the dentist:

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

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

(c) Holds privileges either:

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

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

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

Stat. Auth.: ORS 679 & 680

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

Hist.: OBD 6-2001, f. & cert. ef. 1-8-01; OBD 1-2013, f. 5-15-13, cert. ef. 7-1-13; OBD 3-2013, f. 10-24-13, cert. ef. 1-1-14; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14

DRAFT

818-012-0010

Unacceptable Patient Care

The Board finds, using the criteria set forth in ORS 679. 140(4), that a licensee engages in or permits the performance of unacceptable patient care if the licensee does or permits any person to:

- (1) Provide treatment which exposes a patient to risk of harm when equivalent or better treatment with less risk to the patient is available.
- (2) Fail to seek consultation whenever the welfare of a patient would be safeguarded or advanced by having recourse to those who have special skills, knowledge and experience; provided, however, that it is not a violation of this section to omit to seek consultation if other competent licensees in the same locality and in similar circumstances would not have sought such consultation.
- (3) Fail to provide or arrange for emergency treatment for a patient currently receiving treatment.
- (4) Fail to exercise supervision required by the Dental Practice Act over any person or permit any person to perform duties for which the person is not licensed or certified.
- (5) Render services which the licensee is not licensed to provide.
- (6) Fail to comply with ORS 453.605 to 453.755 or rules adopted pursuant thereto relating to the use of x-ray machines.
- (7) Fail to maintain patient records in accordance with OAR 818-012-0070.
- (8) Fail to provide goods or services in a reasonable period of time which are due to a patient pursuant to a contract with the patient or a third party.
- (9) Attempt to perform procedures which the licensee is not capable of performing due to physical or mental disability.
- (10) Perform any procedure for which the patient or patient's guardian has not previously given informed consent provided, however, that in an emergency situation, if the patient is a minor whose guardian is unavailable or the patient is unable to respond, a licensee may render treatment in a reasonable manner according to community standards.
- (11) Use the behavior management technique of Hand Over Mouth (HOM) without first obtaining informed consent for the use of the technique.
- (12) Use the behavior management technique of Hand Over Mouth Airway Restriction (HOMAR) on any patient.
- (13) Fail to determine and document a dental justification prior to ordering a Cone Beam CT series with field greater than 6x6 cm for patients under 20 years of age where**

pathology, anatomical variation or potential treatment complications would not be readily discernible with a Full Mouth Series, Panoramic or Cephalometric radiographs.

(14) Fail to advise a patient of any treatment complications or treatment outcomes.

Stat. Auth.: ORS 679 & ORS 680

Stats. Implemented: ORS 679.140(1)(e), ORS 679.140(4) & ORS 680.100

Hist.: DE 6, f. 8-9-63, ef. 9-11-63; DE 14, f. 1-20-72, ef. 2-10-72; DE 5-1980, f. & ef. 12-26-80; DE 2-1982, f. & ef. 3-19-82; DE 5-1982, f. & ef. 5-26-82; DE 9-1984, f. & ef. 5-17-84; Renumbered from 818-010-0080; DE 3-1986, f. & ef. 3-31-86; DE 1-1988, f. 12-28-88, cert. ef. 2-1-89, DE 1-1989, f. 1-27-89, cert. ef. 2-1-89; Renumbered from 818-011-0020; DE 2-1997, f. & cert. ef. 2-20-97; DE 3-1997, f. & cert. ef. 8-27-97; OBD 7-2001, f. & cert. ef. 1-8-01

DRAFT

818-012-0030

Unprofessional Conduct

~~The Board finds that in addition to the conduct set forth in ORS 679.140(2), a licensee engages in unprofessional conduct if the licensee does or permits any person to:~~ The Board finds that in addition to the conduct set forth in ORS 679.140(2), unprofessional conduct includes, but is not limited to, the following in which a licensee does or permits any person to:

- (1) Attempt to obtain a fee by fraud, lying or misrepresentation.
- (2) Obtain~~ing~~ a fee by fraud, lying or misrepresentation.
 - (a) A licensee obtains a fee by fraud if the licensee ~~obtains a fee by~~ knowingly makinges, or permittings any person to make, a material, false statement intending that a recipient, who is unaware of the truth, rely upon the statement.
 - (b) A licensee obtains a fee by misrepresentation if the licensee obtains a fee through making or permitting any person to make a material, false statement.
 - (c) Giving cash discounts and not disclosing them to third party payors is not fraud or misrepresentation.
- (3) Offer rebates, split fees, or commissions for services rendered to a patient to any person other than a partner, employee, or employer.
- (4) Accept rebates, split fees, or commissions for services rendered to a patient from any person other than a partner, employee, or employer.
- (5) Initiate, or engage in, with a patient, any behavior with sexual connotations. The behavior can include but is not limited to, inappropriate physical touching; kissing of a sexual nature; gestures or expressions, any of which are sexualized or sexually demeaning to a patient; inappropriate procedures, including, but not limited to, disrobing and draping practices that reflect a lack of respect for the patient's privacy; or initiating inappropriate communication, verbal or written, including, but not limited to, references to a patient's body or clothing that are sexualized or sexually demeaning to a patient; and inappropriate comments or queries about the professional's or patient's sexual orientation, sexual performance, sexual fantasies, sexual problems, or sexual preferences.
- (6) Engage in an unlawful trade practice as defined in ORS 646.605 to 646.608.
- (7) Fail to present a treatment plan with estimated costs to a patient upon request of the patient or to a patient's guardian upon request of the patient's guardian.
- (8) Misrepresent any facts to a patient concerning treatment or fees.
- (9)(a) Fail to provide a patient or patient's guardian within 14 days of written request:
 - (A) Legible copies of records; and

(B) Duplicates of study models, ~~and~~ diagnostic quality radiographs, and photographs ~~of legible copies thereof~~ if the ~~y radiographs, photographs or study models~~ have been paid for.

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

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

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

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

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

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

(15) Becomes addicted to, or dependent upon, or abuses alcohol, illegal or controlled drugs, or mind altering substances, or practice with a substance use disorder diagnosis.

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

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

(18) Fail to maintain at a minimum a current BLS for Healthcare Providers certificate or its equivalent. (Effective January 2015).

(19) Conduct unbecoming a licensee or detrimental to the best interests of the public, including conduct contrary to the recognized standards of ethics of the licensee's profession or conduct that endangers the health, safety or welfare of a patient or public.

(20) Deceiving or attempting to deceive the Board, an employee of the Board, or an agent of the Board in any application or renewal, or in reference to any matter under investigation by the Board. This includes but is not limited to the omission, alteration or destruction of any record in order to obstruct or delay an investigation by the Board, or to omit, alter or falsify any information in patient or business records.

(21) Practicing with a physical or mental impairment that renders the Licensee unable or potentially unable to safely conduct the practice of dentistry or dental hygiene.

(22) Take any action, or permit any other person to take any action, to determine the identity of a complainant or witness beyond mere inquiry in an ongoing Board investigation.

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

Stat. Auth.: ORS 679 & 680

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

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

Renumbered from 818-010-0080; DE 3-1986, f. & ef. 3-31-86; DE 1-1988, f. 12-28-88, cert. ef. 2-1-89; DE 1-1989, f. 1-27-89, cert. ef. 2-1-89; Renumbered from 818-011-0020; DE 1-1990, f. 3-19-90, cert. ef. 4-2-90; DE 2-1997, f. & cert. ef. 2-20-97; OBD 3-1999, f. 6-25-99, cert. ef. 7-1-99; OBD 1-2006, f. 3-17-06, cert. ef. 4-1-06; OBD 1-2007, f. & cert. ef. 3-1-07; OBD 3-2007, f. & cert. ef. 11-30-07; OBD 1-2008, f. 11-10-08, cert. ef. 12-1-08; OBD 2-2009, f. 10-21-09, cert. ef. 11-1-09; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14; OBD 3-2015, f. 9-8-15, cert. ef. 10-1-15

679.535 Requirement to test heat sterilization device; rules. A dentist shall test, at least once per week, any autoclave or other heat sterilization device that is used by the dentist in the practice of dentistry, in order to ensure that the device is functioning properly. The Oregon Board of Dentistry shall adopt rules to implement this section. [2014 c.16 §2]

818-012-0040

Infection Control Guidelines

In determining what constitutes unacceptable patient care with respect to infection control, the Board may consider current infection control guidelines such as those of the Centers for Disease Control and Prevention and the American Dental Association. Additionally, licensees must comply with the following requirements:

- (1) Disposable gloves shall be worn whenever placing fingers into the mouth of a patient or when handling blood or saliva contaminated instruments or equipment. Appropriate hand hygiene shall be performed prior to gloving.
- (2) Masks and protective eyewear or chin-length shields shall be worn by licensees and other dental care workers when spattering of blood or other body fluids is likely.
- (3) Between each patient use, instruments or other equipment that come in contact with body fluids shall be sterilized.
- (4) Heat sterilizing devices shall be tested for proper function by means of a biological monitoring system that indicates micro-organisms kill each calendar week in which scheduled patients are treated. Testing results shall be retained by the licensee for the current calendar year and the two preceding calendar years.
- (5) Environmental surfaces that are contaminated by blood or saliva shall be disinfected with a chemical germicide which is mycobactericidal at use.
- (6) Impervious backed paper, aluminum foil, or plastic wrap may be used to cover surfaces that may be contaminated by blood or saliva and are difficult or impossible to disinfect. The cover shall be replaced between patients.
- (7) All contaminated wastes and sharps shall be disposed of according to any governmental requirements.

Stat. Auth.: ORS 679.120, 679.250(7), 680.075 & 680.150

Stats. Implemented: ORS 679.140, 679.140(4) & 680.100

Hist.: DE 1-1988, f. 12-28-88, cert. ef. 2-1-89; DE 1-1989, f. 1-27-89, cert. ef. 2-1-89; DE 2-1992, f. & cert. ef. 6-24-92; OBD 1-2004, f. 5-27-04, cert. ef. 6-1-04; OBD 1-2008, f. 11-10-08, cert. ef. 12-1-08; OBD 3-2013, f. 10-24-13, cert. ef. 1-1-14; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14

818-012-0040

Infection Control Guidelines

In determining what constitutes unacceptable patient care with respect to infection control, the Board may consider current infection control guidelines such as those of the Centers for Disease Control and Prevention and the American Dental Association.

(1) Additionally, licensees must comply with the following requirements:

(a) ~~(4)~~ Disposable gloves shall be worn whenever placing fingers into the mouth of a patient or when handling blood or saliva contaminated instruments or equipment. Appropriate hand hygiene shall be performed prior to gloving.

(b) ~~(2)~~ Masks and protective eyewear or chin-length shields shall be worn by licensees and other dental care workers when spattering of blood or other body fluids is likely.

(c) ~~(3)~~ Between each patient use, instruments or other equipment that come in contact with body fluids shall be sterilized.

(d) ~~(4)~~ Environmental surfaces that are contaminated by blood or saliva shall be disinfected with a chemical germicide which is mycobactericidal at use.

(e) ~~(5)~~ Impervious backed paper, aluminum foil, or plastic wrap may be used to cover surfaces that may be contaminated by blood or saliva and are difficult or impossible to disinfect. The cover shall be replaced between patients.

(f) ~~(6)~~ All contaminated wastes and sharps shall be disposed of according to any governmental requirements.

(2) Dentists must comply with the requirement that heat sterilizing devices shall be tested for proper function by means of a biological monitoring system that indicates micro-organisms kill each calendar week in which scheduled patients are treated. Testing results shall be retained by the **dentist licensee** for the current calendar year and the two preceding calendar years.

Stat. Auth.: ORS 679.120, 679.250(7), **679.535**, 680.075 & 680.150

Stats. Implemented: ORS 679.140, 679.140(4) & 680.100

Hist.: DE 1-1988, f. 12-28-88, cert. ef. 2-1-89; DE 1-1989, f. 1-27-89, cert. ef. 2-1-89; DE 2-1992, f. & cert. ef. 6-24-92; OBD 1-2004, f. 5-27-04, cert. ef. 6-1-04; OBD 1-2008, f. 11-10-08, cert. ef. 12-1-08; OBD 3-2013, f. 10-24-13, cert. ef. 1-1-14; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14

818-012-0060

Failure to Cooperate with Board

(1) No licensee shall:

~~(4)~~a Fail to report to the Board violations of the Dental Practice Act.

~~(2)~~b Use threats or harassment to delay or obstruct any person in providing evidence in any investigation, contested case, or other legal action instituted by the Board.

~~(3)~~c Discharge an employee based primarily on the employee's attempt to comply with or aid in the compliance with the Dental Practice Act.

~~(4)~~d Use threats or harassment to obstruct or delay the Board in carrying out its functions under the Dental Practice Act.

~~(5)~~e Deceive or attempt to deceive the Board with respect to any matter under investigation including altering or destroying any records.

~~(6)~~f Make an untrue statement on any document, letter, or application submitted to the Board.

~~(7)~~g Fail to temporarily surrender custody of original patient records to the Board when the Board makes a written request for the records. For purposes of this rule, the term records includes, but is not limited to, the jacket, treatment charts, models, radiographs, photographs, health histories, billing documents, correspondence and memoranda.

(h) Fail to attend a Board requested investigative interview or failure to fully cooperate in any way with an ongoing Board investigation.

(2) No ~~person~~ **Applicant** shall:

~~(8)~~a Deceive or attempt to deceive the Board with respect to any matter under investigation including altering or destroying any records.

~~(9)~~b Make an untrue statement on any document, letter, or application submitted to the Board.

(c) Fail to fully cooperate with the Board during the course of an investigation, including but not limited to, waiver of confidentiality privileges, except attorney-client privilege.

Stat. Auth.: ORS 679 & 680

Stats. Implemented: ORS 679.060(4), 679.170(5), 679.250(8), 679.290, 679.310(1), 680.050(4) & 680.100

Hist.: DE 9-1984, f. & ef. 5-17-84; DE 1-1988, f. 12-28-88, cert. ef. 2-1-89; DE 1-1989, f. 1-27-89, cert. ef. 2-1-89; Renumbered from 818-011-0050; DE 2-1997, f. & cert. ef. 2-20-97; OBD 1-2008, f. 11-10-08, cert. ef. 12-1-08

818-012-0070

Patient Records

(1) Each licensee shall have prepared and maintained an accurate record for each person receiving dental services, regardless of whether any fee is charged. The record shall contain the name of the licensee rendering the service and include:

(a) Name and address and, if a minor, name of guardian;

(b) Date description of examination and diagnosis;

(c) An entry that informed consent has been obtained and the date the informed consent was obtained. Documentation may be in the form of an acronym such as "PARQ" (Procedure, Alternatives, Risks and Questions) or "SOAP" (Subjective Objective Assessment Plan) or their equivalent.

(d) Date and description of treatment or services rendered;

(e) Date ~~and~~, description and documentation of informing the patient of treatment complications or treatment outcomes;

(f) Date and description of all radiographs, study models, and periodontal charting;

(g) Health history; and

(h) Date, name of, quantity of, and strength of all drugs dispensed, administered, or prescribed.

(2) Each ~~dentist~~ licensee shall have prepared and maintained an accurate record of all charges and payments for services including source of payments.

(3) Each ~~dentist~~ licensee shall maintain patient records and radiographs for at least seven years from the date of last entry unless:

(a) The patient requests the records, radiographs, and models be transferred to another ~~dentist~~ licensee who shall maintain the records and radiographs;

(b) The ~~dentist~~ licensee gives the records, radiographs, or models to the patient; or

(c) The ~~dentist~~ licensee transfers the ~~dentist's~~ licensee's practice to another ~~dentist~~ licensee who shall maintain the records and radiographs.

(4) When changing practice locations, closing a practice location or retiring, each licensee must retain patient records for the required amount of time or transfer the custody of patient records to another licensee licensed and practicing dentistry in Oregon. Transfer of patient records pursuant to this section of this rule must be reported to the Board in writing within 14 days of transfer, but not later than the effective date of the change in practice location, closure of the practice location or retirement. Failure to transfer the custody of patient records as required in this rule is unprofessional conduct.

(5) Upon the death or permanent disability of a licensee, the administrator, executor, personal representative, guardian, conservator or receiver of the former licensee must notify the Board in writing of the management arrangement for the custody and transfer of patient records. This individual must ensure the security of and access to patient records by the patient or other authorized party, and must report arrangements for permanent custody of patient records to the Board in writing within 90 days of the death of the licensee.

Stat. Auth.: ORS 679

Stats. Implemented: ORS 679.140(1)(e) & ORS 679.140(4)

Hist.: DE 9-1984, f. & ef. 5-17-84; DE 1-1988, f. 12-28-88, cert. ef. 2-1-89, DE 1-1989, f. 1-27-90, cert. ef. 2-1-90; Renumbered from 818-011-0060; DE 1-1990, f. 3-19-90, cert. ef. 4-2-90; OBD 7-2001, f. & cert. ef. 1-8-01

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Division 21

818-021-0011

Application for License to Practice Dentistry Without Further Examination

(1) The Oregon Board of Dentistry may grant a license without further examination to a dentist who holds a license to practice dentistry in another state or states if the dentist meets the requirements set forth in ORS 679.060 and 679.065 and submits to the Board satisfactory evidence of:

(a) Having graduated from a school of dentistry accredited by the Commission on Dental Accreditation of the American Dental Association; or

(b) Having graduated from a dental school located outside the United States or Canada, completion of a predoctoral dental education program of not less than two years at a dental school accredited by the Commission on Dental Accreditation of the American Dental Association or completion of a postdoctoral General Dentistry Residency program of not less than two years at a dental school accredited by the Commission on Dental Accreditation of the American Dental Association, and proficiency in the English language; and

(c) Having passed the dental clinical examination conducted by a regional testing agency or by a state dental licensing authority; and

(d) Holding an active license to practice dentistry, without restrictions, in any state; including documentation from the state dental board(s) or equivalent authority, that the applicant was issued a license to practice dentistry, without restrictions, and whether or not the licensee is, or has been, the subject of any final or pending disciplinary action; and

(e) Having conducted licensed clinical practice in Oregon, other states or in the Armed Forces of the United States, the United States Public Health Service or the United States Department of Veterans Affairs for a minimum of 3,500 hours in the five years immediately prior to application. For dentists employed by a dental education program, documentation from the dean or appropriate administration of the institution regarding length and terms of employment, the applicant's duties and responsibilities, the actual hours involved in teaching all disciplines of clinical dentistry, and any adverse actions or restrictions; and

(f) Having completed 40 hours of continuing education in accordance with the Board's continuing education requirements contained in these rules within the two years immediately preceding application.

(2) Applicants must pass the Board's Jurisprudence Examination.

(3) A dental license granted under this rule will be the same as the license held in another state; i.e., if the dentist holds a general dentistry license, the Oregon Board will issue a general (unlimited) dentistry license. If the dentist holds a license limited to the practice of a specialty, the Oregon Board will issue a license limited to the practice of that specialty. If the dentist holds more than one license, the Oregon Board will issue a dental license which is least restrictive.

Stat. Auth.: ORS 679

Stats. Implemented: ORS 679.060, 679.065, 679.070, 679.080 & 679.090

Hist.: OBD 4-1999, f. 6-25-99, cert. ef. 7-1-99; OBD 4-2001, f. & cert. ef. 1-8-01; OBD 12-2001(Temp), f. & cert. ef. 1-9-01 thru 7-7-01; OBD 14-2001(Temp), f. 8-2-01, cert. ef. 8-15-01 thru 2-10-02; OBD 15-2001, f. 12-7-01, cert. ef. 1-1-02; OBD 1-2002(Temp), f. & cert. ef. 7-17-02 thru 1-12-03; Administrative correction 4-16-03; OBD 1-2003, f. & cert. ef. 4-18-03; OBD 1-2004, f. 5-27-04, cert. ef. 6-1-04; OBD 3-2004, f. 11-23-04 cert. ef. 12-1-04; OBD 1-2006, f. 3-17-06, cert. ef. 4-1-06

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818-021-0025

Application for License to Practice Dental Hygiene Without Further Examination

(1) The Oregon Board of Dentistry may grant a license without further examination to a dental hygienist who holds a license to practice dental hygiene in another state or states if the dental hygienist meets the requirements set forth in ORS 680.040 and 680.050 and submits to the Board satisfactory evidence of:

(a) Having graduated from a dental hygiene program accredited by the Commission on Dental Accreditation of the American Dental Association; or

(b) Having graduated from a dental hygiene program located outside the United States or Canada, completion of not less than one year in a program accredited by the Commission on Dental Accreditation of the American Dental Association, and proficiency in the English language; and

(c) ~~Evidence of n~~Having passed the clinical dental hygiene examination conducted by a regional testing agency or by a state dental or dental hygiene licensing authority; and

(d) Holding an active license to practice dental hygiene, without restrictions, in any state; including documentation from the state dental board(s) or equivalent authority, that the applicant was issued a license to practice dental hygiene, without restrictions, and whether or not the licensee is, or has been, the subject of any final or pending disciplinary action; and

(e) Having conducted licensed clinical practice in Oregon, in other states or in the Armed Forces of the United States, the United States Public Health Service, the United States Department of Veterans Affairs, or teaching all disciplines of clinical dental hygiene at a dental hygiene education program accredited by the Commission on Dental Accreditation of the American Dental Association for a minimum of 3,500 hours in the five years immediately preceding application. For dental hygienists employed by a dental hygiene program, documentation from the dean or appropriate administration of the institution regarding length and terms of employment, the applicant's duties and responsibilities, the actual hours involved in teaching all disciplines of clinical dental hygiene, and any adverse actions or restrictions; and

(f) Having completed 24 hours of continuing education in accordance with the Board's continuing education requirements contained in these rules within the two years immediately preceding application.

(2) Applicants must pass the Board's Jurisprudence Examination.

Stat. Auth.: ORS 680

Stats. Implemented: ORS 680.040, 680.050, 680.060, 680.070 & 680.072

Hist.: OBD 4-1999, f. 6-25-99, cert. ef. 7-1-99; OBD 4-2001, f. & cert. ef. 1-8-01; OBD 12-2001(Temp), f. & cert. ef. 1-9-01 thru 7-7-01; OBD 14-2001(Temp), f. 8-2-01, cert. ef. 8-15-01 thru 2-10-02; OBD 15-2001, f. 12-7-01, cert. ef. 1-1-02; OBD 1-2002(Temp), f. & cert. ef. 7-17-02 thru 1-12-03; Administrative correction 4-16-03; OBD 1-2003, f. & cert. ef. 4-18-03; OBD 1-

2004, f. 5-27-04, cert. ef. 6-1-04; OBD 3-2004, f. 11-23-04 cert. ef. 12-1-04; OBD 1-2006, f. 3-17-06, cert. ef. 4-1-06; OBD 2-2009, f. 10-21-09, cert. ef. 11-1-09; OBD 4-2011, f. & cert. ef. 11-15-11

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Division 26

818-026-0010

Definitions

As used in these rules:

(1) "Anesthesia Monitor" means a person trained in monitoring patients under sedation and capable of assisting with procedures, problems and emergency incidents that may occur as a result of the sedation or secondary to an unexpected medical complication.

(2) "Anxiolysis" means the diminution or elimination of anxiety.

(3) "General Anesthesia" means a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

(4) "Deep Sedation" means a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

(5) "Moderate Sedation" means a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

(6) "Minimal Sedation" means minimally depressed level of consciousness, produced by non-intravenous pharmacological methods, that retains the patient's ability to independently and continuously maintain an airway and respond normally to tactile stimulation and verbal command. When the intent is minimal sedation for adults, the appropriate initial dosing of a single non-intravenous pharmacological method is no more than the maximum recommended dose (MRD) of a drug that can be prescribed for unmonitored home use. Nitrous oxide/oxygen may be used in combination with a single non-intravenous pharmacological method in minimal sedation.

(7) "Nitrous Oxide Sedation" means an induced, controlled state of minimal sedation, produced solely by the inhalation of a combination of nitrous oxide and oxygen in which the patient retains the ability to independently and continuously maintain an airway and to respond purposefully to physical stimulation and to verbal command.

(8) "Maximum recommended dose" (MRD) means ~~maximum Food and Drug Administration-recommended dose of a drug, as printed in Food and Drug Administration Approved labeling for~~

~~unmonitored dose.~~ maximum Food and Drug Administration (FDA) recommended dose of a drug, as printed in FDA approved labeling for unmonitored home use.

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

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

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

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

Stat. Auth.: ORS 679

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

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

818-026-0030

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

(1) A permit holder who administers sedation shall assure that drugs, drug dosages, and/or techniques used to produce sedation shall carry a margin of safety wide enough to prevent unintended deeper levels of sedation.

(2) No licensee shall induce central nervous system sedation or general anesthesia without first having obtained a permit under these rules for the level of anesthesia being induced.

(3) A licensee may be granted a permit to administer sedation or general anesthesia with documentation of training/education and/or competency in the permit category for which the licensee is applying by any one the following:

(a) Initial training/education in the permit category for which the applicant is applying shall be completed no more than two years immediately prior to application for sedation or general anesthesia permit; or

(b) If greater than two years but less than five years since completion of initial training/education, an applicant must document completion of all continuing education that would have been required for that anesthesia/permit category during that five year period following initial training; or

(c) If greater than two years but less than five years since completion of initial training/education, immediately prior to application for sedation or general anesthesia permit, current competency or experience must be documented by completion of a comprehensive review course approved by the Board in the permit category to which the applicant is applying and must consist of at least one-half (50%) of the hours required by rule for Nitrous Oxide, Minimal Sedation, Moderate Sedation and General Anesthesia Permits. Deep Sedation and General Anesthesia Permits will require at least 120 hours of general anesthesia training.

(d) An applicant for sedation or general anesthesia permit whose completion of initial training/education is greater than five years immediately prior to application, may be granted a sedation or general anesthesia permit by submitting documentation of the requested permit level from another state or jurisdiction where the applicant is also licensed to practice dentistry or dental hygiene, and provides documentation of the completion of at least 25 cases in the requested level of sedation or general anesthesia in the 12 months immediately preceding application; or

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

(4) Persons serving as anesthesia monitors in a dental office shall maintain current **certification** in **BLS for Health Care Provider certification, or its equivalent, and shall be trained in**

monitoring patient vital signs, and be competent in the use of monitoring and emergency equipment appropriate for the level of sedation utilized. (The term "competent" as used in these rules means displaying special skill or knowledge derived from training and experience.)

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

(5) A licensee holding a nitrous or minimal sedation permit, shall at all times maintain a current BLS for Health Care Provider certificate or its equivalent. A licensee holding an anesthesia permit for moderate sedation, shall at all times maintain a current BLS for Health Care Provider certificate or its equivalent, and a current Advanced Cardiac Life Support (ACLS) certificate or Pediatric Advanced Life Support (PALS) certificate, whichever is appropriate for the patient being sedated. If a licensee sedates only patients under the age of 12, only PALS is required. If a licensee sedates only patients age 12 and older, only ACLS is required. If a licensee sedates patients younger than 12 years of age as well as older than 12 years of age, both ACLS and PALS are required. For licensees with a moderate sedation permit only, successful completion of the American Dental Association's course "*Managing Sedation Complications Part 1 and 2 (Formerly Recognition and Management of Complications during Minimal and Moderate Sedation)*" at least every two years may be substituted for ACLS, but not for PALS. Advanced Cardiac Life Support (ACLS) and/or Pediatric Advanced Life Support (PALS) training do not serve as a substitute for the BLS for Health Care Provider certification or its equivalent).

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

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

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

Stat. Auth.: ORS 679 & 680

Stats. Implemented: ORS 679.250

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

818-026-0050

Minimal Sedation Permit

Minimal sedation and nitrous oxide sedation.

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

(a) Is a licensed dentist in Oregon;

(b) Maintains a current BLS for Healthcare Providers certificate or its equivalent; and

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

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

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

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

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

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

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

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

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

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

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

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

(a) Evaluate the patient;

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

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

(d) Obtain written informed consent from the patient or patient's guardian for the anesthesia. The obtaining of the informed consent shall be documented in the patient's record.

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

(5) While the patient is being treated under minimal sedation, an anesthesia monitor shall be present in the room in addition to the treatment provider. The anesthesia monitor may be the dental assistant. ~~After training, a~~ [A certified anesthesia](#) dental assistant, when directed by a dentist, may administer oral sedative agents or anxiolysis agents calculated and dispensed by a dentist under the direct supervision of a dentist.

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

(7) The patient shall be monitored as follows:

(a) Color of mucosa, skin or blood must be evaluated continually. Patients must have continuous monitoring using pulse oximetry. The patient's response to verbal stimuli, blood pressure, heart rate, and respiration shall be monitored and documented if they can reasonably be obtained.

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

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

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

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

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

(d) The patient can sit up unaided;

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

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

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

(9) Permit renewal. In order to renew a Minimal Sedation Permit, the permit holder must provide documentation of a current BLS for Healthcare Providers certificate or its equivalent. In addition, Minimal Sedation Permit holders must also complete four (4) hours of continuing education in one or more of the following areas every two years: sedation, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current BLS for Healthcare Providers certificate, or its equivalent, may not be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060.

Stat. Auth.: ORS 679

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

Hist.: OBD 6-1999, f. 6-25-99, cert. ef. 7-1-99; Administrative correction 8-12-99; OBD 3-2003, f. 9-15-03, cert. ef. 10-1-03; OBD 1-2005, f. 1-28-05, cert. ef. 2-1-05; OBD 2-2005, f. 1-31-05, cert. ef. 2-1-05; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14; OBD 4-2015, f. 9-8-15, cert. ef. 1-1-16

818-026-0055

Dental Hygiene and Dental Assistant Procedures Performed Under Nitrous Oxide or Minimal Sedation

(1) Under indirect supervision, dental hygiene procedures may be performed for a patient who is under nitrous oxide or minimal sedation under the following conditions:

(a) A licensee holding a Nitrous Oxide, Minimal, Moderate, Deep Sedation or General Anesthesia Permit administers the sedative agents;

(b) The permit holder, or an anesthesia monitor, monitors the patient; or

(c) if a dental hygienist with a nitrous oxide permit administers nitrous oxide sedation to a patient and then performs authorized procedures on the patient, an anesthesia monitor is not required to be present during the time the patient is sedated unless the permit holder leaves the patient.

(d) The permit holder performs the appropriate pre- and post-operative evaluation and discharges the patient in accordance with 818-026-0050(7) and (8).

(2) Under [in](#)direct supervision, a dental assistant may perform those procedures for which the dental assistant holds the appropriate certification for a patient who is under nitrous oxide or minimal sedation under the following conditions:

(a) A licensee holding the Nitrous Oxide, Minimal, Moderate, Deep Sedation or General Anesthesia Permit administers the sedative agents;

(b) The permit holder, or an anesthesia monitor, monitors the patient; and

(c) The permit holder performs the appropriate pre- and post-operative evaluation and discharges the patient in accordance with 818-026-0050(7) and (8).

Stat. Auth.: ORS 679 & 680

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

Hist.: OBD 3-2003, f. 9-15-03, cert. ef. 10-1-03; OBD 1-2005, f. 1-28-05, cert. ef. 2-1-05; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10; OBD 2-2012, f. 6-14-12, cert. ef. 7-1-12; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14

818-026-0060

Moderate Sedation Permit

Moderate sedation, minimal sedation, and nitrous oxide sedation.

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

(a) Is a licensed dentist in Oregon;

(b) In addition to a current BLS for Healthcare Providers certificate or its equivalent, either maintains a current Advanced Cardiac Life Support (ACLS) certificate and/or a Pediatric Advanced Life Support (PALS) certificate, whichever is appropriate for the patient being sedated. Successful completion of a board approved course on minimal/moderate sedation at least every two years may be substituted for ACLS, but not for PALS; and

(c) Satisfies one of the following criteria:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) During the administration of moderate sedation, and at all times while the patient is under moderate sedation, an anesthesia monitor, and one other person holding a current BLS for Healthcare Providers certificate or its equivalent, shall be present in the operatory, in addition to the dentist performing the dental procedures.

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

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

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

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

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

(7) The patient shall be monitored as follows:

(a) Patients must have continuous monitoring using pulse oximetry, and End-tidal CO₂ monitors. Patients with cardiovascular disease shall have continuous electrocardiograph (ECG) monitoring. The patient's blood pressure, heart rate, and respiration shall be recorded at regular intervals but at least every 15 minutes, and these recordings shall be documented in the patient record. The record must also include documentation of preoperative and postoperative vital signs, all medications administered with dosages, time intervals and route of administration. If this information cannot be obtained, the reasons shall be documented in the patient's record. A patient under moderate sedation shall be continuously monitored and shall not be left alone while under sedation;

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

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

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

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

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

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

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

(d) The patient can sit up unaided;

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

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

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

(11) ~~After adequate training, an~~ A Certified Anesthesia Dental Assistant, when directed by a dentist, may dispense oral medications that have been prepared by the dentist permit holder for oral administration to a patient under direct supervision or introduce additional anesthetic agents into an infusion line under the direct visual supervision of a dentist.

(12) Permit renewal. In order to renew a Moderate Sedation Permit, the permit holder must provide documentation of a current BLS for Healthcare Providers certificate or its equivalent; a current Advanced Cardiac Life Support (ACLS) certificate and/or a current Pediatric Advanced Life Support (PALS) certificate; Successful completion of a board approved course on

minimal/moderate sedation at least every two years may be substituted for ACLS, but not for PALS; and must complete 14 hours of continuing education in one or more of the following areas every two years: sedation, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current ACLS or PALS certification or successful completion of the American Dental Association's course "Recognition and Management of Complications during Minimal and Moderate Sedation" may be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060.

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

Stat. Auth.: ORS 679

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

Hist.: OBD 2-1998, f. 7-13-98, cert. ef. 10-1-98; OBD 1-1999, f. 2-26-99, cert. ef. 3-1-99; OBD 6-1999, f. 6-25-99, cert. ef. 7-1-99; Administrative correction 8-12-99; OBD 2-2000(Temp), f. 5-22-00, cert. ef. 5-22-00 thru 11-18-00; OBD 2-2001, f. & cert. ef. 1-8-01; OBD 3-2003, f. 9-15-03, cert. ef. 10-1-03; OBD 1-2005, f. 1-28-05, cert. ef. 2-1-05; OBD 2-2005, f. 1-31-05, cert. ef. 2-1-05; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10; OBD 2-2011(Temp), f. 5-9-11, cert. ef. 6-1-11 thru 1-27-11; OBD 4-2011, f. & cert. ef. 11-15-11; OBD 1-2013, f. 5-15-13, cert. ef. 7-1-13; OBD 3-2013, f. 10-24-13, cert. ef. 1-1-14; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14; OBD 4-2015, f. 9-8-15, cert. ef. 1-1-16

818-026-0065

Deep Sedation

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

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

(a) Is a licensed dentist in Oregon; and

(b) In addition to a current BLS for Healthcare Providers certificate or its equivalent, maintains a current Advanced Cardiac Life Support (ACLS) certificate and/or a Pediatric Advanced Life Support (PALS) certificate, whichever is appropriate for the patient being sedated.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(7) The patient shall be monitored as follows:

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

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

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

(8) A dentist shall not release a patient who has undergone deep sedation except to the care of a responsible third party. When a reversal agent is administered, the dentist shall document justification for its use and how the recovery plan was altered.

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

- (a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;
 - (b) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;
 - (c) The patient can talk and respond coherently to verbal questioning;
 - (d) The patient can sit up unaided;
 - (e) The patient can ambulate with minimal assistance; and
 - (f) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.
- (10) A discharge entry shall be made by the dentist in the patient's record indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.
- (11) ~~After adequate training, an~~ **A Certified Anesthesia Dental Assistant**, when directed by a dentist, may administer oral sedative agents calculated by a dentist or introduce additional anesthetic agents into an infusion line under the direct visual supervision of a dentist
- (12) Permit renewal. In order to renew a Deep Sedation Permit, the permit holder must provide documentation of a current BLS for Healthcare Providers certificate or its equivalent; a current Advanced Cardiac Life Support (ACLS) certificate and/or a current Pediatric Advanced Life Support (PALS) certificate; and must complete 14 hours of continuing education in one or more of the following areas every two years: sedation, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current ACLS and/or PALS certificates may be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060.

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

Stat. Auth.: ORS 679

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

Hist. : OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10; OBD 2-2011(Temp), f. 5-9-11, cert. ef. 6-1-11 thru 1-27-11; OBD 4-2011, f. & cert. ef. 11-15-11; OBD 1-2013, f. 5-15-13, cert. ef. 7-1-13; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14; OBD 4-2015, f. 9-8-15, cert. ef. 1-1-16

818-026-0070

General Anesthesia Permit

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

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

(a) Is a licensed dentist in Oregon;

(b) In addition to a current BLS for Healthcare Providers certificate or its equivalent, maintains a current Advanced Cardiac Life Support (ACLS) certificate and/or a Pediatric Advanced Life Support (PALS) certificate, whichever is appropriate for the patient being sedated, and

(c) Satisfies one of the following criteria:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(7) The patient shall be monitored as follows:

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

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

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

(8) A dentist shall not release a patient who has undergone deep sedation or general anesthesia except to the care of a responsible third party. When a reversal agent is administered, the dentist shall document justification for its use and how the recovery plan was altered.

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

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

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

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

(d) The patient can sit up unaided;

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

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

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

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

(12) Permit renewal. In order to renew a General Anesthesia Permit, the permit holder must provide documentation of a current BLS for Healthcare Providers certificate or its equivalent; a current Advanced Cardiac Life Support (ACLS) certificate and/or a current Pediatric Advanced Life Support (PALS) certificate; and must complete 14 hours of continuing education in one or

more of the following areas every two years: sedation, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current ACLS and/or PALS certificates may be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060.

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

Stat. Auth.: ORS 679

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

Hist.: OBD 2-1998, f. 7-13-98, cert. ef. 10-1-98; OBD 6-1999, f. 6-25-99, cert. ef. 7-1-99; Administrative correction 8-12-99; OBD 2-2000(Temp), f. 5-22-00, cert. ef. 5-22-00 thru 11-18-00; Administrative correction 6-21-01; OBD 3-2003, f. 9-15-03, cert. ef. 10-1-03; OBD 1-2005, f. 1-28-05, cert. ef. 2-1-05; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10; OBD 2-2011(Temp), f. 5-9-11, cert. ef. 6-1-11 thru 1-27-11; OBD 4-2011, f. & cert. ef. 11-15-11; OBD 1-2013, f. 5-15-13, cert. ef. 7-1-13; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14; OBD 4-2015, f. 9-8-15, cert. ef. 1-1-16

DRAFT

818-026-0080

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

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

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

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

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

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

(6) The qualified anesthesia provider who induces [moderate sedation, deep sedation or general](#) anesthesia shall monitor the patient's condition until the patient is discharged and record the patient's condition at discharge in the patient's dental record as required by the rules applicable to the level of anesthesia being induced. The anesthesia record shall be maintained in the patient's dental record and is the responsibility of the dentist who is performing the dental procedures.

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

Stat. Auth.: ORS 679

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

Hist.: OBD 2-1998, f. 7-13-98, cert. ef. 10-1-98; OBD 3-2003, f. 9-15-03, cert. ef. 10-1-03; OBD 1-2005, f. 1-28-05, cert. ef. 2-1-05; OBD 1-2006, f. 3-17-06, cert. ef. 4-1-06; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10; OBD 3-2015, f. 9-8-15, cert. ef. 10-1-15

Division 42

818-042-0020

Dentist and Dental Hygienist Responsibility

(1) A dentist is responsible for assuring that a dental assistant has been properly trained, has demonstrated proficiency, and is supervised in all the duties the assistant performs in the dental office. Unless otherwise specified, dental assistants shall work under indirect supervision in the dental office.

(2) A dental hygienist who works under general supervision may supervise ~~a~~ dental assistants in the dental office if the dental assistants ~~is~~ are rendering assistance to the dental hygienist in providing dental hygiene services and the dentist is not in the office to provide indirect supervision. A dental hygienist with an Expanded Practice Permit may hire and supervise ~~a~~ dental assistants who will render assistance to the dental hygienist in providing dental hygiene services.

(3) The supervising dentist or dental hygienist is responsible for assuring that all required licenses, permits or certificates are current and posted in a conspicuous place.

(4) Dental assistants who are in compliance with written training and screening protocols adopted by the Board may perform oral health screenings under general supervision.

Stat. Auth.: ORS 679 & 680

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

Hist.: OBD 9-1999, f. 8-10-99, cert. ef. 1-1-00; OBD 1-2004, f. 5-27-04, cert. ef. 6-1-04; OBD 2-2012, f. 6-14-12, cert. ef. 7-1-12

818-042-0050

Taking of X-Rays — Exposing of Radiographs

(1) A dentist may authorize the following persons to place films, adjust equipment preparatory to exposing films, and expose the films under general supervision:

(a) A dental assistant certified by the Board in radiologic proficiency; or

(b) A radiologic technologist licensed by the Oregon Board of Medical Imaging and certified by the Oregon Board of Dentistry (OBD) who has completed ten (10) clock hours in a Board approved dental radiology course and submitted a satisfactory full mouth series of radiographs to the OBD.

(2) A dentist or dental hygienist may authorize a dental assistant who has completed a course of instruction approved by the Oregon Board of Dentistry, and who has passed the written Dental Radiation Health and Safety Examination administered by the Dental Assisting National Board, or comparable exam administered by any other testing entity authorized by the Board, or other comparable requirements approved by the Oregon Board of Dentistry to place films, adjust equipment preparatory to exposing films, and expose the films under the indirect supervision of a dentist, dental hygienist, or dental assistant who holds an Oregon Radiologic Proficiency Certificate. The dental assistant must successfully complete the clinical examination within six months of the dentist [or dental hygienist](#) authorizing the assistant to take radiographs.

Stat. Auth.: ORS 679

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

Hist.: OBD 9-1999, f. 8-10-99, cert. ef. 1-1-00; OBD 2-2003, f. 7-14-03 cert. ef. 7-18-03; OBD 4-2004, f. 11-23-04 cert. ef. 12-1-04; OBD 4-2011, f. & cert. ef. 11-15-11; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14; OBD 3-2015, f. 9-8-15, cert. ef. 10-1-15

818-042-0070 EFDA Coronal Polishing (must be seen prior to release)

818-042-0070

Expanded Function Dental Assistants (EFDA)

The following duties are considered Expanded Function Duties and may be performed only after the dental assistant complies with the requirements of 818-042-0080:

- (1) Polish the coronal surfaces of teeth with a brush or rubber cup as part of oral prophylaxis to remove stains, providing that the procedure is checked by the dentist or dental hygienist prior to the patient being dismissed;
- (2) Remove temporary crowns for final cementation and clean teeth for final cementation;
- (3) Preliminarily fit crowns to check contacts or to adjust occlusion outside the mouth;
- (4) Place temporary restorative material (i.e., zinc oxide eugenol based material) in teeth providing that the patient is checked by a dentist before and after the procedure is performed;
- (5) Place and remove matrix retainers for alloy and composite restorations;
- (6) Polish amalgam or composite surfaces with a slow speed handpiece;
- (7) Remove excess supragingival cement from crowns, bridges, bands or brackets with hand instruments providing that the patient is checked by a dentist after the procedure is performed;
- (8) Fabricate temporary crowns, and temporarily cement the temporary crown. The cemented crown must be examined and approved by the dentist prior to the patient being released;
- (9) Under general supervision, when the dentist is not available and the patient is in discomfort, an EFDA may recement a temporary crown or recement a permanent crown with temporary cement for a patient of record providing that the patient is rescheduled for follow-up care by a licensed dentist as soon as is reasonably appropriate; and
- (10) Perform all aspects of teeth whitening procedures.

Stat. Auth.: ORS 679 & 680

Stats. Implemented: ORS 679.020, 679.025 & 679.250

Hist.: OBD 9-1999, f. 8-10-99, cert. ef. 1-1-00; OBD 1-2004, f. 5-27-04, cert. ef. 6-1-04; OBD 3-2005, f. 10-26-05, cert. ef. 11-1-05; OBD 2-2009, f. 10-21-09, cert. ef. 11-1-09; OBD 3-2015, f. 9-8-15, cert. ef. 10-1-15

818-042-XXXX

Expanded Function Preventive Dental Assistants (EFPDA)

The following duties are considered Expanded Function Preventive Duties and may be performed only after the dental assistant complies with the requirements of 818-042-XXXX:

(1) Polish the coronal surfaces of teeth with a brush or rubber cup as part of oral prophylaxis to remove stains; and

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

DRAFT

818-042-XXXX

Certification — Expanded Function Preventive Dental Assistants (EFPDA)

The Board may certify a dental assistant as an expanded function preventive dental assistant:

(1) By credential in accordance with OAR 818-042-0120, or

(2) If the assistant submits a completed application, pays the fee and provides evidence of;

(a) Certification of Radiologic Proficiency (OAR 818-042-0060); and satisfactory completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association; or

(b) Certification of Radiologic Proficiency (OAR 818-042-0060); and passage of the Oregon Basic or Certified Preventive Functions Dental Assistant (CPFDA) examination, and the Expanded Function Dental Assistant examination, or equivalent successor examinations, administered by the Dental Assisting National Board, Inc. (DANB), or any other testing entity authorized by the Board; and certification by an Oregon licensed dentist that the applicant has successfully polished the coronal surfaces of teeth with a brush or rubber cup as part of oral prophylaxis to remove stains on six patients; and

(c) Completion of a Board approved course in pit and fissure.

818-042-0120

Certification by Credential

(1) Dental Assistants who wish to be certified by the Board in Radiologic Proficiency or as Expanded Function Dental Assistants, ~~or as~~ Expanded Function Orthodontic Dental Assistants, or as Expanded Function Preventive Dental Assistants shall:

(a) Be certified by another state in the functions for which application is made. The training and certification requirements of the state in which the dental assistant is certified must be substantially similar to Oregon's requirements; or

(b) Have worked for at least 1,000 hours in the past two years in a dental office where such employment involved to a significant extent the functions for which certification is sought; and

(c) Shall be evaluated by a licensed dentist, using a Board approved checklist, to assure that the assistant is competent in the expanded functions.

(2) Applicants applying for certification by credential in Radiologic Proficiency must obtain certification from the Oregon Health Authority, Center for Health Protection, Radiation Protection Services, of having successfully completed training equivalent to that required by OAR 333-106-0055 or approved by the Oregon Board of Dentistry.

Stat. Auth.: ORS 679

Stats. Implemented: ORS 679.020, 679.025 & 679.250

Hist.: OBD 9-1999, f. 8-10-99, cert. ef. 1-1-00; OBD 2-2003, f. 7-14-03 cert. ef. 7-18-03; OBD 4-2004, f. 11-23-04 cert. ef. 12-1-04; OBD 3-2005, f. 10-26-05, cert. ef. 11-1-05; OBD 4-2011, f. & cert. ef. 11-15-11; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14

818-042-0130

Application for Certification by Credential

An applicant for certification by credential shall submit to the Board:

- (1) An application form approved by the Board, with the appropriate fee;
- (2) Proof of certification by another state and any other recognized certifications (such as CDA or COA certification) and a description of the examination and training required by the state in which the assistant is certified submitted from the state directly to the Board; or
- (3) Certification that the assistant has been employed for at least 1,000 hours in the past two years as a dental assistant performing the functions for which certification is being sought.
- (4) If applying for certification by credential as an EFDA, ~~or EFODA~~ or EFPDA, certification by a licensed dentist that the applicant is competent to perform the functions for which certification is sought; and
- (5) If applying for certification by credential in Radiologic Proficiency, certification from the Oregon Health Authority, Center for Health Protection, Radiation Protection Services, or the Oregon Board of Dentistry, that the applicant has met that agency's training requirements for x-ray machine operators, or other comparable requirements approved by the Oregon Board of Dentistry.

Stat. Auth.: ORS 679

Stats. Implemented: ORS 679.020, 679.025 & 679.250

Hist.: OBD 9-1999, f. 8-10-99, cert. ef. 1-1-00; OBD 2-2003, f. 7-14-03 cert. ef. 7-18-03; OBD 4-2004, f. 11-23-04 cert. ef. 12-1-04; OBD 3-2005, f. 10-26-05, cert. ef. 11-1-05; OBD 4-2011, f. & cert. ef. 11-15-11; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14

CORRESPONDENCE



Memo

To: Stephen Prisby, Executive Director
From: Stacey Kjeldgaard, Executive Director
Date: March 1, 2016
Re: EBAS

I want to personally extend an invitation to you to attend the **Ethics and Boundaries Assessment Services, LLC (EBAS), Agency Workshop, April 8 and April 9 in Greeley, Colorado**. EBAS offers a computerized essay exam that assists regulatory and licensing agencies with their disciplinary cases. The **Essay Examination for Licensed Professionals**, a five-part computerized essay exam, evaluates a licensee's overall comprehension of accepted professional standards.

At this workshop participants are given the opportunity to get a better understanding of our exam through a hands on experience. We guide participants along every step of the process, from the initial application right through to how the essay is graded, scored and results delivered. Attached is a copy of the invitation to that workshop as well as brochure giving you an overview of our exam, along with my business card.

Our computerized essay examine covers five areas of importance:

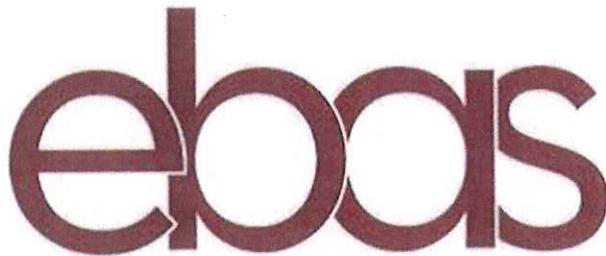
- Boundary Violations
- Fraud
- Professional Standards
- Unprofessional Conduct
- Substance Abuse

We offer four exam forms:

- General Healthcare
- Chiropractic
- Regulated Professions Outside of Healthcare
- Veterinary Medicine

We would love to have you, members from your board and/or staff in attendance.

Agency Orientation Workshop



ETHICS AND BOUNDARIES
ASSESSMENT SERVICES LLC

Springtime in the Rockies!

April 8 - 9, 2016

You are cordially invited to join us and learn more about our essay exam through a hands on experience.

- Overview of the essay examination
- Participate in writing responses to the five (5) part essay
- Introduction to the grading process with a focus on essay grading guidelines
- Interactive grader calibration training
- No charge to the Board or Agency. EBAS covers all costs to attend the workshop

At the conclusion of the weekend you will have a thorough understanding of our exam and how it can assist you assess a licensee's comprehension of ethical and boundary issues.

**For more information or to register please contact,
Stacey Kjeldgaard
EBAS Executive Director
skjeldgaard@ebas.org
888 676 3227 – ph.**

EBAS, 901 54th Avenue, Greeley, CO 80634

Ethics and Boundaries Essay Examination

Ethics and Boundaries Assessment Services, LLC (EBAS), was established in 2013 to address the post licensure testing needs of regulated professions concerning ethical and boundary issues.

A few of the unique features of the Ethics and Boundaries Essay Exam

- Essay scenarios are realistic ethics and boundary situations
- Timed essay exam
- Test is not profession specific
- Trained Graders have licensing and regulatory experience
- Multiple graders scoring each essay
- Delivered six days a week at secure testing centers throughout the U.S.
- Offers independent third party evaluation

This exam requires the individual to demonstrate an understanding of appropriate protocols and judgments relevant to their profession.

Successful completion of the essay exam requires the examinee to compose a response to scenarios, one from each of the **Test Plan** topic areas.

Test Plan

- **Boundary Violations**
Licensee with client, patient, staff including harassment concerns, both verbal and nonverbal.
- **Fraud**
Fraudulent billing, coding, falsification or alteration of any document, performing unwarranted services.
- **Professional Standards**
Quality assurance issues, negligent performance of duties, safety concerns, improper diagnoses and or treatments, improper client patient management, improper records and documentation
- **Unprofessional Conduct**
Inappropriate behavior, prescription forgery, aiding and abetting unlicensed activity, practicing with revoked suspended license.
- **Substance Abuse**
Drug and alcohol misconduct or violations

Exam Grading

Scoring of the Ethics and Boundaries Essay Examination is based on the relevance and thoroughness of response to each of the five test plan essay scenarios.

Each of the five sections of the essay has a possible maximum score of 16 points, 12 points is a passing score.

Scores below 12 points on three or more essays, the entire examination will need to be retaken with new scenarios randomly selected.

Scores below 12 points on no more than two essays, only the failed portions of the examination will need to be retaken with scenarios randomly selected.

Graders do not grade examinees from their own state.

Graders do not see the name or state of the examinee.

Types of Essays

EBAS presently offers four essay forms, relevant to examinees profession

- General Healthcare
- Regulated Professionals Outside of Healthcare
- Chiropractic
- Veterinarian Medicine

Fees

Full Exam..... \$1500
Retakes..... \$300 each Test Plan

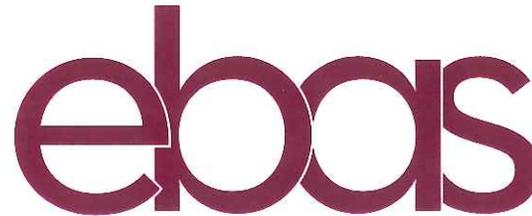
All fees are paid by the applicant

Agency Orientation Workshops

EBAS hosts Agency Orientation Workshops either at a site of your preference or on our campus. At this workshop participants are given the opportunity to get a better understanding of our exam through a hands on experience. We guide participants along every step of the process from the initial application right through to how the essay is graded, scored and results delivered.

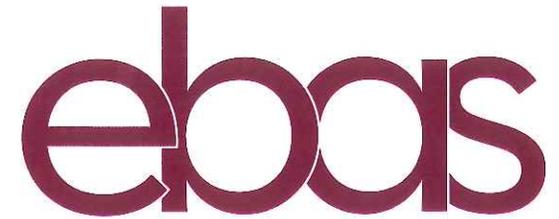
"The Ethics and Boundaries Assessment Services, LLC (EBAS) Essay Examination provides a stellar program for evaluation of a licensee's understanding of the actions which precipitated their discipline. The scoring of the essays has exemplary rigors ensuring reliability because of a comprehensive grader training process."

-William J. Rademacher, DC
Former Member, IL Medical Licensing Board



**ETHICS AND BOUNDARIES
ASSESSMENT SERVICES LLC**

Stacey Kjeldgaard
Executive Director
901 84th Avenue
Greeley, CO 80634
Office 888-676-3227
Cell 970-775-3729
skjeldgaard@ebas.org



**ETHICS AND BOUNDARIES
ASSESSMENT SERVICES LLC**

**ETHICS AND BOUNDARIES
ESSAY EXAMINATION**



Ethics and Boundaries
Assessment Services, LLC

Stacey Kjeldgaard
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Phone: 888-676-3227
Mobile: 970-775-3729

www.ebas.org





PUBLIC HEALTH DIVISION
Center for Health Protection, Radiation Protection Services

Kate Brown, Governor

Oregon
Health
Authority

800 NE Oregon Street, Suite 640
Portland, OR 97232
Voice 971-673-0490
FAX 971-673-0553

Informational Bulletin 2016-02

February 18, 2016

To: Dental Facilities X-ray Machine Registrants and Interested Parties

From: David M. Howe, Program Director 
Radiation Protection Services

Subject: Use of Lead Aprons on Patients during Dental X-Ray Procedures

The Center for Health Protection, Radiation Protection Services (RPS) is releasing this informational bulletin to notify dental facilities they are no longer required to provide the patient with a leaded apron while taking patient dental X-rays.

Oregon regulations have been repealed relating to the requirement of providing shielding to the adult patient during dental x-ray procedures. Over the last 50 years, X-ray equipment and procedures have been optimized with improved technology thereby significantly reducing radiation exposure to the patient. Lead aprons can be used as a precautionary measure if a facility chooses to use them.

RPS does recommend providing lead aprons to pregnant patients, individuals who choose to remain in the exam area during the exposure, and to any patient who requests the use of an apron. The International Atomic Energy Association (IAEA) does recommend providing a lead apron in vertex occlusal examinations which may provide some additional protection to the patient.

Thyroid collars should be provided to pediatric dental patients during x-ray examinations, especially if the thyroid could be in the direct beam. The thyroid gland, especially in children, is among the most sensitive organ to radiation which can induce both benign and malignant tumors. RPS is currently considering amending its regulations to require dental facilities to provide the pediatric patient with thyroid shielding when it will not interfere with the examination.

RPS based the above recommendations on dental lead apron use from guidance provided by the IAEA and the National Council on Radiation Protection and Measurements. If you would like further clarification, please feel free to contact Todd S. Carpenter, Radiation Protection Services, (971) 673-0500; email: Todd.s.carpenter@state.or.us.

From: Dr. Richard Dietrich, DMD [<mailto:dr@northwestportlanddental.com>]
Sent: Friday, February 26, 2016 11:31 AM
To: OBD Info
Subject: FW: Sleep Apnea in the Dental Office/ Verb Discussion with Paul

To Whom it Concerns;

Thank you Paul for discussing Oral Sleep Medicine with me today.

This letter is to request that the Oregon Board of Dentistry present in writing to the dental community their position on the relationship between Medicine and Dentistry toward diagnosis, prescribing and fabrication of oral sleep apnea appliances and snore appliances.

Thank you, Richard Dietrich

From: Dr. Richard Dietrich, DMD
Sent: Thursday, January 14, 2016 3:23 PM
To: 'information@oregondentistry.org'
Subject: Sleep Apnea in the Dental Office

To Whom it Concerns:

What is the current position of the board in terms of two questions*:

- 1.) Screening patients using a take home device, using out of state physician to interrupt the results?
 - 2.) After the Diagnosis (either via above or referral to a physician) and an oral appliance is indicated, can I as a dentist determine which type of oral appliance that I recommend?
- *This assumes that I have taken education and CE class work and understand the parameters of doing sleep appliances.

Thank you for your response.

Richard

Richard Dietrich, DMD, PC
Northwest Portland Dental
2250 NW Flanders Street, Suite 109
Portland, Oregon 97210
P. (503) 228-6294
F. (503) 228-6295
www.northwestportlanddental.com

Like us on Facebook: <https://www.facebook.com/NorthwestPortlandDental>

The PHI (Protected Health Information) contained in this e-mail is HIGHLY CONFIDENTIAL. It is intended for the exclusive use of the addressee. It is to be used only to aid in providing specific healthcare services to this patient. Any other use is a violation of federal law (HIPPA) and will be reported as such.*

CORRESPONDENCE

The Board received a letter from John L. Krump, D.D.S.

Dr. Krump sent a letter to the Board asking them to consider a rule change regarding patient records for individuals who have received dental implants. Ms. Mason moved and Dr. Magnuson seconded that this be moved to the Rules Committee for establishment of rules as this is currently an issue for dentists. The motion passed with Dr. Hongo, Dr. Schwindt, Mr. Harvey, Dr. Smith, Dr. Huddleston, Ms. Mason, Dr. Magnuson and Ms. Davidson voting aye.

The Board received a letter from Louis Malcmacher, D.D.S., M.A.G.D.

Dr. Malcmacher sent a letter to the Board, as well as several articles, in an attempt to show the Board that Botox and dermal fillers are well within the scope of the practice of Dentistry.

The Board received a letter from Samuel A. Fleishman, M.D.

Dr. Fleishman sent a letter to the Board asking for their professional opinion regarding the scope of Dentistry as it pertains to dentists and some recent advertising claims that dentists are within their scope of practice to diagnose sleep apnea by utilizing home sleep tests. The Board directed Mr. Braatz to respond with a letter stating that, "The ordering, interpreting and managing of tests for sleep apnea is outside the scope of dentistry, whereas making the appliance is well within the scope of dentistry."

Patrick D. Braatz
Executive Director

October 9, 2012

Samuel A. Fleishman, MD., President
American Academy of Sleep Medicine
2510 North Frontage Road
Darien, IL 60561-1511

Dear Dr. Fleischman:

The Oregon Board of Dentistry (OBD) reviewed your letter of September 6, 2012 at the October 5, 2012 Board Meeting and they have directed me to respond to you.

The OBD agrees that the scope of Dentistry as interpreted by the OBD would not include administering or conducting a diagnostic test for the purpose of determining a medial disease.

The OBB agrees that an oral appliance configured and fitted by an Oregon Licensed Dentist is within the scope of ORS 676.010(6).

If you have any further questions, please feel free to contact me.

Sincerely yours,

Patrick D. Braatz
Executive Director

Patrick D. Braatz
Executive Director

December 19, 2012

Shawn Murray, Chair
Oregon Board Denture Technology
Oregon Health Licensing Agency
700 Summer Street NE
Salem, OR 97301-1287

Dear Chair Murray:

The Oregon Board of Dentistry (OBD) has reviewed your recent column in “The Oregon Denturist Winter 2012 Issue” and has concerns regarding your portrayal of changes made as result of the passage of House Bill 2145.

As you recall, the OBD did not oppose HB 2145 as it was explained to the Board the changes would only allow for denturists to be able to construct additional dental appliances. It was the Board’s understanding that the passage of HB 2145 did not expand the scope of practice for denturist enumerated in ORS 680.500.

In your article you state “We were having a lot of patients asking us to bleach their teeth.” HB 2145 does not allow for denturists to provide treatment or services that result in the bleaching of teeth, but only allows for denturists to make the bleaching trays that a patient may want to use to bleach their own teeth.

You also mentioned in the newsletter, “With sleep apnea devices, however, the need is not as obvious. “Just because a patient snores, it doesn’t follow that they have sleep apnea.’ Shawn cautions. “Denturists need to be careful and gather a treatment team of sleep specialists to help diagnose a patient’s situation, just as we consult with dentists and oral surgeons when working with partial patients.” The Board is concerned with this statement because the law does not allow a denturist to diagnose the medical condition of sleep apnea nor provide treatment for that condition. Please note this same issue was recently addressed by the Board regarding the scope of practice of dentists as it pertains to diagnosing sleep apnea and the OBD opined that only a medical doctor can diagnose this medical condition.

Shawn Murray
December 19, 2012
Page 2

Please review the enclosed advertisement the OBD recently received which states that this dentist provides sleep apnea treatment along with devices.

In regards to the recent promulgation of rules to implement HB 2145, the OBD has been made aware that the Oregon Dental Association (ODA) has some significant concerns and has provided written testimony regarding these proposed rules and the OBD joins them in their concerns.

It is our hope that by bringing these matters to your attention that we can work together on our ultimate goals of public protection of the citizens of Oregon.

Sincerely yours,

Patrick D. Braatz
Executive Director

CC: Holly Mercier, Director - Oregon Health Licensing Agency
Kathleen Haley, Executive Director – Oregon Medical Board
Beryl Fletcher, Oregon Dental Association

Enclosures

OTHER ISSUES

Health Professionals Services Program Update
Oregon Board of Dentistry
Friday, April 22, 2016

Background-

Oregon's Health Professionals' Services Program (HPSP) has operated since July 2010 following the legislative consolidation of professional health board's alternative to discipline monitoring programs under ORS 676.190. The program supports public safety while helping licensed health professionals continue practicing. To be eligible for the program, the licensed health professional must have a diagnosed substance use disorder, a mental health disorder, or both types of disorders.

Four health profession regulatory boards currently participate in HPSP: Board of Dentistry (OSBD), Oregon Medical Board (OMB), Board of Nursing (OSBN), and Board of Pharmacy (OSBP).

	Enrolled		Completed		Terminated	
	ALL	BOD	All	BOD	ALL	BOD
7/1/2010	345	8	0	0	0	0
7/1/2010- 6/30/2011	97	8	18	0	64	1
7/1/2011- 6/30/2012	82	5	71	0	52	1
7/1/2012-6/30/2013	69	3	57	4	42	1
7/1/2013-6/30/2014	60	5	76	2	31	2
7/2014-6/30/2015	64	3	66	7	27	3
7/1/2015-12/31/2015	25	2	16	1	7	0
Total	742	34	304	14	223	8

Key HPSP Changes-

- In-person onboarding and annual review.
- New panels for unemployed and underemployed licensees.
- SoberLink
- Nurse added to the team to assist with medication management.

HPSP Outcomes-

- 73.5% (520/706) of all licensees have completed or are on target to complete HPSP.
- 80% (36/43) of self-referred licensees who become known to their boards complete or are still active in the program.
- 139 licensees self-referred into the program.
- 95% (209/219) of licensees have had no subsequent board action after completing HPSP.
- 78.5% of licensees complete without positive toxicology.

Contact Information-

Christopher J. Hamilton, PhD, MPA
 Monitoring Programs Director
 (503) 802-9813
 chamilton@reliantbh.com



HealthProCHOICES

A newsletter for participants in the Health Professionals' Services Program (HPSP)

February 2016



"Recovery is not simple abstinence. It's about healing the brain, remembering how to feel, learning how to make good decisions becoming the kind of person who can engage in healthy relationships, cultivating the willingness to accept help from others, daring to be honest, and opening up to doing." ~ Debra Jay

HPSP Guidelines

Have a question about toxicology, medications, or third party evaluations? Please remember to review HPSP Guidelines at www.rbhhealthpro.com/Guidelines. Ask your agreement monitor if you have any questions.

Portland Metro Test Sites Updates

Care Testing Services (CTS) (No Saturday Testing)

Care Testing is moving to a new location. Beginning February 29, 2016, Care Testing Services' new address:

9730 SW Greenburg RD #200 (Jefferson Building)
Tigard, OR 97223

The new location is open Monday through Friday 8:00am to 5:00pm and closed from 1:00pm to 2:00pm for lunch. Beginning February 29, CTS will **not** have Saturday collections.

Portland Metro Saturday Test Sites

GS Testing – Electronic Site (Saturday Testing)

17649 SW 65th Ave
Lake Oswego, OR 97035
Phone: 503-992-6359
Hours: Open 24/7

Someone will be present from 7am to 7pm Monday – Sunday and you are asked to call 20 minutes in advance.

Legacy Central Lab – Electronic Site (Saturday Testing)

1225 NE 2nd Avenue - 1st Floor Draw Station
Portland, OR 97232
Hours: M-F 7am-7pm (Open 24 hours during the week, after 7pm, pick up phone to be buzzed in) and Sat 8am-4:30pm
Phone: 503-413-5113

Concentra – Airport – Electronic Site (Saturday Testing)

12518 NE Airport Way Suite 110
Portland, OR 97230
Hours: M-F 7am-6pm and Sat 8am-5pm
Phone: 503-256-2992

Adventist Health Conven Care - Paper Site (Saturday Testing)

18750 SE Stark
Portland, OR 97233
Hours: M-F 9am-7:30pm and Sat 9am-4pm
Phone: 503-666-6717

Professional Recovery Network of Oregon 2016 Conference

Saturday, April 16, 2016 in West Salem at Chemeketa Eola. 215 Doaks Ferry Road NW, Salem, OR

Speakers

Greg Skipper, MD - Director, Professionals Health Services, Promises Treatment Centers
Robbie Bahl, MD - Monitoring Programs Medical Director, Reliant Behavioral Health,
Christopher Hamilton, PhD - Monitoring Programs Director, Reliant Behavioral Health
Anne Kathryn Johnston - Silverberg, cFNP, MS - Nurse Practitioner, Hazelden/Betty Ford
Maryann Rosenthal, PhD - Executive Director, Recovery Ways Treatment Center
Stormy Hill, MD, OTR/L - Life Skills Program Director, Recovery Ways Treatment Center
Cheryl A. Fox, RPh - Board of Pharmacy Inspector
Edwin Schneider, RPh - ORPRN President

Register today @ <https://orprn.wufoo.com/forms/orprn-2016-registration/>



HPSP: 888.802.2843
www.RBHHealthPro.com

Control Breathing, Control Stress



You're stuck in rush-hour traffic, glancing at your car's clock every few minutes as you strain to get to work on time. You may not notice, but your breathing is shallow, your pulse rate is high, and your chest feels tight. In fact, you feel this way in many stressful situations.

Sound familiar? Modern society creates more than its share of stress. It's difficult to change some situations — but you can manage how you feel about them, experts say.

Begin with something you take for granted — your breathing. If you're on that busy highway, pay attention to what's going on around you, but pay attention to your breathing, too. It's one of the few things you can control.

"Focusing on your breathing is one of the highly effective ways of reducing stress," says cardiologist James Rippe, M.D., author of 10 books on health and fitness, including "Healthy Heart for Dummies." "It brings you into the here and now," distracting you from your worries.

"We've become addicted to moving and thinking at hyper-speed," adds Stephan Rechtschaffen, M.D., wellness expert and author of the book *Timeshifting*. "When we're under stress, our breathing is short, high up in the lungs. More relaxed breathing doesn't rely on the chest wall, but rather on the abdomen."

Abdominal breathing, experts say, provides the lungs with more oxygen and is more rhythmic. It's something that opera singers and other performers have known for years: Abdominal breathing allows them to take control of their breath, to sing or speak with greater power, and to help them focus on the moment.

Breathing is just the beginning. If you can adjust your breath, you can adjust other things in your life, experts say. Slow your breathing down when you walk into your office or home and you'll notice that you won't jump at the first problem that hits you. When your breath is quiet, you are quiet.

Practice Your Breathing

Believe it or not, most of us could use a lesson on how to breathe. Practice at home a few times when you're not under stress. Then, try putting these techniques into practice when a stressful situation occurs.

In a relaxed setting, take three really deep breaths, focusing on your exhalations. "Really let it out," says Dr. Rechtschaffen. "It may feel unnatural at first, but stick with it."

Now, begin focusing on where your breath is coming from, experts say. Here's one practice method:

- Sit on the edge of a chair, feet flat on the floor.
- Place one hand on your lower back and the other hand on your abdomen, with three fingers below your navel.
- As you breathe in, your abdomen should rise, like a balloon inflating.
- As you breathe out, your abdomen should fall, with the sensation that the balloon is losing its air.

Concentrate on your abdomen, not your chest. Practice from a few minutes to 20 minutes each day. Soon, it will come naturally.

Wellness Library Health Ink and Vitality Communications ©2016

Opportunities

The National Certification Commission for Addiction Professionals has announced a one-time grandfather credentialing offer to attain a National Certified Addiction Counselor Level I or Level II credential with no testing. The offer is available to all current state certified or licensed addiction counselors who meet eligibility criteria until April 30, 2016. Visit <http://www.naadac.org/NCCAP-NCAC-GrandfatherCredentialOffer> for more information.

Hazelden Betty Ford - Portland/Beaverton Recovery Speakers

Anger Expression - Jerry Higgins, CASCI, Family Professional I. March 1 (Portland) and March 17 (Beaverton).
To register: <http://www.hazelden.org/web/public/event.view?eventId=4747922>

Betty Ford Center's 2016 Women's Symposium - Living the Truth

March 24, 2016 at the University of California at Los Angeles. Five CEs.
To Register: <http://www.hazelden.org/web/public/event.view?eventId=4995688>

Upcoming Center for Personalized Education for Physicians (CPEP) Courses:

- Medical Record Keeping Seminar - March 4, 2016 - Denver
- Improving Inter-Professional Communication: Working Effectively in Medical Teams - May 12-14 - Denver
- Professional Ethics and Boundaries Program - Multiple

HealthProCHOICES

A newsletter for participants in the Health Professionals' Services Program (HPSP)

March 2016

"It is a paradoxical but profoundly true and important principle of life that the most likely way to reach a goal is to be aiming not at that goal itself but at some more ambitious goal beyond it."

- Arnold Toynbee



Reminder and Correct Address

Care Testing Services (CTS) - Electronic Site
(No Saturday Testing)
Care Testing Services new location:

Care Testing Services
9370 SW Greenburg RD #200 (Jefferson Building)
Tigard, OR 97223

The new location is open Monday through Friday 8:00am to 5:00pm and closed from 1:00pm to 2:00pm for lunch. No Saturday Testing.

Satisfaction Survey

HPSP's Policy Advisory Committee (PAC) is completing their review of January's Satisfaction Survey and we will comment on licensee program feedback next month. In the interim, please remember that you can meet your agreement monitor for your annual review. Additionally, please let me know if you have any difficulty reaching your agreement monitor (chamilton@reliantbh.com; (503) 802-9813).

2016 Oregon Legislative Session

House Bill 4016 (2016), pertaining to HPSP, passed through Oregon's month long legislative session and was signed on March 1st by the Governor. The bill retains HPSP but transfers the program's oversight from the Oregon Health Authority to a newly established Impaired Health Professional Program Work Group in July 2017. The Impaired Health Professional Program Work Group will be comprised of designees from Oregon's health professional boards participating in HPSP. The Oregon Medical Board will staff the Work Group. It is not expected that HPSP licensees or collaborating partners will experience any operational changes.

Licensure After HPSP

As of March 1, 2016, 97 Oregon Medical Board licensees have successfully completed HPSP. Of these 97 professionals, 92 (95%) have had no subsequent board orders. Of the five with a subsequent board order, three continue to practice with specific restrictions and two are not currently practicing. In total, there are 95 of the 97 (98%) licensees that are still eligible to practice. (Included in these 98% are two licensees who have since retired their licenses and four licensees who have allowed their licenses to lapse; these licensees were of traditional retirement age.)

New Medication Management Form

HPSP's Registered Nurse, Megan Roe has revised the HPSP Medication Management Form. The new form is available at www.rbhealthpro.com under forms. The new form is not a radical departure, but will provide HPSP's Medical Director, Dr. Bahl, with information needed for medication review.

Speak Up For Safety – Oregon Nurses Foundation's Education

Early in 2015, with the assistance of a State Innovation Grant from the Addictions and Mental Health Department, the Oregon Nurses Foundation (ONF) developed, piloted, and evaluated a student nurse education program aimed at improving a nurse's response to workplace concerns related to a peer's behavior or performance in the workplace. The program,



HPSP: 888.802.2843
www.RBHHealthPro.com

called Speak Up For Safety, showed positive results amongst nursing students at both Chemeketa Community College and Linfield Community College. In both pilots there was observed significant improvement in knowledge, self-rated knowledge, and confidence to speak up about performance. Significant reduction in substance abuse stigma was also observed, and both students and faculty generally felt the training was useful and effective.

Since the initial pilot ONF has conducted trainings at Walla Walla University, School of Nursing, and Treasure Valley Community College, School of Nursing. Additionally, ONF has been asked to return to Chemeketa and Linfield to present the training to their next cycle of nursing students. Following these positive results ONF, in partnership with the Florida Intervention Project for Nurses, embarked on expanding the educational program with the development of two additional versions: staff and workplace monitor.

The staff version of the Speak Up For Safety program is specifically designed for staff nurses currently in the workforce. The training is designed to improve a nurse's level of skill and confidence in recognizing and assessing the level of risk when they have concerns that a colleague's performance doesn't meet professional and/or practice standards that may be harmful to patient safety. In addition, it provides nurses with the necessary tools to address common barriers to taking action, clearly communicate their concerns, and determine the appropriate course of action required.

Recently completed, the staff version of Speak Up For Safety is now ready for pilot. ONF is currently in discussions with one major hospital organization in the Portland Metro area for a potential partnership and is currently seeking for other organizations that would be interested in piloting the staff version of the Speak Up for Safety program while obtaining valuable training and education for their staff nurses.

Currently in development, the workplace monitor version is designed for nurses who are presently in the role of workplace monitor or anticipate taking on the role of workplace monitor for a nurse participating in monitoring through either the Oregon State Board of Nursing's Probation program or the alternative to discipline program, Health Professionals' Services Program. ONF anticipates having this version completed in early spring and ready for pilot shortly thereafter.

If you have questions about any of the different versions of the Speak Up For Safety program, are interested in accessing the training, or wish to partner with ONF to pilot our most recent versions, please feel free to contact Perla Estrada at estrada@oregonrn.org.

Spring Sunshine Brightens Mood

After months of low temperatures and dark skies, isn't it delightful to celebrate spring again? For many people, this wonderful season of new life is a real morale booster. One reason: a brain chemical known as serotonin that soothes and balances the nervous system. For most people, serotonin production is linked closely to the amount of sunlight that strikes the retina of the eye.

When people are deprived of light, as usually happens during the winter months, the production of serotonin is slowed, and that could be a factor that produces a bad case of the winter blues. Conversely, the arrival of spring means more light, and for most of us, possibly a more cheerful mood. Here are a few suggestions on taking advantage of spring sunshine.

- Adjust your schedule, whenever possible, to spend time with the sun. When the weather is bright outside, why not grab a sandwich and a soda and carry them to your favorite outdoor bench? If you can get 30-40 minutes of exposure to bright sunlight periodically, your serotonin level will rise and the winter blahs will begin to fade.
- Get serious about exercise. Try committing to three or four half-hour workouts per week to shed that weight. (Consult your family physician before beginning any new exercise program.) About 30 minutes of brisk walking, every other day, is enough to improve cardiovascular fitness, while also elevating your mood.
- Change your diet to match the more active, outdoor lifestyle that begins with spring. You'll feel lighter and quicker.

Opportunities

ORPRN Conference

The Professional Recovery Network of Oregon 2016 Conference is Saturday, April 16, 2016 in West Salem at Chemeketa Eola. 215 Doaks Ferry Road NW, Salem, OR. Register today @ <https://orprn.wufoo.com/forms/orprn-2016-registration/>

The National Certification Commission for Addiction Professionals has announced a one-time grandfather credentialing offer to attain a National Certified Addiction Counselor Level I or Level II credential with no testing. The offer is available to all current state certified or licensed addiction counselors who meet eligibility criteria until April 30, 2016. Visit <http://www.naadac.org/NCCAP-NCAC-GrandfatherCredentialOffer> for more information.

Hazelden Betty Ford - Portland/Beaverton Recovery Speakers

Anger Expression - Jerry Higgins, CASCI, Family Professional I. March 1 (Portland) and March 17 (Beaverton).

To register: <http://www.hazelden.org/web/public/event.view?eventId=4747922>

Betty Ford Center's 2016 Women's Symposium - Living the Truth

March 24, 2016 at the University of California at Los Angeles. Five CEs.

To Register: <http://www.hazelden.org/web/public/event.view?eventId=4995688>

Upcoming Center for Personalized Education for Physicians (CPEP) Courses:

- Improving Inter-Professional Communication: Working Effectively in Medical Teams - May 12-14 - Denver

Health Professionals' Services Program
www.rbhhealthpro.com

HPSP: 888.802.2843

From: Oregon Oral Health Coalition [<mailto:philip@orohc.ccsend.com>] **On Behalf Of** Oregon Oral Health Coalition

Sent: Wednesday, March 30, 2016 10:19 AM

To: OBD Info

Subject: Important Dates and Corrected Story



Improving general health through oral health for all Oregonians

(971) 224-1038

OrOHC.org

Firsttooth@ocdc.net



Second Dental Pilot Project Approved

The goal of the second pilot project to be approved in Oregon is to train expanded practice dental hygienists to provide Interim Therapeutic Restorations (ITRs) as a part of a dental team that is connected through telehealth technology.

This project will improve dental care utilization in Polk County by keeping kids healthy through preventive measures outside of the dental clinic. The pilot project adds the telehealth model to existing preventive services, which includes oral assessments, radiographs, intra-oral photographs, cleanings, sealants, fluoride varnish, oral health instruction, and ITR if indicated. Children with complex dental problems will be referred to the dental clinic.

This dental team approach will allow dental professionals to work at the top of their licensure while addressing the need to provide more dental access in areas that have a high shortage of dentists. The objective will be to reach about 10 children a day with services, translating into 1,200 to 1,500 encounters during the course of the pilot project.

Oregon Health Science University is sponsoring the pilot and partnering with Capitol Dental Care to provide direct services.



Improving general health through oral health for all Oregonians

Oregon Oral Health Coalition, 9140 SW Pioneer Ct, Suite E, Wilsonville, OR 97070

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Sent by arien.bates@ocdc.net in collaboration with



**Oregon Health Authority
Dental Pilot Project Program**

Dental Pilot Project: Application #200

<p>Abstract Training Dental Hygienists to Place Interim Therapeutic Restorations February 19, 2016</p>

Applicant/Sponsor:	Oregon Health & Science University, School of Dentistry, 3181 SW Sam Jackson Park Road, Portland, OR 97239
Project Director:	Eli Schwarz, DDS, MPH, PhD Department of Community Dentistry, Oregon Health & Science University 3030 SW Moody Ave, Suite 135B Portland, OR 97201
Training Supervisor(s):	Eli Schwarz, DDS, MPH, PhD & Richie Kohli, BDS, MS

Sponsor Type:	Non-Profit Educational Institution
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Oregon Health & Science University is a nationally prominent research university and Oregon's only public academic health center. It educates health professionals and scientists and provides leading-edge patient care, community service and biomedical research.

The OHSU School of Dentistry shares the mission of the Oregon Health & Science University to provide educational programs, basic and clinical research, and high quality care and community programs. We strive to foster an environment of mutual respect where the free exchange of ideas can flourish. The dental school prepares graduates in general dentistry and the dental specialties to deliver compassionate and ethical oro-facial health care.

The mission of the Department of Community Dentistry is to promote critical analysis of social, behavioral, and policy-influenced factors that affect oral health outcomes in both individual patients and the entire population. These goals are achieved through a comprehensive didactic and experiential learning curriculum that begins in year one of the pre-doctoral program and culminates with the DS4 clinical rotations in community based dental clinics. We strive to develop curricula that lay the foundation for the student's life-time professional

development, commitment to service and community collaboration, and ensure awareness and cultural competency of the comprehensive and complex nature of health care for vulnerable populations.

Purpose:	<ul style="list-style-type: none"> • Teaches new skills to existing categories of dental health care personnel.
	<ul style="list-style-type: none"> • To train Expanded Practice Dental Hygienists (EPDHs) and demonstrate that EPDHs can successfully place “Interim Therapeutic Restorations” (ITRs) when directed to do so by a collaborating dentist. The ITR is an interim restoration designed to stop the progression of dental caries until the patient can receive treatment for that tooth by a dentist.

Proposed Project Period:	11/1/2015 – 9/1/2020
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Proposed Number of Sites:	Polk County: Central School District School: 5 School Sites
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Site Locations:	
Training/Didactic Phase:	<ul style="list-style-type: none"> • Didactic training will be held via online management system called Sakai, webinars, and in-person meetings in the conference rooms at Capitol Dental Care. • Didactic resources are available through University of the Pacific (UoP). • Laboratory and clinical training will take place at Capitol Dental Care which has fully equipped dental clinics.
Utilization Phase:	<ul style="list-style-type: none"> • Ash Creek Elementary, Independence OR. 492 total student enrollment, 243 K-2nd grade students. 64% free and reduced lunch population • Independence Elementary, Independence, OR. 421 total student enrollment, 200 K-2nd grade students. 77.7% free and reduced lunch population • Monmouth Elementary, Monmouth OR. 547 total student enrollment. 266 K-2nd grade students. 55.9% free and reduced lunch population. • Falls City Elementary, Falls City, OR. 97 total school enrollment. 31 K-2nd grade students. 70.1% free and reduced lunch population.

	<ul style="list-style-type: none"> • Community Action Head Start-Independence Site. 40 children, age 3-5. OCDC Head Start-Independence Site. • In addition, we have also been meeting regularly with a Steering Group of those likely to participate in the pilot project, now and at a future time. These include representatives from: <ul style="list-style-type: none"> • Capitol Dental Care • Virginia Garcia Memorial Health Center • Advantage Dental • Kemple Memorial Children’s Dental Clinic
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Proposed Number of Trainees:	10-12
Proposed Number of Supervisors:	4
Number of Collaborating Dentists:	4
Proposed Number of Sites:	5

Application Chronology:

Application Submitted:	November 2, 2015
Application Approved for Completeness:	November 30, 2015
Application Received by Technical Review Board:	December 11, 2015
TRB Application Review Comments Due:	January 28, 2016
MOA Received by Program:	February 5, 2016
Applicants Notified of Intent to Approve:	February 19, 2016
Application Under 10 Day Period of Public Comment:	February 22, 2016 – March 4, 2016

Estimated Cost and Funding Source(s):

Estimated Cost:	\$111,797.01
Funding Source(s) Committed:	<p>Three sources of funding have been identified:</p> <ol style="list-style-type: none"> 1) Oregon Health Plan (OHP) covers dental care for Medicaid members through capitated payments to the Dental Care Organization (DCO) to which the CCO has assigned the members; 2) The training, technical assistance, and evaluation will be funded in the initial year through a telehealth grant from the Oregon Health Authority through September 2016; 3) A group of funders of Oregon Oral Health Funders Collaborative that has supported the planning grant to develop the present application has expressed an interest to fund ongoing support of the evaluation and

	testing of the pilot project.
Total Committed:	\$111,797.01 for first 18 months

Background and History of the Project:
Selected Passages from the DPP #200 Application

Need for the Project:

Numerous reports within the last ten years have addressed workforce shortages in the dental field, lack of access to oral health care among low-income, rural, and other disadvantaged population groups, and the resulting profound oral health disparities experienced by these groups. Recent reports document that very slow progress is being made in improving the access to oral health care for these population groups. The health transformation process underway in Oregon has recently expanded access to the Oregon Health Plan for around 250,000 additional members. However, since the workforce situation has not been addressed, the existing dental workforce is under additional pressure and overall, access to dental care may further deteriorate. According to an Oregon Healthcare Workforce Institute analysis, the number of dentists practicing in Oregon decreased by 8% from 2010 to 2012 which may indicate a continuous trend. The traditional dental care delivery model of stationary dental offices or community health centers with dental practitioners and auxiliaries needs to be expanded to test alternative and sustainable models.

Studies in other states have shown that a remotely located dentist, working with an Expanded Practice Dentist Hygienist (EPDH), who is seeing a patient at a different location, can collaboratively deliver quality dental care. Led by an EPDH, Capitol Dental Care will implement telehealth-connected oral health teams to reach children who have not been receiving dental care on a regular basis and to provide community-based dental diagnostic, prevention and early intervention services, including ITR placement when indicated by the dentist.

Description of patients:

Demographic Data about Availability of Health Care Services

Polk County continues to show an increase in diversity, especially within the Hispanic population. 11.2% of the population considers themselves Hispanic compared to 10% in 2007. The Caucasian population has grown from 86% to 87.9% while the American Indian/Alaskan Native population has remained consistent at 1.9%. There were slight increases in the African American population from .4% to .5% and in the Asian/Pacific Islander population from 1.6% to 1.9% in 2009. According to the 2005-2009 US Census Bureau data, 11.4% of Polk County residents speak a language other than English in their home compared to 14% of Oregon residents and 19.6% of US residents.

Oral Health needs assessment suggested that 34.3% of the Polk County residents had no dental visit in the last 12 months. Currently, only about 20% of Oregon dentists accept Oregon Health Plan (OHP) members. In Marion and Polk Counties, there are 122 OHP enrolled dentists. This is approximately 1 dentist for every 550 members of the Willamette Valley Community Health (WVCH) Coordinated Care Organization. Although this may be considered an acceptable ratio issues remain of provider timely availability, appointment timing, and insurance coverage; thus, there are still barriers for OHP members' access.

Oregon 2012 Smile Survey: This statewide survey gauges the health of the Oregon dental system by looking at the oral health, access, and overall quality of dental care for school children, aged 6 to 9. The survey examines the percentage of children who need urgent dental care, have any tooth decay, have rampant tooth decay (7 or more cavities), and have received dental sealants. The survey showed those with lower incomes, non-English speaking, and Hispanic background generally have worse dental health outcomes than those who have higher incomes, speak only English, and are white.

Purpose of the Project:

To train Expanded Practice Dental Hygienists (EPDHs) and demonstrate that EPDHs can successfully place “Interim Therapeutic Restorations” (ITRs) when directed to do so by a collaborating dentist. The ITR is an interim restoration designed to stop the progression of dental caries until the patient can receive treatment for that tooth by a dentist.

Oregon is in the midst of a dental health care crisis with more than 91 areas in the state designated as dental care health professional shortage areas (Kaiser Family Foundation study, April 28, 2014). This level of “deficiency” translates to more than 61% of Oregon residents not having their dental care needs met. One county where the need is particularly great is Polk County, and it is within this county - and the Polk County School District that a collaborative consisting of OHSU School of Dentistry, University of the Pacific Center for Special Care, and Capitol Dental Care (CDC) will implement its pilot project to train Expanded Dental Hygienists to place interim therapeutic restorations (ITR) within the context of a telehealth connected dental team.

This OHSU project has been planned and developed in collaboration with the University of the Pacific, Arthur A. Dugoni School of Dentistry (UoP) and Capitol Dental Care (CDC).

Project Description:

Under the dental pilot project program [Capitol Dental Care] CDC will build upon existing community outreach programs in Polk County by adding the telehealth model to existing preventive services, which include assessment, radiographs, intra-oral photographs, cleanings, sealants, fluorides, oral health instruction, and ITR if indicated. CDC’s telehealth connected dental team of Expanded Practice Dental Hygienists, dental assistants, and supervising dentist, will visit three schools within the District, serving approximately 10 children per day~75 per month with a total expected population of 1200-1500 measurable encounters over the life of the 15-month project.

Those children with advanced disease in need of additional care will be referred for care either through CDC’s mobile van operator, or directed to a dental clinic for restorative care, as needed.

This Dental Workforce Pilot Project (DWPP) will add one new duty to those currently permitted for Expanded Practice Dental Hygienists (EPDHs) that are part of a community-based telehealth connected team system of care already under way.

The Oregon Health and Science University will train Expanded Practice Dental Hygienists

(EPDH) to perform a new duty in community settings to improve the oral health of underserved populations and demonstrate their ability to carry out this duty.

Project Objectives:

Short-Term Objectives:	<ul style="list-style-type: none"> • Train EPDHs and evaluate their competence to place ITRs.
Long-Term Objectives:	<ul style="list-style-type: none"> • Through the performance of these duties to allow EPDHs working in community settings with underserved populations to facilitate collaboration with a dentist and to develop an appropriate plan of care for the patient. The placement of ITRs when directed to do so by a collaborating dentist will allow EPDHs to stabilize patients' oral health from further deterioration until they can be seen by a dentist in an appropriate setting. • To facilitate the development of new models of care designed to improve the oral health status of underserved populations.

Laws and Regulations Pertinent to the Proposed Project:	<p>The Dental Practice Act governs the scope of practice for both dentists and dental hygienists operating in the state of Oregon. The key provisions can be found at Oregon Revised Statutes, Chapter 680 (680.010 – 680.210 and 680.990 (Dental Hygienists).</p> <p>Currently, an Expanded Practice Dental Hygienist (EPDH) may only perform the placement and finishing of direct alloy and direct composite restorations after the supervising dentist has prepared the tooth (teeth) for restorations (ORS 818-035-0072).</p>
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February 19, 2016

Attention: Richie Kohli, BDS, MS
Eli Schwarz, KOD, DDS, MPH, PhD, FHKAM, FCDSHK, FACD, FRACDS
Department of Community Dentistry
School of Dentistry
Oregon Health & Science University
3030 SW Moody Avenue, Suite 135
Portland, OR 97201

Dear Drs. Kohli & Schwarz,

This letter is to inform you of the **Intent to Approve** the application received on November 2, 2015 from the Department of Community Dentistry at Oregon Health & Science University to the Dental Pilot Project Program at the Oregon Health Authority.

Intent to Approve Dental Pilot Project #200: The Oregon Health Authority intends to approve Dental Pilot Project Application #200 “Training Dental Hygienists to place Interim Therapeutic Restorations” with modifications noted:

- Modified Project Timeline: March 14, 2016 – September 1, 2020

At this time, the Technical Review process has been completed. Per Oregon Administrative Rule 333-010-0445, Application Review Process:

(5) Once project staff have completed an application review a Notice of Intent to approve or deny an application will be provided to the applicant and the Notice and application will be posted for public comment for a period of 10 business days. The Notice will be sent to interested parties.

At the conclusion of the public comment period, per Oregon Administrative Rule 333-010-0450, Project Approval:

- (1) Once the public comment period described in OAR 333-010-0445(5) has closed the director or his or her designee shall grant or deny approval of a pilot project applicant within 30 calendar days of receiving the application from the program.
- (2) If the director grants approval, he or she will specify the length of time the project can operate.
- (3) The director’s decision shall be transmitted in writing to the applicant.
- (4) A sponsor whose project has been denied may not submit a new application within six months from the date the director denied the application.

(5) The program staff shall notify the Oregon Board of Dentistry when a project is approved.

(6) The director or his or her designee may extend the length of time a project can operate at his or her discretion.

Thank you for your interest in the Dental Pilot Project Program.

Sincerely,

Sarah Kowalski, RDH
Dental Pilot Project Coordinator



HEALTH SYSTEMS DIVISION
Office of the Chief Medical Officer

Kate Brown, Governor

Oregon
Health
Authority

500 Summer Street NE
Salem, OR 97301

March 8, 2016

Bruce Austin, DMD
Statewide Dental Director
Oregon Health Authority

Attention: Eli Schwarz, DDS, MPH, PhD
Department of Community Dentistry
School of Dentistry
Oregon Health & Science University
3030 SW Moody Avenue, Suite 135 B
Portland, OR 97201

RE: Dental Pilot Project Application #200, "Training Dental Hygienists to Place Interim Therapeutic Restorations"

Dear Dr. Schwarz,

I am pleased to announce the approval of the "Training Dental Hygienists to Place Interim Therapeutic Restorations," Dental Pilot Project Program Application #200.

This project will test, demonstrate, and evaluate the role of Expanded Practice Dental Hygienists in the following area:

- Teaches new skills to existing categories of dental health care personnel

DPP #200 will train Expanded Practice Dental Hygienists (EPDHs) and demonstrate that EPDHs can successfully place "Interim Therapeutic Restorations" (ITRs) when directed to do so by a collaborating dentist. This project will also demonstrate the effectiveness and potential of the telehealth connected dental team model.

The Oregon Health and Science University, as the project sponsor, is approved to proceed with all of the concepts and pilot sites proposed in its application for DPP #200.

Project Approval Period	March 14, 2016 – September 1, 2020
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Your application to the Dental Pilot Project Program has been approved to operate from March 14, 2016 through September 1, 2020.

Dental Pilot Projects are intended to evaluate the quality of care, access, cost, workforce, and efficacy by teaching new skills to existing categories of dental personnel; developing new categories of dental personnel; accelerating the training of existing categories of dental personnel; or teaching new oral health care roles to previously untrained persons.

The goal of the Dental Pilot Projects is to encourage the development of innovative practices in oral health care delivery systems with a focus on providing care to populations that evidence-based studies have shown have the highest disease rates and the least access to dental care.

Approved Project Sites:	
Training/Didactic Phase:	<ul style="list-style-type: none"> The didactic training will be held via online management system called Sakai, webinars, and in-person meetings in the conference rooms at Capitol Dental Care. The laboratory and the clinical training will take place at Capitol Dental Care in Salem, Oregon.
Utilization Phase:	<ul style="list-style-type: none"> Approved utilization project sites for this project encompass the following sites in Polk County Central School District: Ash Creek Elementary School 1360 North 16th Street Monmouth, Oregon 97361 Independence Elementary 150 South 4th Street Independence, Oregon 97351 Monmouth Elementary, 958 East Church Street Monmouth, Oregon 97361 Community Action Head Start-Independence site 246 I Street Independence, OR 97351 OCDC Head Start-Independence 535 G Street Independence, OR 97351

Any modifications to the approved project must be submitted in writing to the Dental Pilot Project Program. Modifications require program approval prior to implementation.

Oregon Administrative Rules, 333-010-0460

Modifications:

(1) Any modifications or additions to an approved project shall be submitted in writing to program staff. Modifications include, but are not limited to the following:

(a) Changes in the scope or nature of the project. Changes in the scope or nature of the project require program staff approval;

(b) Changes in selection criteria for trainees, supervisors, or employment/utilization sites; and

(c) Changes in project staff or instructors.

(2) Changes in project staff or instructors do not require prior approval by program staff, but shall be reported to the program staff within two weeks after the change occurs along with the curriculum vitae for the new project staff and instructors.

(3) All other modifications require program staff approval prior to implementation.

The sponsor shall work with the Oregon Health Authority Dental Pilot Project Program to determine the scope and timeline for data submission and reports during the initial six months of the pilot project.

- Baseline data is due to the program by **September 15, 2016**.

Oregon Administrative Rules, 333-010-0435

Evaluation and Monitoring:

(1) Evaluation Plan. A sponsor of a dental pilot project must have an evaluation plan that includes, but is not limited to the following:

(a) A description of the baseline data and information collected about the availability or provision of oral health care delivery, or both, prior to utilization of the trainee;

(b) A description of baseline data and information to be collected about trainee performance, acceptance among patient and community, and cost effectiveness;

(c) A description of methodology to be used in collecting and analyzing the data about trainee performance, acceptance, and cost effectiveness; and

(d) A provision for reviewing and modifying objectives and methodology at least annually.

(2) Monitoring Plan. A sponsor of a dental pilot project must have a monitoring plan that ensures at least quarterly monitoring and describes how the sponsor will monitor and ensure:

(a) Patient safety;

(b) Trainee competency;

(c) Supervisor fulfillment of role and responsibilities; and

(d) Employment/utilization site compliance.

(3) Data. A sponsor's evaluation and monitoring plans must describe:

(a) How data will be collected;

(b) How data will be monitored for completeness; and

(c) How data will be protected and secured.

(4) A sponsor must permit project staff or their designees to visit each employment/utilization site at least monthly during the first six month period and at least quarterly thereafter.

(5) A sponsor must provide a report of information requested by the program in a format and timeframe requested.

(6) A sponsor must report adverse events to the program the day they occur.

The Dental Pilot Project Program is responsible for monitoring approved pilot projects. Program staff shall evaluate approved projects and the evaluation shall include but is not limited to reviewing progress reports and conducting site visits. The program is responsible for ascertaining the progress of the project in meeting its stated objectives and in complying with program statutes and regulations.

The Dental Pilot Project Program will monitor DPP #200 through written reports and site visit evaluations. In addition, we expect the Evaluation Committee to assist the Dental Pilot Project Program with the monitoring and development of guidelines to strengthen protocols, if possible, pursuant to their findings.

Oregon Administrative Rules, 333-010-0455

Program Responsibilities:

(1) Project evaluation. Program staff shall evaluate approved projects and the evaluation shall include but is not limited to:

(a) Periodically requesting written information from the project, at least annually to ascertain the progress of the project in meeting its stated objectives and in complying with program statutes and regulations; and

(b) Periodic, but at least annual, site visits to project offices, locations, or both, where trainees are being prepared or utilized.

(2) Site visits.

(a) Site visits shall include, but are not limited to:

(A) Determination that adequate patient safeguards are being utilized;

(B) Validation that the project is complying with the approved or amended application; and

(C) Interviews with project participants and recipients of care.

(b) An interdisciplinary team composed of representatives of the dental boards, professional organizations, and other state regulatory bodies may be invited to participate in the site visit.

(c) Written notification of the date, purpose, and principal members of the site visit team shall be sent to the project director at least 14 calendar days prior to the date of the site visit.

(d) Plans to interview trainees, supervisors, and patients or to review patient records shall be made in advance through the project director.

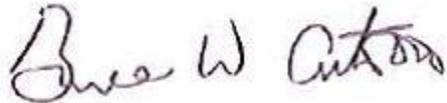
(e) An unannounced site visit may be conducted by program staff if program staff have concerns about patient or trainee safety.

(f) A report of findings and an indication of pass or fail for site visits shall be prepared by program staff and provided to the project director in written format within 60 calendar days following a site visit.

The Dental Pilot Project Program will work collaboratively with the Oregon Health Science and University. An Evaluation Committee will be developed to monitor and review the approved pilot project. The Evaluation Committee is an interdisciplinary team composed of representatives of the dental boards, professional organizations, other state regulatory bodies and interested parties that have applied to participate in evaluating the approved project.

Ms. Sarah Kowalski will serve as the Project Coordinator and you may contact her with any questions at 971-673-1563 or sarah.e.kowalski@state.or.us.

Sincerely,

A handwritten signature in black ink that reads "Bruce W. Austin". The signature is written in a cursive style with a large initial "B" and "A".

Bruce Austin, DMD
Statewide Dental Director



**Dental Pilot Project Application #200
Training Dental Hygienists to Place Interim Therapeutic Restorations
Oregon Health & Science University
Technical Review Board Application Review Process**

The Oregon Health Authority's Dental Pilot Project Technical Review Board (TRB) voted to not meet in person to review the Dental Pilot Project Application #200: Training Dental Hygienists to Place Interim Therapeutic Restorations.

TRB Members reviewed Dental Pilot Project Application #200 and submitted questions and comments to the applicants by completing a worksheet designed by the program. TRB received the application via electronic mail on December 11, 2015. TRB reviewed the application and submitted their comments on January 28, 2016. Applicants had the opportunity to review the TRB worksheet comments and respond accordingly.

The TRB Members who submitted comments each recommended approval of Dental Pilot Project #200: Training Dental Hygienists to Place Interim Therapeutic Restorations.

Comments Submitted by Technical Review Board Members are from the following:

William S. Ten Pas, DMD	Oregon Dental Association
Gail L. Aamodt RDH, MS	Oregon Dental Hygiene Association
Tony Finch, MPH	Oregon Oral Health Coalition
Shannon English, DDS	Willamette Dental

Technical Review Board Members who did not Submit Comments:

Kenneth Wright, DMD, MPH	Kaiser Permanente
Kyle House, DDS	Private Practice, Pediatric Dentist

Subject Matter Experts who Reviewed the Application:

Maria Castro, MS	Office of Equity & Inclusion
Paul Kleinstub, DMD	Oregon Board of Dentistry
Bruce Austin, DMD	Oregon Health Authority

Oregon Health Authority Program Staff:

Sarah Kowalski, RDH	Oregon Health Authority
Laurie Johnson, DHSc, MA, RDH	Oregon Health Authority
Amy Umphlett, MPH	Oregon Health Authority
Cate Wilcox, MPH	Oregon Health Authority
Kelli Hansen	Oregon Health Authority



NOTICE OF PUBLIC COMMENT PERIOD

Oregon Health Authority: Dental Pilot Project Program

**Dental Pilot Project: Application #200
Training Dental Hygienists to Place Interim Therapeutic Restorations
Oregon Health & Science University, School of Dentistry**

The Oral Health Program in the Center for Prevention and Health Promotion in the Public Health Division of the Oregon Health Authority, seeks public comment on an application to the Dental Pilot Project Program.

Documents

The Application is available online at healthoregon.org/dpp.

Background

Information regarding the Dental Pilot Project Program can be found online at healthoregon.org/dpp.

Public Comment Period

The Dental Pilot Project Program at the Oregon Health Authority, will open a public comment period on the proposed application beginning February 22, 2016. The public comment period will close on March 4, 2016.

The purpose of the public comment period is to allow individuals to provide information to the Dental Pilot Project Program that will help inform its decision making. All public comments will be reviewed to assist the Dental Pilot Project Program in the approval process.

To submit public comment on the proposed application please send them by mail, fax or email to:

Sarah Kowalski, RDH
Dental Pilot Project Coordinator
Oral Health Program
800 NE Oregon Street, Suite 825
Portland, Oregon 97232-2186

Fax: 971-673-0231

Email: sarah.e.kowalski@state.or.us

7. Soft Reline Course- Crystal Patton-Doherty & Melissa J. Barfuss

The Board has received a request for approval of a Soft Reline Course. This course would be provided so the EFDA Dental Assistants could qualify to apply soft relines in accordance with OAR 818-042-0090.

"818-042-0090

Additional Functions of EFDAs

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

- (1) Apply pit and fissure sealants providing the patient is examined before the sealants are placed. The sealants must be placed within 45 days of the procedure being authorized by a dentist.
- (2) Apply temporary soft relines to full dentures.
- (3) Place cord subgingivally."

Blue Mountain Community College
P.O. Box 100
2411 NW Carden Avenue
Pendleton, OR 97801

Course Title: Full Denture (temporary) Soft Reline
Course Number: 009.414-02

Length of Course: 4 hours

Course Introduction:

Upon successful completion of this course of instruction on soft denture relines, the participant will be able to place a soft denture reline as prescribed by the dentist through indirect supervision as outlined in OAR 818-042-0090 of the Oregon Board of Dentistry (OBD) Practice Act.

The participant will be able to identify health and safety risks and precautions associated with soft denture reline materials, indications and contraindications for a soft reline, manipulate and apply various brands and types of soft denture reline materials, trim and finish the reline, give patient post-operative instructions, and properly document the procedure in the patient's chart.

Instructor Qualifications:

The instructor for this course is a DANB certified dental assistant, and Oregon EFDA since 2011. Mrs. Barfuss was employed in private practice(s) for 5 years before becoming a full time instructor in the Dental Assistant Program at Blue Mountain Community College (BMCC) in 2015. In addition, Mrs. Barfuss successfully completed an OBD approved denture soft reline course in 2011.

*Note: The Dental Assistant Program at BMCC has been continuously accredited by the Commission on Dental Accreditation (CODA) since 1965.

Course Prerequisites:

1. The participant must be an Oregon Expanded Function Dental Assistant.
2. The participant must provide a copy of their EFDA certification with course registration.

Special Services:

Persons having questions about or requests for special needs and accommodation should contact the Associate Vice President of Enrollment Management at Blue Mountain Community College, 2411 N.W. Carden Ave, Pendleton OR 97801, Phone 541-278-5774 or TDD 541-278-2174. Contact should be made 72 hours in advance of the event.

Instructional Activities:

1. Lecture and discussion.
2. Watch and discuss various media presentations on denture relining.
3. Identify instruments used in performing a denture reline.
4. Prepare materials for soft denture reline.
5. Role playing of post-operative instructions given to patients.

Method of Evaluation

Written examination

Competency (skills evaluation)

Grading Policy:

Written Exam: The student must achieve a minimum of 80% on the written examination *before proceeding to the lab portion of the course.*

Lab: Participants will perform denture soft relines to laboratory standards (on typodonts). The participant must achieve 80% on the lab work (in addition to 80% on the written exam) to successfully complete the course.

The participant will receive a Pass/Fail grade.

Suggested Textbooks and Resources:

Bird Robinson, Modern Dental Assisting, eleventh edition, Elsevier.

In-class handouts: manufacturer's instructions, PowerPoint presentation, etc.

Course Format:

1. OAR Division 42 regarding placement of denture soft relines by an EFDA.
2. Health history
 - Medical
 - Overall health
 - Medications
 - Implications (mental, compromised, etc.)
 - Dental
 - Cancer screening
 - Age and condition of existing denture
 - Bone loss
 - Occlusion
 - Speech

3. Infection Control:

- Principals of disease transmission
 - Universal and standard precautions
 - Personal protective equipment
4. OSHA:
- Occupational injury protocol
 - o First Aid
 - Material spill clean up protocol
 - Personal protective equipment
5. Indications/contraindications for soft denture reline
- Indications:
- Uncomfortable
 - Mastication
 - Retention
 - Forward mandible
 - Maxillary lip line shortened
 - TMD issues
 - Angular cheilosis
 - Anatomic irregularities (Torus palatinus or mandibularis)
 - Patient's age or health
 - Oral habits
 - Unable to accommodate rigid base
- Contraindication:
- Temporary measure
 - Loss of bond between base and liner
 - Longevity of soft reline material
 - Supports yeast growth
 - Discoloration of material
6. History of denture relines (tissue conditioner, soft, hard) and denture rebasing.
7. Material(s)
- Self cure
 - Light cure
 - Cartridge system
 - Powder and liquid
8. Tray set-up and armamentarium
9. Terminology
10. Procedural Steps and techniques
11. Post operative instructions
12. Current and future trends
13. Charting

Crystal Patton-Doherty

1313 SW 23rd Street, Pendleton, Oregon 97801 • Phone: (541) 276-3719

Education:

September 1984 – December 1986

September 1978 – June 1981

- Bachelor of Science – Elementary Education –
Eastern Oregon State College, LaGrande, Oregon
Reading Endorsement,
Specializations:
Early Childhood
Health Education
- Bachelor of Science – General Studies
Eastern Oregon State College, LaGrande, Oregon

September 1981 – June 1982

Blue Mountain Community College, Pendleton, Oregon

- Certificate Dental Assisting

License

February 1987-Present

Basic Teaching License

Oregon Teacher Standards and Practices Commission

Certifications

May 2013

Soft Denture Reline, Oregon Board of Dentistry

March 1999

Pit and Fissure Sealant, Oregon Board of Dentistry

July 1982

Expanded Function Dental Assistant, Oregon Board of
Dentistry

July 1982

Radiologic Proficiency, Oregon Board of Dentistry

July 1982

Certified Dental Assistant, Dental Assisting National Board

Work Experience:

July 1989 to Present – Blue Mountain Community College, Pendleton, Oregon

- Dental Assisting Program Director
- Dental Assisting Instructor
- Dental Assisting Department Chair

September 2006-2014 Allied Health and Human Performance Department Chair

September 2004-2014 Allied Health Academic Advisor
July 1999-June- 2003 Allied Health and Human Performance Department Chair
September 1997- June 1998 Allied Health Department Chair
September 1989 - June 1997 Dental Assisting Department Chair

November 1988 – June 1989 – Weston McEwen School District, Weston, Oregon

- Resource Room Teacher, Grades 1-9

May 1987 – June 1988 – Weston-McEwen School District, Athena, Oregon

- Classroom Teacher, Grade 5

February 1987 – May 1987 – Pendleton School District, Helix School District, Pilot Rock School District, Stanfield School District, Weston-McEwen School District.

- Substitute Teacher, Grades K-12

January 2009 Processed National Guard soldiers for deployment readiness

April 2007 Exposed Radiographs on National Guard Soldiers for deployment readiness , Dental Health Management Solutions, Inc. Austin Texas

June 2004- Exposed Radiographs on National Guard soldiers about to be deployed.

May to July
2003 Chairside Assistant with Northwest Medical Mobile Dental Van

August 1982 – August 1984- A. Scott Herman, DMD, Pendleton, Oregon

- Chairside Assistant, Office Manger

Professional Membership:

2015 Pendleton Round-Up and Happy Canyon Hall of Fame Director

2012 Altrusa International

1989 to Present – Oregon Community College Dental Assisting Educators Consortium

Continuing Education (Post Graduate-Dental Assisting Certificate):

October 2015	First Aid/CPR/AED Red Cross
August 2015	DANB RHS Review The Dale Foundation
April 2015	OSHA Hazard Communication Standard, AIDS training, CDC Infection Control Guidelines in dentistry and Waste Management Sullivan Schein
May 2014	OSHA Hazard Communication Standard, AIDS training, CDC Infection Control Guidelines in dentistry and Waste Management Sullivan Schein
April 2014	Pediatric Dentistry DANB's /PDEP
September 2013	Biofilm: A new view of Plaque Dentalcare.com
June 2013	Diseases of the Teeth and Jaws Dentalcare.com
April 2013	Diabetes: An epidemic of Proportions Academy of General Dentistry, PACE, Hu-Friedy
April 2013	Risk Management Record Keeping from the Boards Perspective Ask the Board The Stress Mess The Hottest Topics in Dentistry Today
January 2013	An Integrated Clinical Summary: Professional Tooth Bleaching using 14% Hydrogen Peroxide Whitening Strips Dentalcare.com
January 2012	Orthodontic Assistant DANB's /PDEP

February 2011	Professional Development Examination Program (PDEP) for Radiation Health and Safety, Dental Assisting National Board
April 2010	Record Keeping from the Board's Perspective Ask the Board Burning Down the House: Understanding Inflammations Role in Oral/Systemic Connections Malpractice Prophylaxis Oregon Dental Association, Portland, Oregon
April 2009	Hottest Topics in Dentistry What is it? How do I use it? Today's Dental Products and Treatment Options Deeping out of HR Hot water The Why of "Y" Oregon Dental Association, Portland, Oregon
October 2008	Professional Development Examination Program (PDEP) for Radiation Health and Safety, Dental Assisting National Board
April, 2008	Record Keeping from the Boards Perspective How to keep your Office out of Trouble Let me See Your Body Talk Pediatric Risk Assessment Oregon Dental Association, Portland, Oregon
February 2008	Professional Development Examination Program (PDEP) for General Chairside, Dental Assisting National Board
April 2007	Practice Management, Defensive Charting Seminar Behavior-Behavioral Mysteries in your Workplace Explained Oregon Dental Association, Portland, Oregon
March 2007	Team Work Dream Work

Eastern Oregon Dental Society, LaGrande, Oregon

- October 2007 Understanding Digital Radiography
Stephen M. Miller, DMD, MAGD,
Sponsored by Kodak, Portland, Oregon
- October 2006 The ABC's Of Image Processing
Teamwork Strategies: From sabotage to Support
Human Maltreatment and Malpractice Prevention
Clinical Documentation and Record Keeping: Your Best Defense
in Dental Malpractice
Dental Assisting Round Table Learning
Meeting the Needs of Individual with Dementia
The Dentistry Practiced Daily
Dentistry's Response to Bioterrorism
American Dental Association Annual Session, LasVegas, Nevada
- April 2006 Risk Management Seminar
Identity Theft: Your Liability as an Employer
Digital Photography in Today's Dental Practice
From Methamphetamine to Zometa
Clinical Update: Developmental anomalies and Oral Pathology in
Children
Oregon Dental Association, Portland, Oregon
- November 2005 Dentrux Software Training
Jalene Wangsgaard
- April 2005- Comparison Analysis of Different Implant Surface Characteristics
and Designs, and their Effects on the Prognosis of Treatment;
Cases Only a Mother Could Love;
Dental Anatomy As it Applies to General Dentistry-
Oregon Dental Association Portland, Oregon
- March 2005- Dental Jurisprudence,
Eastern Oregon Dental Society, LaGrande, Oregon
- November 2004- Defensive Charting for Dental Professionals,
Eastern Oregon Dental Society, Pendleton, Oregon

April 2004 A Clinical Approach to Recognition and Classification of Oral Pathological Processes,
Academy of General Dentistry, Portland, Oregon

April 2004 Perioscopy: The Technology and Clinical Application
Oregon Dental Association Portland, Oregon

April 2004 The Great Interview,
The Super Job, Oregon
Dental Assisting Association (ODAA), Portland, Oregon

June 2003 11th San Antonio Institute for Dental Radiology Educators
University of Texas Health Science Center at San Antonio, TX

March 2003 Dentistry's Expanding Role in the Management of Snoring and Obstructive Sleep Apnea,
Eastern Oregon Dental Society, La Grande, Oregon

April 2002 Current Concepts and Controversies in Implant Dentistry,
Where Are We Now? Where Are We Heading?
Oregon Dental Association, Portland, Oregon

March 2000 Practice Management, Dental Emergencies
Forensic Dentistry
Professionalism
Oregon Dental Association, Portland, Oregon

March 1999 Pit and Fissure Sealants Course
Blue Mountain Community College, Pendleton, Oregon

April 1999 Effective Clinical Teaching,
University of Texas Health Science Center, San Antonio, TX

July 1998 New Aspects of Dentistry
Eastern Oregon Dental Society, Pendleton, Oregon

July 1994 San Antonio Institute for Dental Radiology Educations, San
University of Texas Health Science Center , San Antonio, TX

Continuing Education (Post Graduate-Education Degree):

- October 2015 ED 558u Problem Behaviors & At Risk Youth
Antioch University, Seattle Washington
- March 2015 ED 556x Understanding Mental Health Concerns in Students
Antioch University, Seattle Washington
- October 2014 ED 555z Understanding the Function of Behavior
Antioch University, Seattle Washington
- June 2013 SS 516i Emotional Connections
Antioch University, Seattle Washington
- June 2013 SS516j Trauma & Loss
Antioch University, Seattle Washington
- February 2011 ED 545s From Chaos to Calm
Antioch University, Seattle Washington
- February 2011 ED 519k Reducing Stress in the student and the Classroom
Antioch University, Seattle Washington
- June 2010 ED 543p Teaching and Communicating Effectively,
Antioch University, Seattle Washington
- June 2010 ED 542c Releasing Enthusiasm in Students
Antioch University, Seattle Washington
- February 2009 ED 538p Understanding Autism and Special Needs Children,
Antioch University, Seattle Washington
- June 2008 ED 534w Drug Abuse Issues in Students
Antioch University, Seattle Washington
- June 2008 ED 534x Helping Children Heal
Antioch University, Seattle Washington

February 2008 ED 533q Leadership Strategies for Teachers
Antioch University, Seattle Washington

January 2008 ED 533r Developing Healthy Choices Changing School Culture
Antioch University, Seattle Washington

June 2007 ED 531p The Angry Child
Antioch University, Seattle Washington

June 2007 ED 531o The Bully, the Bullied, & the Bystander
Antioch University, Seattle Washington

January 2007 Cultural Competency Training
Blue Mountain Community College, Pendleton, Oregon

November 2006 ED 529t Angry Children
Antioch University, Seattle Washington

November 2006 ED 529t Teaching Self Control
Antioch University, Seattle Washington

May 2005 ED 426n Stop the BULLYING-EE
Antioch University, Seattle Washington

June 2004 ED 523y Constructive Discipline
Antioch University, Seattle Washington

April 2004 ED523j Effective Classroom Discussions
Antioch University, Seattle Washington

August 2003 ED521g Preparing for a New Year
Antioch University, Seattle Washington

July 2003 ED 521f The Clutter Free Classroom
Antioch University, Seattle Washington

- June 2003 ED512e Helping the At-Risk Student (and Teacher)
Antioch University, Seattle Washington
- May 2000 Ed 406s Discipline Strategies: A Practical Approach
Antioch University, Seattle Washington
- July 1999 EED X701 Focus on Classroom Instruction and Strategies,
Humboldt State University
- July 1997 TPMX X701 Strategies/Teaching Success
Humboldt State University
- June 1997 ED 5123u Profile of the High Risk Student
Antioch University, Seattle Washington
- Mar 1997 Ed512q High Maintenance Relationships: Dealing with Difficult People
Antioch University, Seattle Washington
- July 1995 HI 493d Oregon Trail: The Blue Mountain Experience
Antioch University, Seattle Washington
- July 1995 HI 400b Exploring the Wallowa County
Antioch University, Seattle Washington
- June 1991 SPED 509 Outdoor Education/Recreation
Portland State University
- January 1987 ED 402X Instructional Theory into Practice
Eastern Oregon State College

Community Activities:

- December
2011 Co-organized and managed dental assisting students during dental
Presentation, Umatilla County, Head Start Program children.
- September
2009 Selection Committee member for the Griffith-Paul Scholarship
- April 2009 Organized panel discussion and activities for area high school students
Allied Health Pathways Conference
- April 2008 Presented Allied Health Programs and had dental activities for Riverside
High School students/
- March 2008 Presented at Oregon FFA Convention "Animals and Their Teeth"

February 2008-2011 Sponsored mouth guards and helped with BMCC's Rodeo Boxing Tournament

January-March

2008 Participated in planning of Oregon FFA State Convention
"Discovery Day" activities

January 2008 Processed National Guard soldiers for deployment

February 2007 "Give a Child a Smile Day", LaGrande, Oregon

March 2005-2015 Presented Allied Health Occupations to Leadership Pendleton Members

June 2004- Exposed Radiographs on National Guard soldiers about to be deployed.

May to July 2003 Chairside Assistant with Northwest Medical Mobile Dental Van

1998 to 2003 - Co-organized and set up "dental office visit" to Umatilla County Head Start for three and four year old children

June 2002 Committee member to reconstruct Committee's at BMCC

2001 Umatilla-Morrow County Head Start Advisory Board Member

2000 - 2002 Umatilla County Head Start Advisory Board Member

1999 Fifth Graders to Blue Mountain College for "Early Awareness"

1999 Presentation to Head Start Parents/ Alternative Education Students about Oral Health Care and the Dental Assisting Program
Hermiston, Oregon

1999 Presented Dental Careers - Career Fair for Fourth Graders at Good Shepherd Hospital, Hermiston, Oregon.

1999 Presented Dental Field Employment opportunity during Umatilla County Career Showcase

1999 Presented Dental Field Employment Union Union County Career Showcase

1984 to Present Pendleton Round-Up Volunteer

Blue Mountain Community College

Certificate of Completion

This is to Certify That

Crystal Patton-Doherty

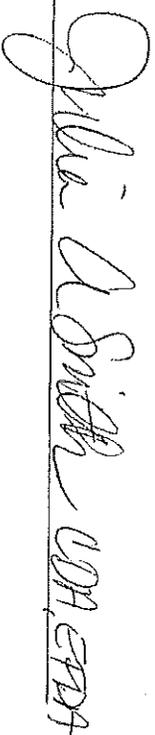
has successfully completed

Soft Denture Reline

approved course and is hereby entitled to place soft denture relines

Oregon Board of Dentistry


Bethel Sweet, CDA, EFDA, BA
Board/Approved Instructor


Julie A Smith, CDA, EFDA

4 Hours of Instruction


Date 11 May 24, 2013

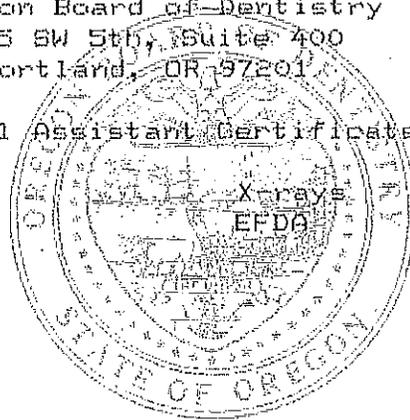
Oregon Board of Dentistry
1515 SW 5th, Suite 400
Portland, OR 97201

Dental Assistant Certificate

A6504

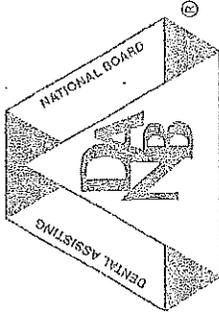
CRYSTAL D PATTON
3012 SW LADD

PENDLETON, OR 97801



Issued: 06/14/91

Dental Assisting National Board, Inc.



This confirms that

Crystal D Patton-Doherty

has fulfilled the certification requirements approved by the Board of Directors of the Dental Assisting National Board, Inc. and is authorized to use the certification mark

Certified Dental Assistant

R. L. M. G. Groggin

Frank Maggio, DDS

DANB Board Chair

Mary Harrison

Mary Harrison CDA, EFDA, EFODA, EFADA

DANB Secretary

CDA

Certification Number: 086395

Expiration Date: 10/28/2016

TSPC License Information

The following is current information* regarding
Crystal Denise Patton-Doherty

Most recent application materials pertaining to this file were received on 3/18/2016
 We are currently processing application materials that were received by TSPC on
 10/19/2015.

The following application materials have been received by TSPC

Form / Document	Source	Date Received
(C-1) Application for Educator License	Applicant	3/18/2016
(FPC) Background Check Request	Applicant	4/16/1996

Account Number: 51439

E-Mail Address: cpattondoherty@msn.com

OSP Fingerprint Clearance	8/16/1996
FBI Fingerprint Clearance	8/16/1996

Renewal / application materials have been sent for the following license(s):		
License Type	Date Mailed (approximate)	Materials sent to:
Basic Teaching	1/4/2010	Home Address

Teacher License				
License Type	Effective	Expiration	Status	Image
Basic Teaching	4/18/2013	4/17/2016	Active	YES

Endorsements	Authorization Level(s) *
Basic Elementary	014
Basic Reading	019

Date Sent	Correspondence	Description
4/24/2013	License Approval	B2a
3/25/2010	License Approval	B2a
7/5/2007	License Approval	B2a
1/15/2004	License Approval	B2a
1/15/2004	Miscellaneous	NCLB Subjects
4/6/1993	Miscellaneous	B2a

=====
 ===== End of Teacher License Information =====
 =====

* Authorization Level Codes	Authorization Description
014	To teach multiple general education subjects in grades pre-kindergarten through 9 of an elementary, middle or junior high school. May not teach assignments of 51% or more in any environment in art, educational media, ESOL, ESOL/Bilingual, foreign language, health, home economics, music, physical education, reading, and technology education.
019	To teach {endorsement} in grades pre-kindergarten through 9 in an elementary, middle, or junior high school.

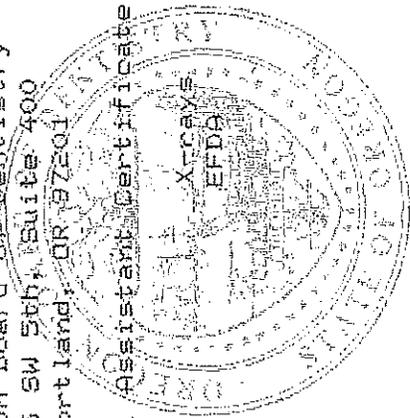
Oregon Board of Dentistry
1515 SW 5th, Suite 400
Portland, OR 97201

Dental Assistant Certificate

A6504

CRYSTAL D PATTON
3012 SW LADOW

PENDLETON, OR 97801



Issued: 06/14/91

Melissa J. Barfuss

1804 Southwest Third Street • Pendleton, Or 97801
Phone (541) 215-2805 • Email Mbarfuss@Bluecc.Edu

EDUCATION

Blue Mountain Community College, Pendleton, OR 2011

Expanded Functions Certified Dental Assistant Technician

- Infection Control
- Radiology Proficiency
- Expanded Functions Dental Assistant

CERTIFICATIONS

- Certified Dental Assistant, State of Oregon 2011
- Oregon Expanded Functions Dental Assistant, State of Oregon 2011
- Certified Dental Assistant, State of Washington 2012
- Pit and Fissure Sealant, State of Oregon 2011
- Soft Denture Reline, State of Oregon 2011
- Radiography Proficiency, State of Oregon 2011

AWARDS & HONORS

Presidents List 4.00, BMCC Fall-Spring 2011

TEACHING EXPERIENCE

Blue Mountain Community College 9/2015- Present
Pendleton, OR

Dental Assisting Instructor

- Course assignment: Chairside Procedures I, II, III
 - Health Education
 - Pharmacology
 - Dental Materials
 - Lab Materials and Procedures
 - Medical Emergencies, Pathology
 - Dental Office Procedures
 - Clinical Practice III
-

RELATED EXPERIENCE

Desert Dental, Ryan Wieseler DDS
Hermiston, OR

7/2013- Present

Lead Assistant

- Four handed dentistry
- Supply Inventory and Ordering
- Sterilization and Infection Control procedures
- Impressions, models and Occlusal guard Fabrication
- Chart notation, Dentrax Software proficiency
- Scheduling

Thomas Utt Orthodontics
Walla Walla, WA

4/2011-7/2013

Chairside Assistant

- Supply inventory and ordering
- Infection control procedures
- Assisting with bracket bonding
- Patient homecare instructions
- Impressions, models, bleach trays
- ICAT digital imaging
- Treatment charting
- Scheduling

SPECIAL TRAINING

- Cardiopulmonary Resuscitation (CPR)
- HIV Training Certification
- Computer formatting
- Microsoft Office

PROFESSIONAL ACTIVITIES/ CONTINUING EDUCATION

American Association of Orthodontics (Live Webinar)
1/2012

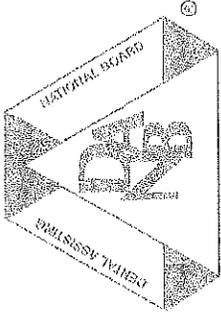
Lights, Camera, Action! Tools and Gadgets that make patient photography easy.

Proctor and Gamble	2/2012
<i>Orthodontics: A Review (Online Interactive course)</i>	
American Association of Orthodontics (Live Webinar)	2/2015
<i>How to Successfully Close Openbites Nonsurgically and Keep Them Closed.</i>	
Washington State Society of Orthodontics (PCSO/WSSO Conference)	2/2015
<i>Destination Success</i>	
<i>The Sky is the Limit!</i>	
Pacific Coast Society of Orthodontics (Dental Board of California)	10/2012
<i>Improving Management of Patients with Autism and ADHD.</i>	
<i>Think Right, Do Right, Be right.</i>	
<i>Managing Your Stress- How to Relax and Enjoy</i>	
<i>Clinical Photography: Taking Quality Extraoral & Intraoral Photos.</i>	
<i>From my side of the chair: Sterilization in Today's Orthodontic Practice.</i>	
<i>High Quality + High Efficiency = A Great Practice!</i>	
<i>Patient Flow Scheduling & Digital Pearls for Efficient Letters and Marketing.</i>	
<i>Creating an Elite Orthodontic Office: A Comprehensive Review.</i>	
<i>Live Life Smiling: The Practice Playbook of a Doctor, a Team and a Dream.</i>	
American Dental Association (ADA CERP)	10/2013
<i>Update with Dental Materials</i>	
<i>Dr. Geoffrey Berg's Implant Overview</i>	
<i>CDC Infection Control Guidelines for Dentistry.</i>	
Great Blue Heron Seminars	5/2015
<i>Some Days you're the Pigeon, Some days the Statue</i>	

PROFESSIONAL MEMBERSHIPS

Dental Assisting National Board Inc.

Dental Assisting National Board, Inc.



This confirms that

Melissa J Barfuss

has fulfilled the certification requirements approved by the Board of Directors of the Dental Assisting National Board, Inc. and is authorized to use the certification mark

Certified Dental Assistant

R. Lynn G. Maggio

Frank Maggio, DDS

DANB Board Chair

Mary Harrison

Mary Harrison CDA, EFDA, EFODA, FADA, FADA

DANB Secretary

Certification Number: 210384

Expiration Date: 06/15/2016

CDA

CDA is a registered certification mark of DANB. Certified Dental Assistant is a certification mark of DANB.

OREGON BOARD OF DENTISTRY
Dental Assistant

Expanded Functions Dental Assistant
Issued: July 29, 2011

120196
CERTIFICATE NUMBER

Melissa J Pace

Radiological Proficiency
Issued: May 23, 2011

THIS CERTIFICATE MUST BE POSTED IN A CONSPICUOUS PLACE IN PLAIN SIGHT OF PATIENTS

Washington State Department of Health

By the authority of RCW 18.260 this person

Melissa June Pace

is granted a

Dental Assistant Registration

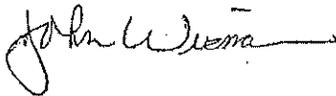
Status
ACTIVE

Effective Date
04/28/2015

Initial Issuance
11/04/2011

Credential Number
D1 60243973

Expiration Date
05/24/2016



Secretary

Blue Mountain Community College
Certificate of Completion

Temporary Soft Denture Reline

certifies to all that

Melissa Pace

has fulfilled the requirements of

Oregon Board of Dentistry

approved course and is hereby entitled to place temporary soft denture reline

February 5, 2014

Michelle Sweet

Michelle Sweet, CDA, EFD, A, BA
Board Approved Instructor

Dir.

4 Hours of Instruction

Blue Mountain Community College
Certificate of Completion

Pit and Fissure Sealants

certifies to all that

Melissa Pace

has fulfilled the requirements of

Oregon Board of Dentistry

approved course and is hereby entitled to place pit and fissure sealants

Melissa Pace
Board-Approved Dentist

Paula Sun Anderson 8-3-2002
Bebe Sweet CDA-ETIDA
Board-Approved Instructor

Hours of Instruction

9



COLORADO

Department of
Regulatory Agencies

Division of Professions and Occupations

Management Branch
Office of Licensing

March 14, 2016

Sam Delp, Licensing Director
Division of Professions and Occupations
1560 Broadway, Suite 1350
Denver, CO 80202

The Colorado Department of Regulatory Agencies, Division of Professions and Occupations has enhanced our online verification system. Our online system provides the official Colorado verification for professions regulated by our office and is updated in real time. Beginning on March 14, 2016, requests for verification will be directed to the online system for the following professions:

- | | | |
|-----------------------------|----------------------------|-----------------------------|
| Acupuncture | Addiction Counselor | Athletic Trainer |
| Audiologist | Barber | Boxer |
| Boxing Promoter | Boxing Official | Cosmetologist |
| Chiropractor | Certified Nurse Aide | Dentist |
| Dental Hygienist | Direct-Entry Midwife | Esthetician |
| Funeral Home & Crematory | Hairstylist | Hearing Aid Provider |
| Marriage & Family Therapist | Massage Therapist | Nail Technician |
| Naturopathic Doctor | Outfitter | Nursing Home Administrator |
| Occupational Therapist | Occupational Therapy Asst. | Optometrist |
| Physical Therapy Asst. | Pharmacist & Pharmacy | Podiatrist |
| Private Investigator | Professional Counselor | Psychologist |
| Registered Psychotherapist | Respiratory Therapist | Physical Therapist |
| Social Worker | Shop Registration | Speech-Language Pathologist |
| Surgical Assistant | Surgical Technologist | Veterinarian |

The verification system is available to the public, at no charge, and can be accessed by visiting www.colorado.gov/dora/dpo and choosing "Request Verification of a License". The system allows for individual verification searches, as well as the ability to download lists of professionals in specific fields. You can enter as much, or as little, information as you have available to search. The printable verification will provide information about the license* and licensee, the date the verification was generated, discipline information, and the Colorado state seal. Colorado will not complete state specific forms or complete verifications manually.

Please make note of this system as our office will no longer provide manual verifications for these professions after March 14, 2016. Should you have questions, please contact our office at 303-894-7800.

Sincerely,

Sam Delp
Licensing Director

*The word "License" is used as a generic term for the purpose of this communication and can refer to a license, registration or certification.



A note from outgoing Oregon Board of Dentistry President, Alton Harvey, Sr.

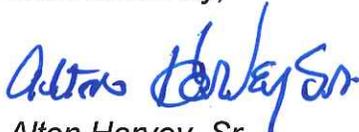
When I was appointed to serve on the Oregon Board of Dentistry I never could have imagined what was before me. Now serving in my sixth year and this past year as President I would like to say to the board, Thank you so very much.

Last year is what I would like to reflect on. In January of 2015, I along with my fellow board members, was informed that the Executive Director of the Board was resigning. Well that meant we the board had to select a new Director. This was a new experience for every member of this Board. Mr. Prisby was the office manager at the time. He immediately accepted the role of Interim Executive Director, and without any hesitation began a dual role serving as executive director and still continuing to fulfill the duties of the office manager. At that time the board was having some internal issues, and in my opinion we were in a very crucial time to stay positive and fulfill our duties. I saw the Board come together, unite, and focus on hiring the next executive director. The Board worked with our assigned HR recruiter from the state. Throughout the Spring of 2015, the Board discussed hiring criteria, reviewed candidates, conducted interviews and ultimately selected Mr. Prisby as the new Executive Director at the June 2015 Board meeting.

My colleagues on the Board chose me as President at the April 2015 Board Meeting. I resolved to work closely with Mr. Prisby and the OBD staff and support them in any way I could. I enjoyed meeting with the staff and was impressed with their determination and focus on doing their jobs as best as they could, and not letting the circumstances negatively impact their work. Mr. Prisby along with the office staff continued to execute the day to day business operations without any glitches. The Board's 2015-17 Budget was approved. The Board conducted all its regularly scheduled Board meetings. The Board dispensed and carried out all its statutory functions. The Board conducted a public rulemaking hearing in August and amended 20 rules. Again that couldn't have happened without the very steady handed leadership of Mr. Prisby.

I just want to say thank you to all of my fellow board members, the OBD Staff and our important stakeholders for a job well done, and as I step out of my role as President, I look forward to this Board continuing on with its important mission and am excited for the Board's future endeavors.

Most Sincerely,



Alton Harvey, Sr.
President, Oregon Board of Dentistry

**NEWSLETTERS
&
ARTICLES OF
INTEREST**

From: Schmitt, Madelaine [<mailto:schmittm@ada.org>] **On Behalf Of** Tooks, Sherin
Sent: Friday, February 26, 2016 12:55 PM
To: Schmitt, Madelaine
Cc: Tooks, Sherin; Albrecht, Cathryn E.
Subject: CODA Winter 2016 Accreditation Actions - Notice
Importance: High

National, Regional, and Specialized Accreditors and State Boards of Dentistry:

In accordance with established policy of the Commission on Dental Accreditation and regulations of the United States Department of Education, please consider this notification that as a result of action taken by the Commission at its February 4 – 5, 2016 meeting, the following education programs have been notified of the Commission's "intent to withdraw accreditation" at its next regularly scheduled meeting on August 4 – 5, 2016 if these programs do not achieve compliance with accreditation standards or policy by that date:

Dental Assisting

Fortis College – Mobile, AL
Kaplan College-Nashville – Nashville, TN
Lake Michigan College – Benton Harbor, MI
Lindsey Hopkins Technical Education Center – Miami, FL
Mid-Plains Community College – North Platte, NE

Oral and Maxillofacial Surgery

Allegheny General Hospital – Pittsburgh, PA

Orthodontics and Dentofacial Orthopedics

Montefiore Medical Center – Bronx, NY

Periodontics

Veterans Affairs Medical Center/New York – New York, NY

Prosthodontics

Veterans Affairs Medical Center/New York – New York, NY

In addition, the Commission recognized that the following programs have voluntarily discontinued their participation in the Commission's accreditation program:

Dental Assisting

Lincoln Technical Institute – Fern Park, FL
University of Hawaii Maui College – Kahului, HI
Brightwood College (Formerly Kaplan College) – Indianapolis, IN
Cumberland County Technical Education Center – Bridgeton, NJ
IntelliTec Medical Institute DBA Institute of Business & Medical Careers – Colorado Springs, CO (by mail ballot on September 28, 2015)

The following new programs have been granted accreditation:

Advanced Education in General Practice Residency

Cabell Huntington Hospital – Huntington, WV

Dental Assisting

Umpqua Community College – Roseburg, OR

Dental Hygiene

Indian Hills Community College – Ottumwa, IA

Oral and Maxillofacial Surgery

Geisinger Medical Center – Danville, PA

Predoctoral Dental Education

Touro College and University System – Hawthorne, NY

The accreditation statuses of programs reviewed by the Commission on Dental Accreditation at its Winter 2016 meeting can be found at

<http://www.ada.org/en/coda/accreditation/accreditation-news/accreditation-notices>

The accreditation statuses of all programs accredited by the Commission on Dental Accreditation can be found at <http://www.ada.org/en/coda/find-a-program/search-dental-programs>

If you have further questions regarding this information, please contact the Commission on Dental Accreditation. Thank you.

Sherin Tooks, Ed.D., M.S. tookss@ada.org

Director, Commission on Dental Accreditation

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MEMO: New 2016 AHA BLS Provider Cards



CPR & Emergency Cardiovascular Care

Date of Release	February 16, 2016
Purpose	To provide direction and information on the 2016 Basic Life Support (BLS) Course eCards and print course completion cards until the revised Course Card Reference Guide is published.
General Information	<p>The Instructor-led BLS Course has been updated to reflect the <i>2015 AHA Guidelines Update for CPR and ECC</i>. The AHA has released new BLS Course materials that aid in providing quality and consistency in all BLS courses. The new BLS Course can only be taught by current BLS Instructors who completed the 2015 Guidelines Science Instructor Update for BLS.</p> <p>The new BLS Course replaces the BLS for Healthcare Providers (BLS HCP) and BLS for Prehospital Providers (BLS PHP) courses.</p>
Course Card Information	<p>As of February 16, 2016, the AHA has released materials for the BLS Instructor-led Course. 2016 BLS materials include new BLS eCards and print course completion cards to be issued when teaching the new BLS Course.</p> <p>During the 60-day transition period of February 16, 2016 - April 15, 2016, Training Centers and Instructors may continue to use remaining stock of BLS Healthcare Provider eCards and print course completion cards.</p> <p>Beginning April 16, 2016, only the new BLS Course may be taught and only the new BLS Provider eCards and print course completion cards can be issued.</p> <p>Please review the new 2016 BLS Course card details below.</p> <p>For information on the 2010 Guidelines version BLS Healthcare Provider eCards and print course completion cards, review the current Course Card Reference Guide here.</p>

Quality Control Checkpoints for both eCards and print Course Completion Cards

- Issue date beginning February 16, 2016
- Valid until further notice
- Renewal date 2 years from month of issue

MEMO: New 2016 AHA BLS Provider Cards

CPR & Emergency Cardiovascular Care

Image of 2016 BLS Print Course Completion Card

BASIC LIFE SUPPORT		BASIC LIFE SUPPORT	
BLS Provider		Training Center Name	TC ID #
		TC Info City, State	TC Phone
The above individual has successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association's Basic Life Support (CPR and AED) Program.		Course Location	
Issue Date	Recommended Renewal Date	Instructor Name	Inst. ID #
		Holder's Signature	
<small>© 2015 American Heart Association. Tampering with this card will alter its appearance. 15-1805</small>			

Images of 2016 BLS eCards

BASIC LIFE SUPPORT	
BLS Provider	
The above individual has successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association's Basic Life Support (CPR and AED) Program.	
Issue Date	Recommended Renewal Date
Training Center Name	Instructor Name
Training Center ID	Instructor ID
Training Center Address	eCard Code
Training Center Phone Number	123456791100
<small>To view or verify authenticity, students and employers should scan this QR code with their mobile device or go to www.heart.org/cpr/mycards. © 2016 American Heart Association. All rights reserved. 15-3001 3/16</small>	

Actual eCard size = 7 3/8 inches wide by 8 inches tall

MEMO: New 2016 AHA BLS Provider Cards



CPR & Emergency Cardiovascular Care

Wallet-sized eCard

BASIC LIFE SUPPORT		BASIC LIFE SUPPORT	
BLS Provider		Training Center Name	
		Training Center ID	
The above individual has successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association Basic Life Support (CPR and AED) Program.		TC Address	
Issue Date	Recommended Renewal Date	TC Phone	
		Instructor Name	
		Instructor ID	
<small>To view or verify authenticity, students and employers should scan this QR code with their mobile device or go to www.heart.org/cpr/mycards.</small>		<small>© 2016 American Heart Association 15-3001 3/16</small>	

Actual eCard size = 3.375 inches wide by x 2.125 inches tall

What is expected of volunteers?

After registering:

- You may be asked to participate in disaster-related training to prepare you for your role in the response;
- You will agree to be contacted in the event of an emergency or future training opportunities;
- Once notified of an emergency or training opportunity, you are free to decide whether or not to participate. (You should consider family needs, professional commitments, the nature and length of the event, your own state of health, etc.)

Registering does NOT obligate you to respond during any given emergency.

“Community emergencies create special challenges to providing health services to people who need them. As a community of health professionals, we may be called on to provide more care than usual, or to provide care in different ways or in different settings.”

Gary Oxman, M.D., M.P.H.

Health Officer – Clackamas, Multnomah and Washington Counties



For more information, e-mail:
SERV.OR@state.or.us
or call **1-877-343-5767**

Visit: <https://SERV-OR.org>

Oregon statutes that apply to the establishment of the registry are:

- ORS 401.651–401.670, and
- OAR 333-003-0100 to 333-003-0140.

This document can be furnished in alternate formats for individuals with disabilities. Available formats are large print, Braille, audio tape, electronic, oral presentation and computer disk (in ASCII format). Call 971-673-1244, or for TTY call 971-673-0372.

SERV-OR

State Emergency Registry
of Volunteers in Oregon



Oregon Health Care Workers...
...When disaster strikes,
can we count on you?

Register now!
**You could make
a difference**

 | Independent. Healthy. Safe.

Put your skills to use.

**Register and train to take
part in Oregon's disaster
response program.**

“In the event of a natural disaster or health crisis, nurses will be at the forefront of providing crucial health care services to our friends, families and neighbors.”

Susan King, M.S., R.N.

Executive Director,
Oregon Nurses Association



What is SERV-OR?

SERV-OR is a statewide registry system to help pre-credentialed health care professionals (physicians, nurses, behavioral health providers and others) volunteer their services during emergencies with significant health impacts. The registry is sponsored by the Oregon Public Health Division in partnership with the Medical Reserve Corps. It utilizes a secure database to register, credential, and alert volunteer health providers.

When disaster strikes, you may be asked to volunteer at the local, state or national level depending on your credentials, interest, availability and the nature and scope of the event.

Why is the registry necessary?

Recent large-scale disasters have shown that an effective response requires pre-credentialed volunteers to provide health services for people impacted by an emergency.

When disaster strikes, health officials will decide what health skills are essential for the response. If your skills match the needs, you will be alerted and given the opportunity to respond.

Who should register?

Physicians of every specialty, nurses, behavioral health providers, pharmacists and all other licensed health care professionals who wish to volunteer in the event of a large-scale health care emergency or mass casualty event.

What do I gain from volunteering?

As a volunteer, you'll gain personal satisfaction, a chance to make a difference in your community and the knowledge that you are part of an effective, official response system.

You will have the opportunity to:

- Train for disaster response;
- Obtain CEU/CME/CNE credits; and
- Participate in community public health events and exercises.

Can I join a Medical Reserve Corps (MRC) unit and also join the state-managed volunteer pool?

Yes: Volunteers are encouraged to join their local MRC unit and the state-managed pool. The MRC program organizes and trains health and medical professionals at the county or regional level. The state-managed pool does the same for those also wishing to volunteer for state-wide and national events.



To learn more about MRCs, visit www.medicalreservecorps.gov.

"We call upon all of our colleagues across the state to put their education and experience to use by becoming a member of the volunteer registry."

Kristine Campbell, Ph.D., R.N.
Executive Director,
Oregon Center for Nursing

What are the liability protections for volunteers?

When you respond to a Governor-declared emergency or state-authorized training or exercise, there are liability protections under the law for purposes of any claim that might be made against you. You may also be entitled to benefits if you are injured while responding. Many counties and other local jurisdictions use the same approach to covering health care volunteers in local emergencies. *You should check with the local jurisdiction to determine liability coverage for a local event.*

HOW DO I REGISTER?

Visit

<https://SERV-OR.org>

where you can watch a short multimedia presentation about the volunteer registry.

State Emergency Registration of Volunteers in Oregon (SERV-OR)

SERV-OR is a statewide registry system to help pre-credentialed health care professionals volunteer their services during emergencies with significant health impacts. The registry is sponsored by the Oregon Public Health Division in partnership with the Medical Reserve Corps. It utilizes a secure database to register, credential, and alert volunteer health providers.

Major Advantages to Pre-Registration:

- Identification
- Licensing Verification / Credentialing
- Training
- Liability coverage
- Avoids Spontaneous Unaffiliated Volunteers
- Retired professionals (up to 10 years)
- Organized response (ICS structure)
- Efficient and appropriate response

Example Professional Healthcare Volunteer Roles:

- Behavioral Health
- Dentists
- EMT's
- Pharmacist
- PA
- Physician
- RN/LPN/APRN
- Respiratory Therapist
- Veterinary
- Non-licensed Volunteers

Benefits to Volunteering:

- Professional and personal fulfillment
- Community pride
- Training courses and exercises
- Continuing education
- Personal safety
- Trained community disaster workforce

Example Assignments

- Triage Center
- Hospital or Clinic
- Rapid Needs Assessment
- Community Wellness Event
- Vaccination or Mass Meds Delivery

Liability Coverage

- During a State declared disaster, SMVP members are covered for liability and tort claims as well as workers compensation as they are working as agents of the state
- Responders volunteering at a local disasters check with local agencies for options of liability coverage

DeWayne Hatcher

SERV-OR Systems Coordinator <https://serv-or.org>

OHA- Public Health Division

Health Security, Preparedness and Response Program

dewayne.r.hatcher@state.or.us

(971) 673-1038

About the Medical Reserve Corps

The Medical Reserve Corps (MRC) is a national network of volunteers, organized locally to improve the health and safety of their communities. The MRC network comprises 993 community-based units and 207,783 volunteers located throughout the United States and its territories.

MRC volunteers include medical and public health professionals, as well as other community members without healthcare backgrounds. MRC units engage these volunteers to strengthen public health, improve emergency response capabilities and build community resiliency. They prepare for and respond to natural disasters, such as wildfires, hurricanes, tornados, blizzards, and floods, as well as other emergencies affecting public health, such as disease outbreaks. They frequently contribute to community health activities that promote healthy habits. Examples of activities that MRC volunteers participate in and support include:

- Emergency Preparedness and Response Trainings
- Emergency Sheltering
- Responder Rehab
- Disaster Medical Support
- Disaster Risk Reduction
- Medical Facility Surge Capacity
- First Aid During Large Public Gatherings
- Planning, Logistical, & Administrative Support
- Veterinary Support and Pet Preparedness
- Health Screenings
- Obesity Reduction
- Vaccination Clinics
- Outreach to Underserved Community Members
- Heart Health
- Tobacco Cessation
- Community Event Support
- Healthy Living
- Health Education and Promotion
- Engaging Youth in Public Health Activities

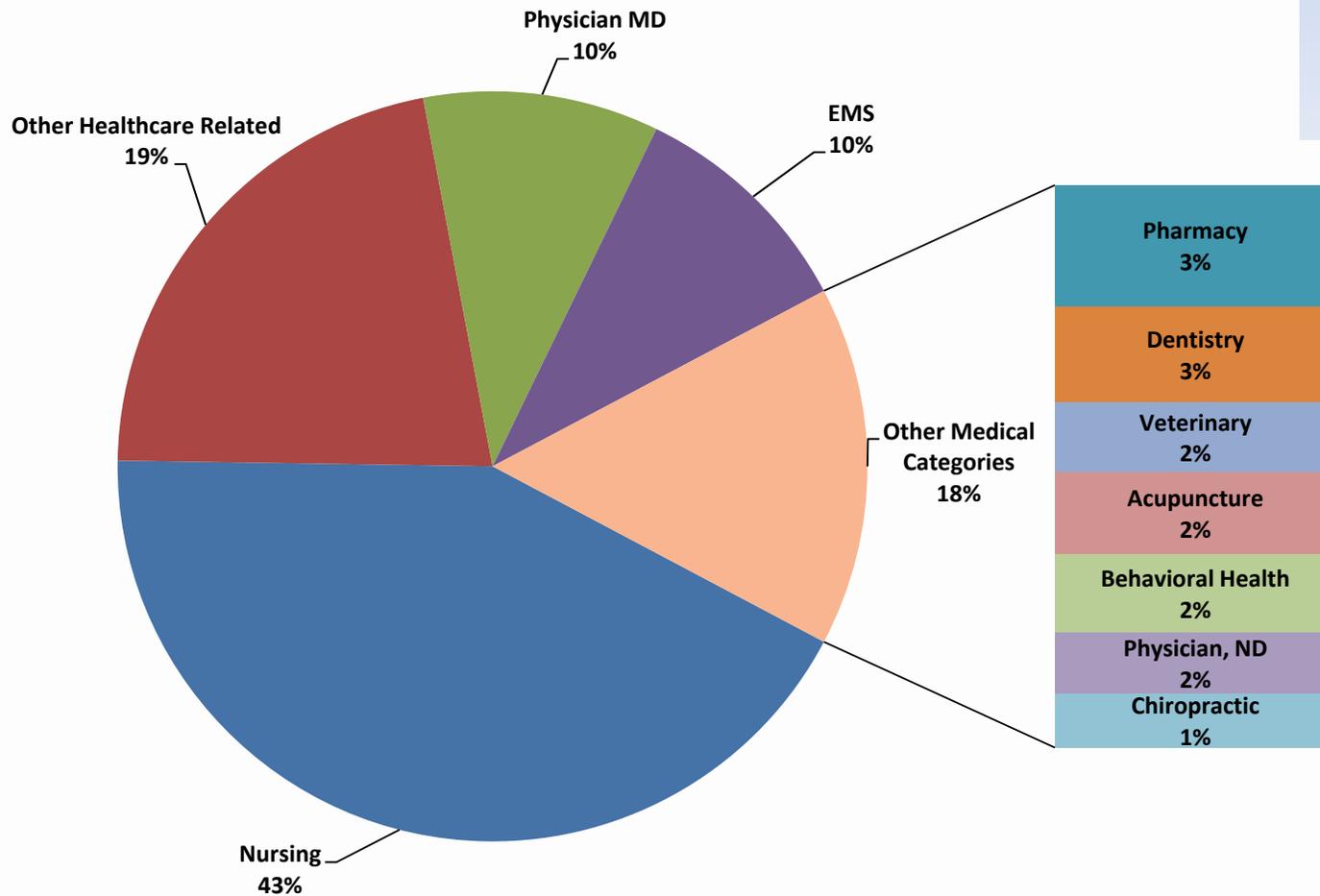
The MRC mission is supported by the Division of the Civilian Volunteer Medical Reserve Corps (DCVMRC), which serves as the National Program Office for the MRC. To learn more about the DCVMRC and staff, please visit the [About the DCVMRC](#) page.

Friday, April 01, 2016

SERV-OR Volunteers March 2016

State Emergency Registry of Volunteers in Oregon

Occupation Profile
* All units, related roles
* By primary occupation
Total Volunteers:
2649



Wilsonville dentist uses history to address rampant tooth decay

Created on Wednesday, 09 March 2016 15:01 | Written by [Jake Bartman](#) | Originally published in The Portland Tribune 
[0 Comments](#)

Old-school technique to treat cavities without fillings gains ground



When Wilsonville dentist Steve Duffin began to look for a way to address soaring rates of dental disease at his Keizer clinic 10 years ago, he didn't expect to find his way into a burgeoning movement in the world of American dentistry.

But when he began to practice a long-forgotten technique for treating cavities without fillings, he discovered what he calls a "miracle" that he believes has the potential to change the lives of the millions around the world who face poor access to dental care.

Duffin became involved with the Oregon Health Plan in 1994, and spent 10 years as the CEO of Capitol Dental Care, which bills itself as "the largest dental contractor with the State of Oregon."

In 2005, Duffin was lost while driving through Keizer looking for an Oregon Health Plan dentist with whom he'd had a business meeting scheduled. He came across an empty building that looked over Staats Lake and, in a moment of inspiration, decided to open his own clinic there to treat low-income children and their families.

Duffin resigned from his position at Capitol and opened Shoreview Dental later that year, and picked up his drill again.

But there was a problem. Every five years, the State of Oregon documents the state of children's oral health in its "Smile Survey." Duffin was troubled by the findings of the 2002 Smile Survey, which found that more than half of the state's first, second and third graders suffered from untreated dental decay — that is, from cavities.

Worse still was the 2007 Smile Survey, which found that incidents of dental decay had increased by 50 percent from the 2002 survey.

"It was really kind of a frustrating time for me, because I felt like I was in the right place, trying to do the right thing, but we weren't really making any progress," Duffin said.

Duffin says that epidemic — which he blames on the rise of high-fructose corn syrup — was so great that he was making weekly trips to the hospital to anesthetize children for treatment. He began to wonder if there was an alternative.

He started at the beginning — the very beginning: he opened a book by G.V. Black, who is considered a progenitor of American dentistry. Duffin had studied Black while a student, but hadn't heard of a 1908 book called "Pathology of the Hard Tissues of the Teeth" until he heard it mentioned during his inquiry.

Duffin was floored by the sophistication of Black's work, which correctly identified bacterial infection as the cause of dental decay. Duffin was especially surprised to find that Black — who is known as a father of the modern filling — had also invented a way to treat that bacterial infection with the chemical compound silver nitrate.

Black argued that by applying the substance several times to a cavity, one could kill the bacteria and prevent the cavity from worsening. Duffin found in his research that the technique had, in fact, been widely used in the United States until sometime around the middle of the century, when fillings became the preferred method of treating cavities.

At around the same time as Duffin discovered silver nitrate through Black, he found that dentists overseas were using a chemical called silver diamine fluoride. The substance was essentially silver nitrate mixed with a fluoride, which strengthens tooth enamel.

Duffin met Mike Shirtcliff, the CEO of Advantage Dental, which is an Oregon Health Plan contractor. Shirtcliff had discovered silver diamine fluoride as well, and was working to get the FDA to OK the product. He provided Duffin with a bottle of the substance that was manufactured in Japan.

"I was just blown away with what I saw. There were just amazing results," Duffin says.

Rather than anesthetizing his patients and performing extensive tooth extractions and fillings, Duffin began to apply the silver diamine fluoride to patients' teeth. The procedure he developed was to apply the substance three times over the course of approximately as many months, killing the bacteria and protecting the tooth from further decay.

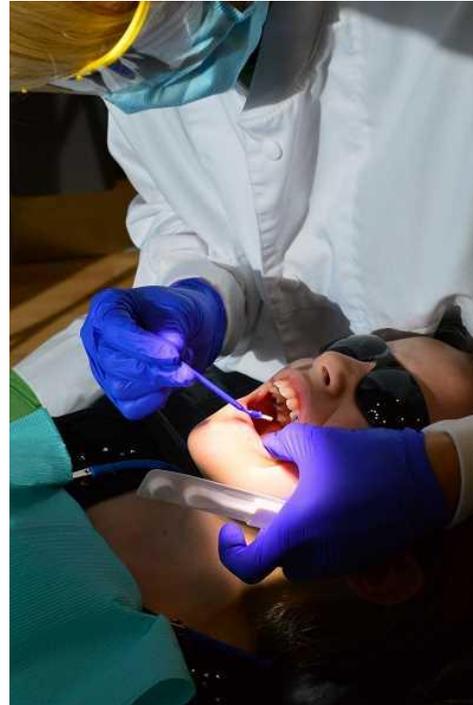
Pending FDA approval, however, Duffin chose to use silver nitrate, since that chemical had already been approved. He would then apply fluoride on top of the treated area, yielding essentially the same effect as could be obtained with the silver diamine fluoride.

Within months, Duffin had stopped taking patients to the hospital entirely, and fillings became a last resort. Better still for patients, the silver nitrate was cheap, costing low-income patients a fraction of what fillings cost.

In the meantime, Duffin and Shirtcliff worked with the FDA to get the silver diamine fluoride approved, which it did in 2014. The FDA also classified the chemical as a fluoride product, meaning that unlike silver nitrate, dental hygienists are permitted to apply it.

Duffin has also increasingly conducted formal research on silver nitrate and silver diamine fluoride. In November 2012, the California Dental Association Journal published as its cover story an article by Duffin called "Back to the Future: The Medical Management of Cavities."

The article ignited a controversy in the dental community. Some worried that the chemical was unsafe. Advocates argued that it's no more dangerous than using mercury, phosphoric acid or other chemicals commonly used by dentists. Others criticized the technique for its tendency to turn treated cavities black — a problem Duffin says is negligible in children who will lose their baby teeth soon anyway, or which can be covered with fillings applied without the usual numbing and drilling combination for adults.



“Some of (the controversy) is, I think, influenced by economics,” Duffin said. “Dentists who make their living doing fillings don’t want to be told “That doesn’t work; here’s something that does work, and it costs pennies, and the patients really like it.””

Duffin says that silver nitrate and silver diamine fluoride are nevertheless gaining ground in the dentistry community, and studies are increasingly being conducted by researchers across the country on the substances.

In the meantime, Duffin continues to conduct his own research. And he is working with his son Marcus — a scientist and entrepreneur— to develop a method for doctors, nurses, teachers and community leaders in developing countries to apply silver nitrate and fluoride.

The Duffins have designed a pen-sized tube that allows administration of both silver nitrate and fluoride with ease, and are currently conducting large-scale, year-long pilot programs of the product in Ecuador and Ghana. The goal is to eradicate dental decay where it’s already begun, as in Ecuador, and to prevent it in countries like Ghana where economic development will soon mean more sugar entering the country.

Although he doesn’t want to give out details in advance of an article he’s writing on the studies, Duffin says that the results have been stellar.

“My life is simpler because I’m not doing complex surgical extractions, and root canals and all those things that happen when prevention fails,” Duffin says. “But I’m also happy that something so effective is now growing, and is going potentially to help millions of people.”

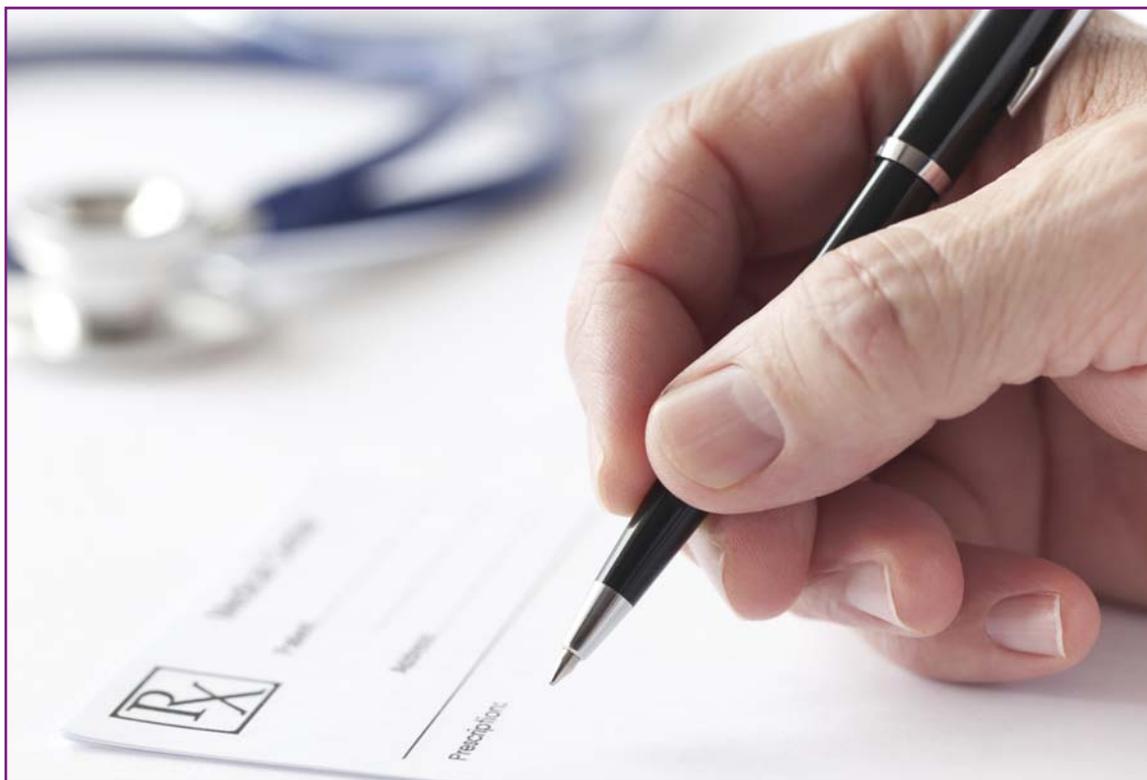
Contact Jake Bartman at 503-636-1281 ext. 113 or jbartman@pamplinmedia.com .

Photos:

Page 1 - SPOKESMAN PHOTO: JAKE BARTMAN - Steve Duffin, left, and Mike Shirtcliff, right, are both vocal advocates for the use of silver nitrate and silver diamine fluoride as an effective and inexpensive way to treat cavities.

Page 2 - SPOKESMAN PHOTO: JAKE BARTMAN - Ashlynn Coster, 7, has silver diamine fluoride applied to several cavities by her mother, Dental Assistant Amber Barnett of Shoreview Dental.

CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016



Continuing Education Examination available at <http://www.cdc.gov/mmwr/cme/conted.html>.



U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

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Disclosure of Relationship

The Core Expert Group (CEG) members disclose that they have no financial conflicts of interest. Experts disclose the following activities related to the content of this guideline: Pam Archer discloses authorship of the Oklahoma Emergency Department and Urgent Care Clinic Opioid Prescribing Guidelines and the Opioid Prescribing Guidelines for Oklahoma Health Care Providers in the Office Based Setting; Bonnie Burman discloses authorship of the Ohio Guidelines for Prescribing Opioids for the Treatment of Chronic, Non-Terminal Pain; Jane Ballantyne discloses that she has served as a paid consultant to Cohen Milstein Sellers & Toll, PLLC, and has special advisory committee responsibilities on the Food and Drug Administration (FDA) Risk Evaluation and Mitigation Strategies committee; Phillip Coffin discloses that in 2012 he provided expert testimony to the California State Assembly regarding a bill to expand naloxone access and reports that he is the principal investigator on a research study of methamphetamine dependence that receives donated injectable naltrexone from Alkermes, Inc.; Gary Franklin discloses authorship of the AMDG Interagency Guideline on Prescribing Opioids for Pain; Erin Krebs discloses that she represented the American College of Physicians at a 2014 Food and Drug Administration meeting on Abuse Deterrent Opioid Formulations; Lewis Nelson discloses his ad-hoc membership on the FDA Drug Safety and Risk Management Advisory Committee; Trupti Patel discloses authorship of the Arizona Opioid Prescribing Guidelines; Robert “Chuck” Rich discloses that he was an author of the 2013 American Academy of Family Physicians position paper on opioids and pain management; Joanna Starrels discloses that she received honoraria from the Betty Ford Institute; Thomas Tape discloses that he was an author of the 2013 American College of Physicians policy

position paper on prescription drug abuse. CDC provided 100% of the funding for the supplemental evidence review tasks and meeting support. No foundation or industry support was accepted.

The Opioid Guideline Workgroup (OGW) members disclose that they have no financial conflicts of interest. Experts disclose the following activities related to the content of this guideline: Anne Burns discloses that she participated in a congressional briefing sponsored by Reps. Carter and DeSaulnier on the pharmacist’s role of furnishing Naloxone and that she participates on the National Advisory Board for the Prescription Drug Abuse and Heroin Summit. Chinazo Cunningham discloses that her husband is employed by Quest Diagnostics and Dr. Cunningham was recused from any discussion related to urine drug testing. Traci Green discloses that she was previously employed by Inflexxion, a small business that conducts Small Business Innovation Research on behavioral interventions for behavioral health and chronic pain and created several psychometric tools for conducting risk assessment for prescription opioid abuse potential. Dr. Green also discloses that while at the hospital where she is employed, she provided consultation to Purdue Pharma Ltd to design overdose prevention brochures for persons who use diverted prescription opioids non-medically with an emphasis on persons who inject prescription drugs, and not for patients using opioid therapy for pain. Dr. Green was recused from any discussion related to risk assessment tools and patient education materials. Erin Krebs discloses that she served on the CDC Opioid Prescribing Guideline CEG. Christina Porucznik discloses that she served on the CDC Opioid Prescribing Guideline CEG. Greg Terman discloses that he serves as the President of the American Pain Society. Mark Wallace discloses that he served on a Kempharma advisory panel for an abuse-deterrent hydrocodone formulation to treat acute postoperative pain and Dr. Wallace was recused from any discussion related to abuse-deterrent drugs.

The NCIPC Board of Scientific Counselors (BSC) members disclose that they have no financial conflicts of interest. Two BSC members, Traci Green and Christina Porucznik, served on the Opioid Guideline Workgroup. Traci Green discloses that she was previously employed by Inflexxion, a small business that conducts Small Business Innovation Research on behavioral interventions for behavioral health and chronic pain and created several psychometric tools for conducting risk assessment for prescription opioid abuse potential. Dr. Green also discloses that while at the hospital where she is employed, she provided consultation to Purdue Pharma Ltd to design overdose prevention brochures for persons who use diverted prescription opioids non-medically with an emphasis on persons who inject prescription drugs, and not for patients using opioid therapy for pain. Dr. Green was recused from any discussion related to risk assessment tools and patient education materials. Christina Porucznik discloses that she served on the CDC Opioid Prescribing Guideline CEG.

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CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016

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Summary

This guideline provides recommendations for primary care clinicians who are prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. The guideline addresses 1) when to initiate or continue opioids for chronic pain; 2) opioid selection, dosage, duration, follow-up, and discontinuation; and 3) assessing risk and addressing harms of opioid use. CDC developed the guideline using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) framework, and recommendations are made on the basis of a systematic review of the scientific evidence while considering benefits and harms, values and preferences, and resource allocation. CDC obtained input from experts, stakeholders, the public, peer reviewers, and a federally chartered advisory committee. It is important that patients receive appropriate pain treatment with careful consideration of the benefits and risks of treatment options. This guideline is intended to improve communication between clinicians and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder, overdose, and death. CDC has provided a checklist for prescribing opioids for chronic pain (<http://stacks.cdc.gov/view/cdc/38025>) as well as a website (<http://www.cdc.gov/drugoverdose/prescribingresources.html>) with additional tools to guide clinicians in implementing the recommendations.

Introduction

Background

Opioids are commonly prescribed for pain. An estimated 20% of patients presenting to physician offices with noncancer pain symptoms or pain-related diagnoses (including acute and chronic pain) receive an opioid prescription (1). In 2012, health care providers wrote 259 million prescriptions for opioid pain medication, enough for every adult in the United States to have a bottle of pills (2). Opioid prescriptions per capita increased 7.3% from 2007 to 2012, with opioid prescribing rates increasing more for family practice, general practice, and internal medicine compared with other specialties (3). Rates of opioid prescribing vary greatly across states in ways that cannot be explained by the underlying health status of the population, highlighting the lack of consensus among clinicians on how to use opioid pain medication (2).

Prevention, assessment, and treatment of chronic pain are challenges for health providers and systems. Pain might go unrecognized, and patients, particularly members of racial and ethnic minority groups, women, the elderly, persons with

cognitive impairment, and those with cancer and at the end of life, can be at risk for inadequate pain treatment (4). Patients can experience persistent pain that is not well controlled. There are clinical, psychological, and social consequences associated with chronic pain including limitations in complex activities, lost work productivity, reduced quality of life, and stigma, emphasizing the importance of appropriate and compassionate patient care (4). Patients should receive appropriate pain treatment based on a careful consideration of the benefits and risks of treatment options.

Chronic pain has been variably defined but is defined within this guideline as pain that typically lasts >3 months or past the time of normal tissue healing (5). Chronic pain can be the result of an underlying medical disease or condition, injury, medical treatment, inflammation, or an unknown cause (4). Estimates of the prevalence of chronic pain vary, but it is clear that the number of persons experiencing chronic pain in the United States is substantial. The 1999–2002 National Health and Nutrition Examination Survey estimated that 14.6% of adults have current widespread or localized pain lasting at least 3 months (6). Based on a survey conducted during 2001–2003 (7), the overall prevalence of common, predominantly musculoskeletal pain conditions (e.g., arthritis, rheumatism, chronic back or neck problems, and frequent severe headaches) was estimated at 43% among adults in the

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United States, although minimum duration of symptoms was not specified. Most recently, analysis of data from the 2012 National Health Interview Study showed that 11.2% of adults report having daily pain (8). Clinicians should consider the full range of therapeutic options for the treatment of chronic pain. However, it is hard to estimate the number of persons who could potentially benefit from opioid pain medication long term. Evidence supports short-term efficacy of opioids for reducing pain and improving function in noncancer nociceptive and neuropathic pain in randomized clinical trials lasting primarily ≤ 12 weeks (9,10), and patients receiving opioid therapy for chronic pain report some pain relief when surveyed (11–13). However, few studies have been conducted to rigorously assess the long-term benefits of opioids for chronic pain (pain lasting >3 months) with outcomes examined at least 1 year later (14). On the basis of data available from health systems, researchers estimate that 9.6–11.5 million adults, or approximately 3%–4% of the adult U.S. population, were prescribed long-term opioid therapy in 2005 (15).

Opioid pain medication use presents serious risks, including overdose and opioid use disorder. From 1999 to 2014, more than 165,000 persons died from overdose related to opioid pain medication in the United States (16). In the past decade, while the death rates for the top leading causes of death such as heart disease and cancer have decreased substantially, the death rate associated with opioid pain medication has increased markedly (17). Sales of opioid pain medication have increased in parallel with opioid-related overdose deaths (18). The Drug Abuse Warning Network estimated that $>420,000$ emergency department visits were related to the misuse or abuse of narcotic pain relievers in 2011, the most recent year for which data are available (19). Although clinical criteria have varied over time, opioid use disorder is a problematic pattern of opioid use leading to clinically significant impairment or distress. This disorder is manifested by specific criteria such as unsuccessful efforts to cut down or control use and use resulting in social problems and a failure to fulfill major role obligations at work, school, or home (20). This diagnosis has also been referred to as “abuse or dependence” and “addiction” in the literature, and is different from tolerance (diminished response to a drug with repeated use) and physical dependence (adaptation to a drug that produces symptoms of withdrawal when the drug is stopped), both of which can exist without a diagnosed disorder. In 2013, on the basis of DSM-IV diagnosis criteria, an estimated 1.9 million persons abused or were dependent on prescription opioid pain medication (21). Having a history of a prescription for an opioid pain medication increases the risk for overdose and opioid use disorder (22–24), highlighting the value of guidance on safer prescribing practices for clinicians. For example, a recent study of patients aged 15–64 years

receiving opioids for chronic noncancer pain and followed for up to 13 years revealed that one in 550 patients died from opioid-related overdose at a median of 2.6 years from their first opioid prescription, and one in 32 patients who escalated to opioid dosages >200 morphine milligram equivalents (MME) died from opioid-related overdose (25).

This guideline provides recommendations for the prescribing of opioid pain medication by primary care clinicians for chronic pain (i.e., pain conditions that typically last >3 months or past the time of normal tissue healing) in outpatient settings outside of active cancer treatment, palliative care, and end-of-life care. Although the guideline does not focus broadly on pain management, appropriate use of long-term opioid therapy must be considered within the context of all pain management strategies (including nonopioid pain medications and nonpharmacologic treatments). CDC’s recommendations are made on the basis of a systematic review of the best available evidence, along with input from experts, and further review and deliberation by a federally chartered advisory committee. The guideline is intended to ensure that clinicians and patients consider safer and more effective treatment, improve patient outcomes such as reduced pain and improved function, and reduce the number of persons who develop opioid use disorder, overdose, or experience other adverse events related to these drugs. Clinical decision making should be based on a relationship between the clinician and patient, and an understanding of the patient’s clinical situation, functioning, and life context. The recommendations in the guideline are voluntary, rather than prescriptive standards. They are based on emerging evidence, including observational studies or randomized clinical trials with notable limitations. Clinicians should consider the circumstances and unique needs of each patient when providing care.

Rationale

Primary care clinicians report having concerns about opioid pain medication misuse, find managing patients with chronic pain stressful, express concern about patient addiction, and report insufficient training in prescribing opioids (26). Across specialties, physicians believe that opioid pain medication can be effective in controlling pain, that addiction is a common consequence of prolonged use, and that long-term opioid therapy often is overprescribed for patients with chronic noncancer pain (27). These attitudes and beliefs, combined with increasing trends in opioid-related overdose, underscore the need for better clinician guidance on opioid prescribing. Clinical practice guidelines focused on prescribing can improve clinician knowledge, change prescribing practices (28), and ultimately benefit patient health.

Professional organizations, states, and federal agencies (e.g., the American Pain Society/American Academy of Pain Medicine, 2009; the Washington Agency Medical Directors Group, 2015; and the U.S. Department of Veterans Affairs/Department of Defense, 2010) have developed guidelines for opioid prescribing (29–31). Existing guidelines share some common elements, including dosing thresholds, cautious titration, and risk mitigation strategies such as using risk assessment tools, treatment agreements, and urine drug testing. However, there is considerable variability in the specific recommendations (e.g., range of dosing thresholds of 90 MME/day to 200 MME/day), audience (e.g., primary care clinicians versus specialists), use of evidence (e.g., systematic review, grading of evidence and recommendations, and role of expert opinion), and rigor of methods for addressing conflict of interest (32). Most guidelines, especially those that are not based on evidence from scientific studies published in 2010 or later, also do not reflect the most recent scientific evidence about risks related to opioid dosage.

This CDC guideline offers clarity on recommendations based on the most recent scientific evidence, informed by expert opinion and stakeholder and public input. Scientific research has identified high-risk prescribing practices that have contributed to the overdose epidemic (e.g., high-dose prescribing, overlapping opioid and benzodiazepine prescriptions, and extended-release/long-acting [ER/LA] opioids for acute pain) (24,33,34). Using guidelines to address problematic prescribing has the potential to optimize care and improve patient safety based on evidence-based practice (28), as well as reverse the cycle of opioid pain medication misuse that contributes to the opioid overdose epidemic.

Scope and Audience

This guideline is intended for primary care clinicians (e.g., family physicians and internists) who are treating patients with chronic pain (i.e., pain lasting >3 months or past the time of normal tissue healing) in outpatient settings. Prescriptions by primary care clinicians account for nearly half of all dispensed opioid prescriptions, and the growth in prescribing rates among these clinicians has been above average (3). Primary care clinicians include physicians as well as nurse practitioners and physician assistants. Although the focus is on primary care clinicians, because clinicians work within team-based care, the recommendations refer to and promote integrated pain management and collaborative working relationships with other providers (e.g., behavioral health providers, pharmacists, and pain management specialists). Although the transition from use of opioid therapy for acute pain to use for chronic pain is hard to predict

and identify, the guideline is intended to inform clinicians who are considering prescribing opioid pain medication for painful conditions that can or have become chronic.

This guideline is intended to apply to patients aged ≥ 18 years with chronic pain outside of palliative and end-of-life care. For this guideline, palliative care is defined in a manner consistent with that of the Institute of Medicine as care that provides relief from pain and other symptoms, supports quality of life, and is focused on patients with serious advanced illness. Palliative care can begin early in the course of treatment for any serious illness that requires excellent management of pain or other distressing symptoms (35). End-of-life care is defined as care for persons with a terminal illness or at high risk for dying in the near future in hospice care, hospitals, long-term care settings, or at home. Patients within the scope of this guideline include cancer survivors with chronic pain who have completed cancer treatment, are in clinical remission, and are under cancer surveillance only. The guideline is not intended for patients undergoing active cancer treatment, palliative care, or end-of-life care because of the unique therapeutic goals, ethical considerations, opportunities for medical supervision, and balance of risks and benefits with opioid therapy in such care.

The recommendations address the use of opioid pain medication in certain special populations (e.g., older adults and pregnant women) and in populations with conditions posing special risks (e.g., a history of substance use disorder). The recommendations do not address the use of opioid pain medication in children or adolescents aged <18 years. The available evidence concerning the benefits and harms of long-term opioid therapy in children and adolescents is limited, and few opioid medications provide information on the label regarding safety and effectiveness in pediatric patients. However, observational research shows significant increases in opioid prescriptions for pediatric populations from 2001 to 2010 (36), and a large proportion of adolescents are commonly prescribed opioid pain medications for conditions such as headache and sports injuries (e.g., in one study, 50% of adolescents presenting with headache received a prescription for an opioid pain medication [37,38]). Adolescents who misuse opioid pain medication often misuse medications from their own previous prescriptions (39), with an estimated 20% of adolescents with currently prescribed opioid medications reporting using them intentionally to get high or increase the effects of alcohol or other drugs (40). Use of prescribed opioid pain medication before high school graduation is associated with a 33% increase in the risk of later opioid misuse (41). Misuse of opioid pain medications in adolescence strongly predicts later onset of heroin use (42). Thus, risk of opioid medication use in pediatric populations is of great concern. Additional clinical trial and observational research is needed,

and encouraged, to inform development of future guidelines for this critical population.

The recommendations are not intended to provide guidance on use of opioids as part of medication-assisted treatment for opioid use disorder. Some of the recommendations might be relevant for acute care settings or other specialists, such as emergency physicians or dentists, but use in these settings or by other specialists is not the focus of this guideline. Readers are referred to other sources for prescribing recommendations within acute care settings and in dental practice, such as the American College of Emergency Physicians' guideline for prescribing of opioids in the emergency department (43); the American Society of Anesthesiologists' guideline for acute pain management in the perioperative setting (44); the Washington Agency Medical Directors' Group Interagency Guideline on Prescribing Opioids for Pain, Part II: Prescribing Opioids in the Acute and Subacute Phase (30); and the Pennsylvania Guidelines on the Use of Opioids in Dental Practice (45). In addition, given the challenges of managing the painful complications of sickle cell disease, readers are referred to the NIH National Heart, Lung, and Blood Institute's Evidence Based Management of Sickle Cell Disease Expert Panel Report for management of sickle cell disease (46).

Guideline Development Methods

Guideline Development Using the Grading of Recommendations Assessment, Development, and Evaluation Method

CDC developed this guideline using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) method (<http://www.gradeworkinggroup.org>). This method specifies the systematic review of scientific evidence and offers a transparent approach to grading quality of evidence and strength of recommendations. The method has been adapted by the CDC Advisory Committee on Immunization Practices (ACIP) (47). CDC has applied the ACIP translation of the GRADE framework in this guideline. Within the ACIP GRADE framework, the body of evidence is categorized in a hierarchy. This hierarchy reflects degree of confidence in the effect of a clinical action on health outcomes. The categories include type 1 evidence (randomized clinical trials or overwhelming evidence from observational studies), type 2 evidence (randomized clinical trials with important limitations, or exceptionally strong evidence from observational studies), type 3 evidence (observational studies or randomized clinical trials with notable limitations), and type 4 evidence (clinical

experience and observations, observational studies with important limitations, or randomized clinical trials with several major limitations). Type of evidence is categorized by study design as well as limitations in study design or implementation, imprecision of estimates, variability in findings, indirectness of evidence, publication bias, magnitude of treatment effects, dose-response gradient, and a constellation of plausible biases that could change observations of effects. Type 1 evidence indicates that one can be very confident that the true effect lies close to that of the estimate of the effect; type 2 evidence means that the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different; type 3 evidence means that confidence in the effect estimate is limited and the true effect might be substantially different from the estimate of the effect; and type 4 evidence indicates that one has very little confidence in the effect estimate, and the true effect is likely to be substantially different from the estimate of the effect (47,48). When no studies are present, evidence is considered to be insufficient. The ACIP GRADE framework places recommendations in two categories, Category A and Category B. Four major factors determine the category of the recommendation: the quality of evidence, the balance between desirable and undesirable effects, values and preferences, and resource allocation (cost). Category A recommendations apply to all persons in a specified group and indicate that most patients should receive the recommended course of action. Category B recommendations indicate that there should be individual decision making; different choices will be appropriate for different patients, so clinicians must help patients arrive at a decision consistent with patient values and preferences, and specific clinical situations (47). According to the GRADE methodology, a particular quality of evidence does not necessarily imply a particular strength of recommendation (48–50). Category A recommendations can be made based on type 3 or type 4 evidence when the advantages of a clinical action greatly outweigh the disadvantages based on a consideration of benefits and harms, values and preferences, and costs. Category B recommendations are made when the advantages and disadvantages of a clinical action are more balanced. GRADE methodology is discussed extensively elsewhere (47,51). The U.S. Preventive Services Task Force (USPSTF) follows different methods for developing and categorizing recommendations (<http://www.uspreventiveservicestaskforce.org>). USPSTF recommendations focus on preventive services and are categorized as A, B, C, D, and I. Under the Affordable Care Act, all “nongrandfathered” health plans (that is, those health plans not in existence prior to March 23, 2010 or those with significant changes to their coverage) and expanded Medicaid plans are required to cover

preventive services recommended by USPSTF with a category A or B rating with no cost sharing. The coverage requirements went into effect September 23, 2010. Similar requirements are in place for vaccinations recommended by ACIP, but do not exist for other recommendations made by CDC, including recommendations within this guideline.

A previously published systematic review sponsored by the Agency for Healthcare Research and Quality (AHRQ) on the effectiveness and risks of long-term opioid treatment of chronic pain (14,52) initially served to directly inform the recommendation statements. This systematic clinical evidence review addressed the effectiveness of long-term opioid therapy for outcomes related to pain, function, and quality of life; the comparative effectiveness of different methods for initiating and titrating opioids; the harms and adverse events associated with opioids; and the accuracy of risk-prediction instruments and effectiveness of risk mitigation strategies on outcomes related to overdose, addiction, abuse, or misuse. For the current guideline development, CDC conducted additional literature searches to update the evidence review to include more recently available publications and to answer an additional clinical question about the effect of opioid therapy for acute pain on long-term use. More details about the literature search strategies and GRADE methods applied are provided in the Clinical Evidence Review (<http://stacks.cdc.gov/view/cdc/38026>). CDC developed GRADE evidence tables to illustrate the quality of the evidence for each clinical question.

As identified in the AHRQ-sponsored clinical evidence review, the overall evidence base for the effectiveness and risks of long-term opioid therapy is low in quality per the GRADE criteria. Thus, contextual evidence is needed to provide information about the benefits and harms of nonpharmacologic and nonopioid pharmacologic therapy and the epidemiology of opioid pain medication overdose and inform the recommendations. Further, as elucidated by the GRADE Working Group, supplemental information on clinician and patient values and preferences and resource allocation can inform judgments of benefits and harms and be helpful for translating the evidence into recommendations. CDC conducted a contextual evidence review to supplement the clinical evidence review based on systematic searches of the literature. The review focused on the following four areas: effectiveness of nonpharmacologic and nonopioid pharmacologic treatments; benefits and harms related to opioid therapy (including additional studies not included in the clinical evidence review such as studies that evaluated outcomes at any duration or used observational study designs related to specific opioid pain medications, high-dose opioid therapy, co-prescription of opioids with other controlled substances, duration of opioid use, special populations, risk

stratification/mitigation approaches, and effectiveness of treatments for addressing potential harms of opioid therapy); clinician and patient values and preferences; and resource allocation. CDC constructed narrative summaries of this contextual evidence and used the information to support the clinical recommendations. More details on methods for the contextual evidence review are provided in the Contextual Evidence Review (<http://stacks.cdc.gov/view/cdc/38027>).

On the basis of a review of the clinical and contextual evidence (review methods are described in more detail in subsequent sections of this report), CDC drafted recommendation statements focused on determining when to initiate or continue opioids for chronic pain; opioid selection, dosage, duration, follow-up, and discontinuation; and assessing risk and addressing harms of opioid use. To help assure the draft guideline's integrity and credibility, CDC then began a multistep review process to obtain input from experts, stakeholders, and the public to help refine the recommendations.

Solicitation of Expert Opinion

CDC sought the input of experts to assist in reviewing the evidence and providing perspective on how CDC used the evidence to develop the draft recommendations. These experts, referred to as the "Core Expert Group" (CEG) included subject matter experts, representatives of primary care professional societies and state agencies, and an expert in guideline development methodology.* CDC identified subject matter experts with high scientific standing; appropriate academic and clinical training and relevant clinical experience; and proven scientific excellence in opioid prescribing, substance use disorder treatment, and pain management. CDC identified representatives from leading primary care professional organizations to represent the audience for this guideline. Finally, CDC identified state agency officials and representatives based on their experience with state guidelines for opioid prescribing that were developed with multiple agency stakeholders and informed by scientific literature and existing evidence-based guidelines.

Prior to their participation, CDC asked potential experts to reveal possible conflicts of interest such as financial relationships with industry, intellectual preconceptions, or previously stated public positions. Experts could not serve if they had conflicts that might have a direct and predictable effect on the recommendations. CDC excluded experts who had a financial or promotional relationship with a company

* A list of the members appears at the end of this report. The recommendations and all statements included in this guideline are those of CDC and do not necessarily represent the official position of any persons or organizations providing comments on the draft guideline.

that makes a product that might be affected by the guideline. CDC reviewed potential nonfinancial conflicts carefully (e.g., intellectual property, travel, public statements or positions such as congressional testimony) to determine if the activities would have a direct and predictable effect on the recommendations. CDC determined the risk of these types of activities to be minimal for the identified experts. All experts completed a statement certifying that there was no potential or actual conflict of interest. Activities that did not pose a conflict (e.g., participation in Food and Drug Administration [FDA] activities or other guideline efforts) are disclosed.

CDC provided to each expert written summaries of the scientific evidence (both the clinical and contextual evidence reviews conducted for this guideline) and CDC's draft recommendation statements. Experts provided individual ratings for each draft recommendation statement based on the balance of benefits and harms, evidence strength, certainty of values and preferences, cost, recommendation strength, rationale, importance, clarity, and ease of implementation. CDC hosted an in-person meeting of the experts that was held on June 23–24, 2015, in Atlanta, Georgia, to seek their views on the evidence and draft recommendations and to better understand their premeeting ratings. CDC sought the experts' individual opinions at the meeting. Although there was widespread agreement on some of the recommendations, there was disagreement on others. Experts did not vote on the recommendations or seek to come to a consensus. Decisions about recommendations to be included in the guideline, and their rationale, were made by CDC. After revising the guideline, CDC sent written copies of it to each of the experts for review and asked for any additional comments; CDC reviewed these written comments and considered them when making further revisions to the draft guideline. The experts have not reviewed the final version of the guideline.

Federal Partner Engagement

Given the scope of this guideline and the interest of agencies across the federal government in appropriate pain management, opioid prescribing, and related outcomes, CDC invited its National Institute of Occupational Safety and Health and CDC's federal partners to observe the expert meeting, provide written comments on the full draft guideline after the meeting, and review the guideline through an agency clearance process; CDC reviewed comments and incorporated changes. Interagency collaboration will be critical for translating these recommendations into clinical practice. Federal partners included representatives from the Substance Abuse and Mental Health Services Administration, the National Institute on Drug Abuse, FDA, the U.S. Department of Veterans Affairs,

the U.S. Department of Defense, the Office of the National Coordinator for Health Information Technology, the Centers for Medicare and Medicaid Services, the Health Resources and Services Administration, AHRQ, and the Office of National Drug Control Policy.

Stakeholder Comment

Given the importance of the guideline for a wide variety of stakeholders, CDC also invited review from a Stakeholder Review Group (SRG) to provide comment so that CDC could consider modifications that would improve the recommendations' specificity, applicability, and ease of implementation. The SRG included representatives from professional organizations that represent specialties that commonly prescribe opioids (e.g., pain medicine, physical medicine and rehabilitation), delivery systems within which opioid prescribing occurs (e.g., hospitals), and representation from community organizations with interests in pain management and opioid prescribing.* Representatives from each of the SRG organizations were provided a copy of the guideline for comment. Each of these representatives provided written comments. Once input was received from the full SRG, CDC reviewed all comments and carefully considered them when revising the draft guideline.

Constituent Engagement

To obtain initial perspectives from constituents on the recommendation statements, including clinicians and prospective patients, CDC convened a constituent engagement webinar and circulated information about the webinar in advance through announcements to partners. CDC hosted the webinar on September 16 and 17, 2015, provided information about the methodology for developing the guideline, and presented the key recommendations. A fact sheet was posted on the CDC Injury Center website (<http://www.cdc.gov/injury>) summarizing the guideline development process and clinical practice areas addressed in the guideline; instructions were included on how to submit comments via email. CDC received comments during and for 2 days following the first webinar. Over 1,200 constituent comments were received. Comments were reviewed and carefully considered when revising the draft guideline.

Peer Review

Per the final information quality bulletin for peer review (<https://www.whitehouse.gov/sites/default/files/omb/memoranda/fy2005/m05-03.pdf>), peer review requirements applied to this guideline because it provides influential

scientific information that could have a clear and substantial impact on public- and private-sector decisions. Three experts independently reviewed the guideline to determine the reasonableness and strength of recommendations; the clarity with which scientific uncertainties were clearly identified; and the rationale, importance, clarity, and ease of implementation of the recommendations.* CDC selected peer reviewers based on expertise, diversity of scientific viewpoints, and independence from the guideline development process. CDC assessed and managed potential conflicts of interest using a process similar to the one as described for solicitation of expert opinion. No financial interests were identified in the disclosure and review process, and nonfinancial activities were determined to be of minimal risk; thus, no significant conflict of interest concerns were identified. CDC placed the names of peer reviewers on the CDC and the National Center for Injury Prevention and Control Peer Review Agenda websites that are used to provide information about the peer review of influential documents. CDC reviewed peer review comments and revised the draft guideline accordingly.

Public Comment

To obtain comments from the public on the full guideline, CDC published a notice in the *Federal Register* (80 FR 77351) announcing the availability of the guideline and the supporting clinical and contextual evidence reviews for public comment. The comment period closed January 13, 2016. CDC received more than 4,350 comments from the general public, including patients with chronic pain, clinicians, families who have lost loved ones to overdose, medical associations, professional organizations, academic institutions, state and local governments, and industry. CDC reviewed each of the comments and carefully considered them when revising the draft guideline.

Federal Advisory Committee Review and Recommendation

The National Center for Injury Prevention and Control (NCIPC) Board of Scientific Counselors (BSC) is a federal advisory committee that advises and makes recommendations to the Secretary of the Department of Health and Human Services, the Director of CDC, and the Director of NCIPC.* The BSC makes recommendations regarding policies, strategies, objectives, and priorities, and reviews progress toward injury and violence prevention. CDC sought the BSC's advice on the draft guideline. BSC members are special government employees appointed as CDC advisory committee members; as such, all members completed an OGE Form 450

to disclose relevant interests. BSC members also reported on their disclosures during meetings. Disclosures for the BSC are reported in the guideline.

To assist in guideline review, on December 14, 2015, via Federal Register notice, CDC announced the intent to form an Opioid Guideline Workgroup (OGW) to provide observations on the draft guideline to the BSC. CDC provided the BSC with the draft guideline as well as summaries of comments provided to CDC by stakeholders, constituents, and peer reviewers, and edits made to the draft guideline in response. During an open meeting held on January 7, 2016, the BSC recommended the formation of the OGW. The OGW included a balance of perspectives from audiences directly affected by the guideline, audiences that would be directly involved with implementing the recommendations, and audiences qualified to provide representation. The OGW comprised clinicians, subject matter experts, and a patient representative, with the following perspectives represented: primary care, pain medicine, public health, behavioral health, substance abuse treatment, pharmacy, patients, and research.* Additional sought-after attributes were appropriate academic and clinical training and relevant clinical experience; high scientific standing; and knowledge of the patient, clinician, and caregiver perspectives. In accordance with CDC policy, two BSC committee members also served as OGW members, with one serving as the OGW Chair. The professional credentials and interests of OGW members were carefully reviewed to identify possible conflicts of interest such as financial relationships with industry, intellectual preconceptions, or previously stated public positions. Only OGW members whose interests were determined to be minimal were selected. When an activity was perceived as having the potential to affect a specific aspect of the recommendations, the activity was disclosed, and the OGW member was recused from discussions related to that specific aspect of the recommendations (e.g., urine drug testing and abuse-deterrent formulations). Disclosures for the OGW are reported. CDC and the OGW identified ad-hoc consultants to supplement the workgroup expertise, when needed, in the areas of pediatrics, occupational medicine, obstetrics and gynecology, medical ethics, addiction psychiatry, physical medicine and rehabilitation, guideline development methodology, and the perspective of a family member who lost a loved one to opioid use disorder or overdose.

The BSC charged the OGW with reviewing the quality of the clinical and contextual evidence reviews and reviewing each of the recommendation statements and accompanying rationales. For each recommendation statement, the OGW considered the quality of the evidence, the balance of benefits and risks, the values and preferences of clinicians and patients, the cost feasibility, and the category designation

of the recommendation (A or B). The OGW also reviewed supplementary documents, including input provided by the CEG, SRG, peer reviewers, and the public. OGW members discussed the guideline accordingly during virtual meetings and drafted a summary report of members' observations, including points of agreement and disagreement, and delivered the report to the BSC.

NCIPC announced an open meeting of the NCIPC BSC in the Federal Register on January 11, 2015. The BSC met on January 28, 2016, to discuss the OGW report and deliberate on the draft guideline itself. Members of the public provided comments at this meeting. After discussing the OGW report, deliberating on specific issues about the draft guideline identified at the meeting, and hearing public comment, the BSC voted unanimously: to support the observations made by the OGW; that CDC adopt the guideline recommendations that, according to the workgroup's report, had unanimous or majority support; and that CDC further consider the guideline recommendations for which the group had mixed opinions. CDC carefully considered the OGW observations, public comments, and BSC recommendations, and revised the guideline in response.

Summary of the Clinical Evidence Review

Primary Clinical Questions

CDC conducted a clinical systematic review of the scientific evidence to identify the effectiveness, benefits, and harms of long-term opioid therapy for chronic pain, consistent with the GRADE approach (47,48). Long-term opioid therapy is defined as use of opioids on most days for >3 months. A previously published AHRQ-funded systematic review on the effectiveness and risks of long-term opioid therapy for chronic pain comprehensively addressed four clinical questions (14,52). CDC, with the assistance of a methodology expert, searched the literature to identify newly published studies on these four original questions. Because long-term opioid use might be affected by use of opioids for acute pain, CDC subsequently developed a fifth clinical question (last in the series below), and in collaboration with a methodologist conducted a systematic review of the scientific evidence to address it. In brief, five clinical questions were addressed:

- The effectiveness of long-term opioid therapy versus placebo, no opioid therapy, or nonopioid therapy for long term (≥ 1 year) outcomes related to pain, function, and quality of life, and how effectiveness varies according to

the type/cause of pain, patient demographics, and patient comorbidities (Key Question [KQ] 1).

- The risks of opioids versus placebo or no opioids on abuse, addiction, overdose, and other harms, and how harms vary according to the type/cause of pain, patient demographics, patient comorbidities, and dose (KQ2).
- The comparative effectiveness of opioid dosing strategies (different methods for initiating and titrating opioids; immediate-release versus ER/LA opioids; different ER/LA opioids; immediate-release plus ER/LA opioids versus ER/LA opioids alone; scheduled, continuous versus as-needed dosing; dose escalation versus dose maintenance; opioid rotation versus maintenance; different strategies for treating acute exacerbations of chronic pain; decreasing opioid doses or tapering off versus continuation; and different tapering protocols and strategies) (KQ3).
- The accuracy of instruments for predicting risk for opioid overdose, addiction, abuse, or misuse; the effectiveness of risk mitigation strategies (use of risk prediction instruments); effectiveness of risk mitigation strategies including opioid management plans, patient education, urine drug testing, prescription drug monitoring program (PDMP) data, monitoring instruments, monitoring intervals, pill counts, and abuse-deterrent formulations for reducing risk for opioid overdose, addiction, abuse, or misuse; and the comparative effectiveness of treatment strategies for managing patients with addiction (KQ4).
- The effects of prescribing opioid therapy versus not prescribing opioid therapy for acute pain on long-term use (KQ5).

The review was focused on the effectiveness of long-term opioid therapy on long-term (>1 year) outcomes related to pain, function, and quality of life to ensure that findings are relevant to patients with chronic pain and long-term opioid prescribing. The effectiveness of short-term opioid therapy has already been established (10). However, opioids have unique effects such as tolerance and physical dependence that might influence assessments of benefit over time. These effects raise questions about whether findings on short-term effectiveness of opioid therapy can be extrapolated to estimate benefits of long-term therapy for chronic pain. Thus, it is important to consider studies that provide data on long-term benefit. For certain opioid-related harms (overdose, fractures, falls, motor vehicle crashes), observational studies were included with outcomes measured at shorter intervals because such outcomes can occur early during opioid therapy, and such harms are not captured well in short-term clinical trials. A detailed listing of the key questions is provided in the Clinical Evidence Review (<http://stacks.cdc.gov/view/cdc/38026>).

Clinical Evidence Systematic Review Methods

Complete methods and data for the 2014 AHRQ report, upon which this updated systematic review is based, have been published previously (14,52). Study authors developed the protocol using a standardized process (53) with input from experts and the public and registered the protocol in the PROSPERO database (54). For the 2014 AHRQ report, a research librarian searched MEDLINE, the Cochrane Central Register of Controlled Trials, the Cochrane Database of Systematic Reviews, PsycINFO, and CINAHL for English-language articles published January 2008 through August 2014, using search terms for opioid therapy, specific opioids, chronic pain, and comparative study designs. Also included were relevant studies from an earlier review (10) in which searches were conducted without a date restriction, reference lists were reviewed, and ClinicalTrials.gov was searched. CDC updated the AHRQ literature search using the same search strategies as in the original review including studies published before April, 2015. Seven additional studies met inclusion criteria and were added to the review. CDC used the GRADE approach outlined in the ACIP Handbook for Developing Evidence-Based Recommendations (47) to rate the quality of evidence for the full body of evidence (evidence from the 2014 AHRQ review plus the update) for each clinical question. Evidence was categorized into the following types: type 1 (randomized clinical trials or overwhelming evidence from observational studies), type 2 (randomized clinical trials with important limitations, or exceptionally strong evidence from observational studies), type 3 (observational studies, or randomized clinical trials with notable limitations), or type 4 (clinical experience and observations, observational studies with important limitations, or randomized clinical trials with several major limitations). When no studies were present, evidence was considered to be insufficient. Per GRADE methods, type of evidence was categorized by study design as well as a function of limitations in study design or implementation, imprecision of estimates, variability in findings, indirectness of evidence, publication bias, magnitude of treatment effects, dose-response gradient, and constellation of plausible biases that could change effects. Results were synthesized qualitatively, highlighting new evidence identified during the update process. Meta-analysis was not attempted due to the small numbers of studies, variability in study designs and clinical heterogeneity, and methodological shortcomings of the studies. More detailed information about data sources and searches, study selection, data extraction and quality assessment, data synthesis, and update search yield and new evidence for the current review is provided in the Clinical Evidence Review (<http://stacks.cdc.gov/view/cdc/38026>).

Summary of Findings for Clinical Questions

The main findings of this updated review are consistent with the findings of the 2014 AHRQ report (14). In summary, evidence on long-term opioid therapy for chronic pain outside of end-of-life care remains limited, with insufficient evidence to determine long-term benefits versus no opioid therapy, though evidence suggests risk for serious harms that appears to be dose-dependent. These findings supplement findings from a previous review of the effectiveness of opioids for adults with chronic noncancer pain. In this previous review, based on randomized trials predominantly ≤ 12 weeks in duration, opioids were found to be moderately effective for pain relief, with small benefits for functional outcomes; although estimates vary, based on uncontrolled studies, a high percentage of patients discontinued long-term opioid use because of lack of efficacy and because of adverse events (10).

The GRADE evidence summary with type of evidence ratings for the five clinical questions for the current evidence review are outlined (Table 1). This summary is based on studies included in the AHRQ 2014 review (35 studies) plus additional studies identified in the updated search (seven studies). Additional details on findings from the original review are provided in the full 2014 AHRQ report (14,52). Full details on the clinical evidence review findings supporting this guideline are provided in the Clinical Evidence Review (<http://stacks.cdc.gov/view/cdc/38026>).

Effectiveness

For KQ1, no study of opioid therapy versus placebo, no opioid therapy, or nonopioid therapy for chronic pain evaluated long-term (≥ 1 year) outcomes related to pain, function, or quality of life. Most placebo-controlled randomized clinical trials were ≤ 6 weeks in duration. Thus, the body of evidence for KQ1 is rated as insufficient (0 studies contributing) (14).

Harms

For KQ2, the body of evidence is rated as type 3 (12 studies contributing; 11 from the original review plus one new study). One fair-quality cohort study found that long-term opioid therapy is associated with increased risk for an opioid abuse or dependence diagnosis (as defined by ICD-9-CM codes) versus no opioid prescription (22). Rates of opioid abuse or dependence diagnosis ranged from 0.7% with lower-dose (≤ 36 MME) chronic therapy to 6.1% with higher-dose (≥ 120 MME) chronic therapy, versus 0.004% with no opioids prescribed. Ten fair-quality uncontrolled studies reported estimates of opioid abuse, addiction, and related outcomes (55–65). In primary care settings, prevalence of opioid dependence

(using DSM-IV criteria) ranged from 3% to 26% (55,56,59). In pain clinic settings, prevalence of addiction ranged from 2% to 14% (57,58,60,61,63–65).

Factors associated with increased risk for misuse included history of substance use disorder, younger age, major depression, and use of psychotropic medications (55,62). Two studies reported on the association between opioid use and risk for overdose (66,67). One large fair-quality retrospective cohort study found that recent opioid use was associated with increased risk for any overdose events and serious overdose events versus nonuse (66). It also found higher doses associated with increased risk. Relative to 1–19 MME/day, the adjusted hazard ratio (HR) for any overdose event (consisting of mostly nonfatal overdose) was 1.44 for 20 to 49 MME/day, 3.73 for 50–99 MME/day, and 8.87 for ≥ 100 MME/day. A similar pattern was observed for serious overdose. A good-quality population-based, nested case-control study also found a dose-dependent association with risk for overdose death (67). Relative to 1–19 MME/day, the adjusted odds ratio (OR) was 1.32 for 20–49 MME/day, 1.92 for 50–99 MME/day, 2.04 for 100–199 MME/day, and 2.88 for ≥ 200 MME/day.

Findings of increased fracture risk for current opioid use, versus nonuse, were mixed in two studies (68,69). Two studies found an association between opioid use and increased risk for cardiovascular events (70,71). Indirect evidence was found for endocrinologic harms (increased use of medications for erectile dysfunction or testosterone from one previously included study; laboratory-defined androgen deficiency from one newly reviewed study) (72,73). One study found that opioid dosages ≥ 20 MME/day were associated with increased odds of road trauma among drivers (74).

Opioid Dosing Strategies

For KQ3, the body of evidence is rated as type 4 (14 studies contributing; 12 from the original review plus two new studies). For initiation and titration of opioids, the 2014 AHRQ report found insufficient evidence from three fair-quality, open-label trials to determine comparative effectiveness of ER/LA versus immediate-release opioids for titrating patients to stable pain control (75,76). One new fair-quality cohort study of Veterans Affairs patients found initiation of therapy with an ER/LA opioid associated with greater risk for nonfatal overdose than initiation with an immediate-release opioid, with risk greatest in the first 2 weeks after initiation of treatment (77).

For comparative effectiveness and harms of ER/LA opioids, the 2014 AHRQ report included three randomized, head-to-head trials of various ER/LA opioids that found no clear differences in 1-year outcomes related to pain or function (78–80) but had methodological shortcomings. A fair-quality retrospective cohort study based on national Veterans Health

Administration system pharmacy data found that methadone was associated with lower overall risk for all-cause mortality versus morphine (81), and a fair-quality retrospective cohort study based on Oregon Medicaid data found no statistically significant differences between methadone and long-acting morphine in risk for death or overdose symptoms (82). However, a new observational study (83) found methadone associated with increased risk for overdose versus sustained-release morphine among Tennessee Medicaid patients. The observed inconsistency in study findings suggests that risks of methadone might vary in different settings as a function of different monitoring and management protocols, though more research is needed to understand factors associated with safer methadone prescribing.

For dose escalation, the 2014 AHRQ report included one fair-quality randomized trial that found no differences between more liberal dose escalation and maintenance of current doses after 12 months in pain, function, all-cause withdrawals, or withdrawals due to opioid misuse (84). However, the difference in opioid dosages prescribed at the end of the trial was relatively small (mean 52 MME/day with more liberal dosing versus 40 MME/day). Evidence on other comparisons related to opioid dosing strategies (ER/LA versus immediate-release opioids; immediate-release plus ER/LA opioids versus ER/LA opioids alone; scheduled continuous dosing versus as-needed dosing; or opioid rotation versus maintenance of current therapy; long-term effects of strategies for treating acute exacerbations of chronic pain) was not available or too limited to determine effects on long-term clinical outcomes. For example, evidence on the comparative effectiveness of opioid tapering or discontinuation versus maintenance, and of different opioid tapering strategies, was limited to small, poor-quality studies (85–87).

Risk Assessment and Mitigation

For KQ4, the body of evidence is rated as type 3 for the accuracy of risk assessment tools and insufficient for the effectiveness of use of risk assessment tools and mitigation strategies in reducing harms (six studies contributing; four from the original review plus two new studies). The 2014 AHRQ report included four studies (88–91) on the accuracy of risk assessment instruments, administered prior to opioid therapy initiation, for predicting opioid abuse or misuse. Results for the Opioid Risk Tool (ORT) (89–91) were extremely inconsistent; evidence for other risk assessment instruments was very sparse, and studies had serious methodological shortcomings. One additional fair-quality (92) and one poor-quality (93) study identified for this update compared the predictive accuracy of the ORT, the Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R), and the Brief Risk Interview.

For the ORT, sensitivity was 0.58 and 0.75 and specificity 0.54 and 0.86; for the SOAPP-R, sensitivity was 0.53 and 0.25 and specificity 0.62 and 0.73; and for the Brief Risk Interview, sensitivity was 0.73 and 0.83 and specificity 0.43 and 0.88. For the ORT, positive likelihood ratios ranged from noninformative (positive likelihood ratio close to 1) to moderately useful (positive likelihood ratio >5). The SOAPP-R was associated with noninformative likelihood ratios (estimates close to 1) in both studies.

No study evaluated the effectiveness of risk mitigation strategies (use of risk assessment instruments, opioid management plans, patient education, urine drug testing, use of PDMP data, use of monitoring instruments, more frequent monitoring intervals, pill counts, or use of abuse-deterrent formulations) for improving outcomes related to overdose, addiction, abuse, or misuse.

Effects of Opioid Therapy for Acute Pain on Long-Term Use

For KQ5, the body of evidence is rated as type 3 (two new studies contributing). Two fair-quality retrospective cohort studies found opioid therapy prescribed for acute pain associated with greater likelihood of long-term use. One study evaluated opioid-naïve patients who had undergone low-risk surgery, such as cataract surgery and varicose vein stripping (94). Use of opioids within 7 days of surgery was associated with increased risk for use at 1 year. The other study found that among patients with a workers' compensation claim for acute low back pain, compared to patients who did not receive opioids early after injury (defined as use within 15 days following onset of pain), patients who did receive early opioids had an increased likelihood of receiving five or more opioid prescriptions 30–730 days following onset that increased with greater early exposure. Versus no early opioid use, the adjusted OR was 2.08 (95% CI = 1.55–2.78) for 1–140 MME/day and increased to 6.14 (95% confidence interval [CI] = 4.92–7.66) for ≥450 MME/day (95).

Summary of the Contextual Evidence Review

Primary Areas of Focus

Contextual evidence is complementary information that assists in translating the clinical research findings into recommendations. CDC conducted contextual evidence reviews on four topics to supplement the clinical evidence review findings:

- Effectiveness of nonpharmacologic (e.g., cognitive behavioral therapy [CBT], exercise therapy, interventional treatments, and multimodal pain treatment) and nonopioid pharmacologic treatments (e.g., acetaminophen, nonsteroidal anti-inflammatory drugs [NSAIDs], antidepressants, and anticonvulsants), including studies of any duration.
 - Benefits and harms of opioid therapy (including additional studies not included in the clinical evidence review, such as studies that were not restricted to patients with chronic pain, evaluated outcomes at any duration, performed ecological analyses, or used observational study designs other than cohort and case-cohort control studies) related to specific opioids, high-dose therapy, co-prescription with other controlled substances, duration of use, special populations, and potential usefulness of risk stratification/mitigation approaches, in addition to effectiveness of treatments associated with addressing potential harms of opioid therapy (opioid use disorder).
 - Clinician and patient values and preferences related to opioids and medication risks, benefits, and use.
 - Resource allocation including costs and economic efficiency of opioid therapy and risk mitigation strategies.
- CDC also reviewed clinical guidelines that were relevant to opioid prescribing and could inform or complement the CDC recommendations under development (e.g., guidelines on nonpharmacologic and nonopioid pharmacologic treatments and guidelines with recommendations related to specific clinician actions such as urine drug testing or opioid tapering protocols).

Contextual Evidence Review Methods

CDC conducted a contextual evidence review to assist in developing the recommendations by providing an assessment of the balance of benefits and harms, values and preferences, and cost, consistent with the GRADE approach. Given the public health urgency for developing opioid prescribing recommendations, a rapid review was required for the contextual evidence review for the current guideline. Rapid reviews are used when there is a need to streamline the systematic review process to obtain evidence quickly (96). Methods used to streamline the process include limiting searches by databases, years, and languages considered, and truncating quality assessment and data abstraction protocols. CDC conducted “rapid reviews” of the contextual evidence on nonpharmacologic and nonopioid pharmacologic treatments, benefits and harms, values and preferences, and resource allocation.

Detailed information about contextual evidence data sources and searches, inclusion criteria, study selection, and

data extraction and synthesis are provided in the Contextual Evidence Review (<http://stacks.cdc.gov/view/cdc/38027>). In brief, CDC conducted systematic literature searches to identify original studies, systematic reviews, and clinical guidelines, depending on the topic being searched. CDC also solicited publication referrals from subject matter experts. Given the need for a rapid review process, grey literature (e.g., literature by academia, organizations, or government in the forms of reports, documents, or proceedings not published by commercial publishers) was not systematically searched. Database sources, including MEDLINE, PsycINFO, the Cochrane Central Register of Controlled Trials, and the Cochrane Database of Systematic Reviews, varied by topic. Multiple reviewers scanned study abstracts identified through the database searches and extracted relevant studies for review. CDC constructed narrative summaries and tables based on relevant articles that met inclusion criteria, which are provided in the Contextual Evidence Review (<http://stacks.cdc.gov/view/cdc/38027>).

Findings from the contextual reviews provide indirect evidence and should be interpreted accordingly. CDC did not formally rate the quality of evidence for the studies included in the contextual evidence review using the GRADE method. The studies that addressed benefits and harms, values and preferences, and resource allocation most often employed observational methods, used short follow-up periods, and evaluated selected samples. Therefore the strength of the evidence from these contextual review areas was considered to be low, comparable to type 3 or type 4 evidence. The quality of evidence for nonopioid pharmacologic and nonpharmacologic pain treatments was generally rated as moderate, comparable to type 2 evidence, in systematic reviews and clinical guidelines (e.g., for treatment of chronic neuropathic pain, low back pain, osteoarthritis, and fibromyalgia). Similarly, the quality of evidence on pharmacologic and psychosocial opioid use disorder treatment was generally rated as moderate, comparable to type 2 evidence, in systematic reviews and clinical guidelines.

Summary of Findings for Contextual Areas

Full narrative reviews and tables that summarize key findings from the contextual evidence review are provided in the Contextual Evidence Review (<http://stacks.cdc.gov/view/cdc/38027>).

Effectiveness of Nonpharmacologic and Nonopioid Pharmacologic Treatments

Several nonpharmacologic and nonopioid pharmacologic treatments have been shown to be effective in managing chronic pain in studies ranging in duration from 2 weeks to 6 months. For example, CBT that trains patients in behavioral techniques

and helps patients modify situational factors and cognitive processes that exacerbate pain has small positive effects on disability and catastrophic thinking (97). Exercise therapy can help reduce pain and improve function in chronic low back pain (98), improve function and reduce pain in osteoarthritis of the knee (99) and hip (100), and improve well-being, fibromyalgia symptoms, and physical function in fibromyalgia (101). Multimodal and multidisciplinary therapies (e.g., therapies that combine exercise and related therapies with psychologically based approaches) can help reduce pain and improve function more effectively than single modalities (102,103). Nonopioid pharmacologic approaches used for pain include analgesics such as acetaminophen, NSAIDs, and cyclooxygenase 2 (COX-2) inhibitors; selected anticonvulsants; and selected antidepressants (particularly tricyclics and serotonin and norepinephrine reuptake inhibitors [SNRIs]). Multiple guidelines recommend acetaminophen as first-line pharmacotherapy for osteoarthritis (104–109) or for low back pain (110) but note that it should be avoided in liver failure and that dosage should be reduced in patients with hepatic insufficiency or a history of alcohol abuse (109). Although guidelines also recommend NSAIDs as first-line treatment for osteoarthritis or low back pain (106,110), NSAIDs and COX-2 inhibitors do have risks, including gastrointestinal bleeding or perforation as well as renal and cardiovascular risks (111). FDA has recently strengthened existing label warnings that NSAIDs increase risks for heart attack and stroke, including that these risks might increase with longer use or at higher doses (112). Several guidelines agree that first- and second-line drugs for neuropathic pain include anticonvulsants (gabapentin or pregabalin), tricyclic antidepressants, and SNRIs (113–116). Interventional approaches such as epidural injection for certain conditions (e.g., lumbar radiculopathy) can provide short-term improvement in pain (117–119). Epidural injection has been associated with rare but serious adverse events, including loss of vision, stroke, paralysis, and death (120).

Benefits and Harms of Opioid Therapy

Balance between benefits and harms is a critical factor influencing the strength of clinical recommendations. In particular, CDC considered what is known from the epidemiology research about benefits and harms related to specific opioids and formulations, high dose therapy, co-prescription with other controlled substances, duration of use, special populations, and risk stratification and mitigation approaches. Additional information on benefits and harms of long-term opioid therapy from studies meeting rigorous selection criteria is provided in the clinical evidence review (e.g., see KQ2). CDC also considered the number of persons experiencing chronic pain, numbers potentially benefiting

from opioids, and numbers affected by opioid-related harms. A review of these data is presented in the background section of this document, with detailed information provided in the Contextual Evidence Review (<http://stacks.cdc.gov/view/cdc/38027>). Finally, CDC considered the effectiveness of treatments that addressed potential harms of opioid therapy (opioid use disorder).

Regarding specific opioids and formulations, as noted by FDA, there are serious risks of ER/LA opioids, and the indication for this class of medications is for management of pain severe enough to require daily, around-the-clock, long-term opioid treatment in patients for whom other treatment options (e.g., nonopioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain (121). Time-scheduled opioid use was associated with substantially higher average daily opioid dosage than as-needed opioid use in one study (122). Methadone has been associated with disproportionate numbers of overdose deaths relative to the frequency with which it is prescribed for pain. Methadone has been found to account for as much as a third of opioid-related overdose deaths involving single or multiple drugs in states that participated in the Drug Abuse Warning Network, which was more than any opioid other than oxycodone, despite representing <2% of opioid prescriptions outside of opioid treatment programs in the United States; further, methadone was involved in twice as many single-drug deaths as any other prescription opioid (123).

Regarding high-dose therapy, several epidemiologic studies that were excluded from the clinical evidence review because patient samples were not restricted to patients with chronic pain also examined the association between opioid dosage and overdose risk (23,24,124–126). Consistent with the clinical evidence review, the contextual review found that opioid-related overdose risk is dose-dependent, with higher opioid dosages associated with increased overdose risk. Two of these studies (23,24), as well as the two studies in the clinical evidence review (66,67), evaluated similar MME/day dose ranges for association with overdose risk. In these four studies, compared with opioids prescribed at <20 MME/day, the odds of overdose among patients prescribed opioids for chronic nonmalignant pain were between 1.3 (67) and 1.9 (24) for dosages of 20 to <50 MME/day, between 1.9 (67) and 4.6 (24) for dosages of 50 to <100 MME/day, and between 2.0 (67) and 8.9 (66) for dosages of ≥100 MME/day. Compared with dosages of 1–<20 MME/day, absolute risk difference approximation for 50–<100 MME/day was 0.15% for fatal overdose (24) and 1.40% for any overdose (66), and for ≥100 MME/day was 0.25% for fatal overdose (24) and 4.04% for any overdose (66). A recent study of Veterans Health Administration patients with chronic pain found that patients who died of overdoses related to opioids were

prescribed higher opioid dosages (mean: 98 MME/day; median: 60 MME/day) than controls (mean: 48 MME/day, median: 25 MME/day) (127). Finally, another recent study of overdose deaths among state residents with and without opioid prescriptions revealed that prescription opioid-related overdose mortality rates rose rapidly up to prescribed doses of 200 MME/day, after which the mortality rates continued to increase but grew more gradually (128). A listing of common opioid medications and their MME equivalents is provided (Table 2).

Regarding coprescription of opioids with benzodiazepines, epidemiologic studies suggest that concurrent use of benzodiazepines and opioids might put patients at greater risk for potentially fatal overdose. Three studies of fatal overdose deaths found evidence of concurrent benzodiazepine use in 31%–61% of decedents (67,128,129). In one of these studies (67), among decedents who received an opioid prescription, those whose deaths were related to opioids were more likely to have obtained opioids from multiple physicians and pharmacies than decedents whose deaths were not related to opioids.

Regarding duration of use, patients can experience tolerance and loss of effectiveness of opioids over time (130). Patients who do not experience clinically meaningful pain relief early in treatment (i.e., within 1 month) are unlikely to experience pain relief with longer-term use (131).

Regarding populations potentially at greater risk for harm, risk is greater for patients with sleep apnea or other causes of sleep-disordered breathing, patients with renal or hepatic insufficiency, older adults, pregnant women, patients with depression or other mental health conditions, and patients with alcohol or other substance use disorders. Interpretation of clinical data on the effects of opioids on sleep-disordered breathing is difficult because of the types of study designs and methods employed, and there is no clear consensus regarding association with risk for developing obstructive sleep apnea syndrome (132). However, opioid therapy can decrease respiratory drive, a high percentage of patients on long-term opioid therapy have been reported to have an abnormal apnea-hypopnea index (133), opioid therapy can worsen central sleep apnea in obstructive sleep apnea patients, and it can cause further desaturation in obstructive sleep apnea patients not on continuous positive airway pressure (CPAP) (31). Reduced renal or hepatic function can result in greater peak effect and longer duration of action and reduce the dose at which respiratory depression and overdose occurs (134). Age-related changes in patients aged ≥65 years, such as reduced renal function and medication clearance, even in the absence of renal disease (135), result in a smaller therapeutic window between safe dosages and dosages associated with respiratory depression and overdose. Older adults might also be at increased risk for falls and fractures related to opioids (136–138). Opioids used

in pregnancy can be associated with additional risks to both mother and fetus. Some studies have shown an association of opioid use in pregnancy with birth defects, including neural tube defects (139,140), congenital heart defects (140), and gastroschisis (140); preterm delivery (141), poor fetal growth (141), and stillbirth (141). Importantly, in some cases, opioid use during pregnancy leads to neonatal opioid withdrawal syndrome (142). Patients with mental health comorbidities and patients with histories of substance use disorders might be at higher risk than other patients for opioid use disorder (62,143,144). Recent analyses found that depressed patients were at higher risk for drug overdose than patients without depression, particularly at higher opioid dosages, although investigators were unable to distinguish unintentional overdose from suicide attempts (145). In case-control and case-cohort studies, substance abuse/dependence was more prevalent among patients experiencing overdose than among patients not experiencing overdose (12% versus 6% [66], 40% versus 10% [24], and 26% versus 9% [23]).

Regarding risk stratification approaches, limited evidence was found regarding benefits and harms. Potential benefits of PDMPs and urine drug testing include the ability to identify patients who might be at higher risk for opioid overdose or opioid use disorder, and help determine which patients will benefit from greater caution and increased monitoring or interventions when risk factors are present. For example, one study found that most fatal overdoses could be identified retrospectively on the basis of two pieces of information, multiple prescribers and high total daily opioid dosage, both important risk factors for overdose (124,146) that are available to prescribers in the PDMP (124). However, limited evaluation of PDMPs at the state level has revealed mixed effects on changes in prescribing and mortality outcomes (28). Potential harms of risk stratification include underestimation of risks of opioid therapy when screening tools are not adequately sensitive, as well as potential overestimation of risk, which could lead to inappropriate clinical decisions.

Regarding risk mitigation approaches, limited evidence was found regarding benefits and harms. Although no studies were found to examine prescribing of naloxone with opioid pain medication in primary care settings, naloxone distribution through community-based programs providing prevention services for substance users has been demonstrated to be associated with decreased risk for opioid overdose death at the community level (147).

Concerns have been raised that prescribing changes such as dose reduction might be associated with unintended negative consequences, such as patients seeking heroin or other illicitly obtained opioids (148) or interference with appropriate pain treatment (149). With the exception of a study noting

an association between an abuse-deterrent formulation of OxyContin and heroin use, showing that some patients in qualitative interviews reported switching to another opioid, including heroin, for many reasons, including cost and availability as well as ease of use (150), CDC did not identify studies evaluating these potential outcomes.

Finally, regarding the effectiveness of opioid use disorder treatments, methadone and buprenorphine for opioid use disorder have been found to increase retention in treatment and to decrease illicit opioid use among patients with opioid use disorder involving heroin (151–153). Although findings are mixed, some studies suggest that effectiveness is enhanced when psychosocial treatments (e.g., contingency management, community reinforcement, psychotherapeutic counseling, and family therapy) are used in conjunction with medication-assisted therapy; for example, by reducing opioid misuse and increasing retention during maintenance therapy, and improving compliance after detoxification (154,155).

Clinician and Patient Values and Preferences

Clinician and patient values and preferences can inform how benefits and harms of long-term opioid therapy are weighted and estimate the effort and resources required to effectively provide implementation support. Many physicians lack confidence in their ability to prescribe opioids safely (156), to predict (157) or detect (158) prescription drug abuse, and to discuss abuse with their patients (158). Although clinicians have reported favorable beliefs and attitudes about improvements in pain and quality of life attributed to opioids (159), most consider prescription drug abuse to be a “moderate” or “big” problem in their community, and large proportions are “very” concerned about opioid addiction (55%) and death (48%) (160). Clinicians do not consistently use practices intended to decrease the risk for misuse, such as PDMPs (161,162), urine drug testing (163), and opioid treatment agreements (164). This is likely due in part to challenges related to registering for PDMP access and logging into the PDMP (which can interrupt normal clinical workflow if data are not integrated into electronic health record systems) (165), competing clinical demands, perceived inadequate time to discuss the rationale for urine drug testing and to order confirmatory testing, and feeling unprepared to interpret and address results (166).

Many patients do not have an opinion about “opioids” or know what this term means (167). Most are familiar with the term “narcotics.” About a third associated “narcotics” with addiction or abuse, and about half feared “addiction” from long-term “narcotic” use (168). Most patients taking opioids experience side effects (73% of patients taking hydrocodone for noncancer pain [11], 96% of patients taking opioids for chronic pain [12]), and side effects, rather than pain relief,

have been found to explain most of the variation in patients' preferences related to taking opioids (12). For example, patients taking hydrocodone for noncancer pain commonly reported side effects including dizziness, headache, fatigue, drowsiness, nausea, vomiting, and constipation (11). Patients with chronic pain in focus groups emphasized effectiveness of goal setting for increasing motivation and functioning (168). Patients taking high dosages report reliance on opioids despite ambivalence about their benefits (169) and regardless of pain reduction, reported problems, concerns, side effects, or perceived helpfulness (13).

Resource Allocation

Resource allocation (cost) is an important consideration in understanding the feasibility of clinical recommendations. CDC searched for evidence on opioid therapy compared with other treatments; costs of misuse, abuse, and overdose from prescription opioids; and costs of specific risk mitigation strategies (e.g., urine drug testing). Yearly direct and indirect costs related to prescription opioids have been estimated (based on studies published since 2010) to be \$53.4 billion for nonmedical use of prescription opioids (170); \$55.7 billion for abuse, dependence (i.e., opioid use disorder), and misuse of prescription opioids (171); and \$20.4 billion for direct and indirect costs related to opioid-related overdose alone (172). In 2012, total expenses for outpatient prescription opioids were estimated at \$9.0 billion, an increase of 120% from 2002 (173). Although there are perceptions that opioid therapy for chronic pain is less expensive than more time-intensive nonpharmacologic management approaches, many pain treatments, including acetaminophen, NSAIDs, tricyclic antidepressants, and massage therapy, are associated with lower mean and median annual costs compared with opioid therapy (174). COX-2 inhibitors, SNRIs, anticonvulsants, topical analgesics, physical therapy, and CBT are also associated with lower median annual costs compared with opioid therapy (174). Limited information was found on costs of strategies to decrease risks associated with opioid therapy; however, urine drug testing, including screening and confirmatory tests, has been estimated to cost \$211–\$363 per test (175).

Recommendations

The recommendations are grouped into three areas for consideration:

- Determining when to initiate or continue opioids for chronic pain.
- Opioid selection, dosage, duration, follow-up, and discontinuation.
- Assessing risk and addressing harms of opioid use.

There are 12 recommendations (Box 1). Each recommendation is followed by a rationale for the recommendation, with considerations for implementation noted. In accordance with the ACIP GRADE process, CDC based the recommendations on consideration of the clinical evidence, contextual evidence (including benefits and harms, values and preferences, resource allocation), and expert opinion. For each recommendation statement, CDC notes the recommendation category (A or B) and the type of the evidence (1, 2, 3, or 4) supporting the statement (Box 2). Expert opinion is reflected within each of the recommendation rationales. While there was not an attempt to reach consensus among experts, experts from the Core Expert Group and from the Opioid Guideline Workgroup (“experts”) expressed overall, general support for all recommendations. Where differences in expert opinion emerged for detailed actions within the clinical recommendations or for implementation considerations, CDC notes the differences of opinion in the supporting rationale statements.

Category A recommendations indicate that most patients should receive the recommended course of action; category B recommendations indicate that different choices will be appropriate for different patients, requiring clinicians to help patients arrive at a decision consistent with patient values and preferences and specific clinical situations. Consistent with the ACIP (47) and GRADE process (48), category A recommendations were made, even with type 3 and 4 evidence, when there was broad agreement that the advantages of a clinical action greatly outweighed the disadvantages based on a consideration of benefits and harms, values and preferences, and resource allocation. Category B recommendations were made when there was broad agreement that the advantages and disadvantages of a clinical action were more balanced, but advantages were significant enough to warrant a recommendation. All recommendations are category A recommendations, with the exception of recommendation 10, which is rated as category B. Recommendations were associated with a range of evidence types, from type 2 to type 4.

In summary, the categorization of recommendations was based on the following assessment:

- No evidence shows a long-term benefit of opioids in pain and function versus no opioids for chronic pain with outcomes examined at least 1 year later (with most placebo-controlled randomized trials ≤6 weeks in duration).
- Extensive evidence shows the possible harms of opioids (including opioid use disorder, overdose, and motor vehicle injury).
- Extensive evidence suggests some benefits of nonpharmacologic and nonopioid pharmacologic treatments compared with long-term opioid therapy, with less harm.

BOX 1. CDC recommendations for prescribing opioids for chronic pain outside of active cancer, palliative, and end-of-life care**Determining When to Initiate or Continue Opioids for Chronic Pain**

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.
5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to ≥ 50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥ 90 MME/day or carefully justify a decision to titrate dosage to ≥ 90 MME/day.
6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

Assessing Risk and Addressing Harms of Opioid Use

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥ 50 MME/day), or concurrent benzodiazepine use, are present.
9. Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.
10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.
11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

*All recommendations are category A (apply to all patients outside of active cancer treatment, palliative care, and end-of-life care) except recommendation 10 (designated category B, with individual decision making required); see full guideline for evidence ratings.

BOX 2. Interpretation of recommendation categories and evidence type**Recommendation Categories**

Based on evidence type, balance between desirable and undesirable effects, values and preferences, and resource allocation (cost).

Category A recommendation: Applies to all persons; most patients should receive the recommended course of action.

Category B recommendation: Individual decision making needed; different choices will be appropriate for different patients. Clinicians help patients arrive at a decision consistent with patient values and preferences and specific clinical situations.

Evidence Type

Based on study design as well as a function of limitations in study design or implementation, imprecision of estimates, variability in findings, indirectness of evidence, publication bias, magnitude of treatment effects, dose-response gradient, and constellation of plausible biases that could change effects.

Type 1 evidence: Randomized clinical trials or overwhelming evidence from observational studies.

Type 2 evidence: Randomized clinical trials with important limitations, or exceptionally strong evidence from observational studies.

Type 3 evidence: Observational studies or randomized clinical trials with notable limitations.

Type 4 evidence: Clinical experience and observations, observational studies with important limitations, or randomized clinical trials with several major limitations.

evidence that exercise therapy (a prominent modality in physical therapy) for hip (100) or knee (99) osteoarthritis reduces pain and improves function immediately after treatment and that the improvements are sustained for at least 2–6 months. Previous guidelines have strongly recommended aerobic, aquatic, and/or resistance exercises for patients with osteoarthritis of the knee or hip (176). Exercise therapy also can help reduce pain and improve function in low back pain and can improve global well-being and physical function in fibromyalgia (98,101). Multimodal therapies and multidisciplinary biopsychosocial rehabilitation—combining approaches (e.g., psychological therapies with exercise) can reduce long-term pain and disability compared with usual care and compared with physical treatments (e.g., exercise) alone. Multimodal therapies are not always available or reimbursed by insurance and can be time-consuming and costly for patients. Interventional approaches such as arthrocentesis and intraarticular glucocorticoid injection for pain associated with rheumatoid arthritis (117) or osteoarthritis (118) and subacromial corticosteroid injection for rotator cuff disease (119) can provide short-term improvement in pain and function. Evidence is insufficient to determine the extent to which repeated glucocorticoid injection increases potential risks such as articular cartilage changes (in osteoarthritis) and sepsis (118). Serious adverse events are rare but have been reported with epidural injection (120).

Several nonopioid pharmacologic therapies (including acetaminophen, NSAIDs, and selected antidepressants and anticonvulsants) are effective for chronic pain. In particular, acetaminophen and NSAIDs can be useful for arthritis and low back pain. Selected anticonvulsants such as pregabalin and gabapentin can improve pain in diabetic neuropathy and post-herpetic neuralgia (contextual evidence review). Pregabalin, gabapentin, and carbamazepine are FDA-approved for treatment of certain neuropathic pain conditions, and pregabalin is FDA approved for fibromyalgia management. In patients with or without depression, tricyclic antidepressants and SNRIs provide effective analgesia for neuropathic pain conditions including diabetic neuropathy and post-herpetic neuralgia, often at lower dosages and with a shorter time to onset of effect than for treatment of depression (see contextual evidence review). Tricyclics and SNRIs can also relieve fibromyalgia symptoms. The SNRI duloxetine is FDA-approved for the treatment of diabetic neuropathy and fibromyalgia. Because patients with chronic pain often suffer from concurrent depression (144), and depression can exacerbate physical symptoms including pain (177), patients with co-occurring pain and depression are especially likely to benefit from antidepressant medication (see Recommendation 8). Nonopioid pharmacologic therapies

Determining When to Initiate or Continue Opioids for Chronic Pain

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain.

Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate (recommendation category: A, evidence type: 3).

Patients with pain should receive treatment that provides the greatest benefits relative to risks. The contextual evidence review found that many nonpharmacologic therapies, including physical therapy, weight loss for knee osteoarthritis, psychological therapies such as CBT, and certain interventional procedures can ameliorate chronic pain. There is high-quality

are not generally associated with substance use disorder, and the numbers of fatal overdoses associated with nonopioid medications are a fraction of those associated with opioid medications (contextual evidence review). For example, acetaminophen, NSAIDs, and opioid pain medication were involved in 881, 228, and 16,651 pharmaceutical overdose deaths in the United States in 2010 (178). However, nonopioid pharmacologic therapies are associated with certain risks, particularly in older patients, pregnant patients, and patients with certain co-morbidities such as cardiovascular, renal, gastrointestinal, and liver disease (see contextual evidence review). For example, acetaminophen can be hepatotoxic at dosages of >3–4 grams/day and at lower dosages in patients with chronic alcohol use or liver disease (109). NSAID use has been associated with gastritis, peptic ulcer disease, cardiovascular events (111,112), and fluid retention, and most NSAIDs (choline magnesium trisilicate and selective COX-2 inhibitors are exceptions) interfere with platelet aggregation (179). Clinicians should review FDA-approved labeling including boxed warnings before initiating treatment with any pharmacologic therapy.

Although opioids can reduce pain during short-term use, the clinical evidence review found insufficient evidence to determine whether pain relief is sustained and whether function or quality of life improves with long-term opioid therapy (KQ1). While benefits for pain relief, function, and quality of life with long-term opioid use for chronic pain are uncertain, risks associated with long-term opioid use are clearer and significant. Based on the clinical evidence review, long-term opioid use for chronic pain is associated with serious risks including increased risk for opioid use disorder, overdose, myocardial infarction, and motor vehicle injury (KQ2). At a population level, more than 165,000 persons in the United States have died from opioid pain-medication-related overdoses since 1999 (see Contextual Evidence Review).

Integrated pain management requires coordination of medical, psychological, and social aspects of health care and includes primary care, mental health care, and specialist services when needed (180). Nonpharmacologic physical and psychological treatments such as exercise and CBT are approaches that encourage active patient participation in the care plan, address the effects of pain in the patient's life, and can result in sustained improvements in pain and function without apparent risks. Despite this, these therapies are not always or fully covered by insurance, and access and cost can be barriers for patients. For many patients, aspects of these approaches can be used even when there is limited access to specialty care. For example, previous guidelines have strongly recommended aerobic, aquatic, and/or resistance exercises for patients with osteoarthritis of the knee or hip (176) and maintenance of

activity for patients with low back pain (110). A randomized trial found no difference in reduced chronic low back pain intensity, frequency or disability between patients assigned to relatively low-cost group aerobics and individual physiotherapy or muscle reconditioning sessions (181). Low-cost options to integrate exercise include brisk walking in public spaces or use of public recreation facilities for group exercise. CBT addresses psychosocial contributors to pain and improves function (97). Primary care clinicians can integrate elements of a cognitive behavioral approach into their practice by encouraging patients to take an active role in the care plan, by supporting patients in engaging in beneficial but potentially anxiety-provoking activities, such as exercise (179), or by providing education in relaxation techniques and coping strategies. In many locations, there are free or low-cost patient support, self-help, and educational community-based programs that can provide stress reduction and other mental health benefits. Patients with more entrenched anxiety or fear related to pain, or other significant psychological distress, can be referred for formal therapy with a mental health specialist (e.g., psychologist, psychiatrist, clinical social worker). Multimodal therapies should be considered for patients not responding to single-modality therapy, and combinations should be tailored depending on patient needs, cost, and convenience.

To guide patient-specific selection of therapy, clinicians should evaluate patients and establish or confirm the diagnosis. Detailed recommendations on diagnosis are provided in other guidelines (110,179), but evaluation should generally include a focused history, including history and characteristics of pain and potentially contributing factors (e.g., function, psychosocial stressors, sleep) and physical exam, with imaging or other diagnostic testing only if indicated (e.g., if severe or progressive neurologic deficits are present or if serious underlying conditions are suspected) (110,179). For complex pain syndromes, pain specialty consultation can be considered to assist with diagnosis as well as management. Diagnosis can help identify disease-specific interventions to reverse or ameliorate pain; for example, improving glucose control to prevent progression of diabetic neuropathy; immune-modulating agents for rheumatoid arthritis; physical or occupational therapy to address posture, muscle weakness, or repetitive occupational motions that contribute to musculoskeletal pain; or surgical intervention to relieve mechanical/compressive pain (179). The underlying mechanism for most pain syndromes can be categorized as neuropathic (e.g., diabetic neuropathy, postherpetic neuralgia, fibromyalgia), or nociceptive (e.g., osteoarthritis, muscular back pain). The diagnosis and pathophysiologic mechanism of pain have implications for symptomatic pain treatment with medication. For example, evidence is limited or insufficient

for improved pain or function with long-term use of opioids for several chronic pain conditions for which opioids are commonly prescribed, such as low back pain (182), headache (183), and fibromyalgia (184). Although NSAIDs can be used for exacerbations of nociceptive pain, other medications (e.g., tricyclics, selected anticonvulsants, or transdermal lidocaine) generally are recommended for neuropathic pain. In addition, improvement of neuropathic pain can begin weeks or longer after symptomatic treatment is initiated (179). Medications should be used only after assessment and determination that expected benefits outweigh risks given patient-specific factors. For example, clinicians should consider falls risk when selecting and dosing potentially sedating medications such as tricyclics, anticonvulsants, or opioids, and should weigh risks and benefits of use, dose, and duration of NSAIDs when treating older adults as well as patients with hypertension, renal insufficiency, or heart failure, or those with risk for peptic ulcer disease or cardiovascular disease. Some guidelines recommend topical NSAIDs for localized osteoarthritis (e.g., knee osteoarthritis) over oral NSAIDs in patients aged ≥ 75 years to minimize systemic effects (176).

Experts agreed that opioids should not be considered first-line or routine therapy for chronic pain (i.e., pain continuing or expected to continue >3 months or past the time of normal tissue healing) outside of active cancer, palliative, and end-of-life care, given small to moderate short-term benefits, uncertain long-term benefits, and potential for serious harms; although evidence on long-term benefits of nonopioid therapies is also limited, these therapies are also associated with short-term benefits, and risks are much lower. This does not mean that patients should be required to sequentially “fail” nonpharmacologic and nonopioid pharmacologic therapy before proceeding to opioid therapy. Rather, expected benefits specific to the clinical context should be weighed against risks before initiating therapy. In some clinical contexts (e.g., headache or fibromyalgia), expected benefits of initiating opioids are unlikely to outweigh risks regardless of previous nonpharmacologic and nonopioid pharmacologic therapies used. In other situations (e.g., serious illness in a patient with poor prognosis for return to previous level of function, contraindications to other therapies, and clinician and patient agreement that the overriding goal is patient comfort), opioids might be appropriate regardless of previous therapies used. In addition, when opioid pain medication is used, it is more likely to be effective if integrated with nonpharmacologic therapy. Nonpharmacologic approaches such as exercise and CBT should be used to reduce pain and improve function in patients with chronic pain. Nonopioid pharmacologic therapy should be used when benefits outweigh risks and should be

combined with nonpharmacologic therapy to reduce pain and improve function. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate, to provide greater benefits to patients in improving pain and function.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety (recommendation category: A, evidence type: 4).

The clinical evidence review found insufficient evidence to determine long-term benefits of opioid therapy for chronic pain and found an increased risk for serious harms related to long-term opioid therapy that appears to be dose-dependent. In addition, studies on currently available risk assessment instruments were sparse and showed inconsistent results (KQ4). The clinical evidence review for the current guideline considered studies with outcomes examined at ≥ 1 year that compared opioid use versus nonuse or placebo. Studies of opioid therapy for chronic pain that did not have a nonopioid control group have found that although many patients discontinue opioid therapy for chronic noncancer pain due to adverse effects or insufficient pain relief, there is weak evidence that patients who are able to continue opioid therapy for at least 6 months can experience clinically significant pain relief and insufficient evidence that function or quality of life improves (185). These findings suggest that it is very difficult for clinicians to predict whether benefits of opioids for chronic pain will outweigh risks of ongoing treatment for individual patients. Opioid therapy should not be initiated without consideration of an “exit strategy” to be used if the therapy is unsuccessful.

Experts agreed that before opioid therapy is initiated for chronic pain outside of active cancer, palliative, and end-of-life care, clinicians should determine how effectiveness will be evaluated and should establish treatment goals with patients. Because the line between acute pain and initial chronic pain is not always clear, it might be difficult for clinicians to determine when they are initiating opioids for chronic pain rather than treating acute pain. Pain lasting longer than 3 months or past the time of normal tissue healing (which could be substantially shorter than 3 months, depending on the condition) is generally no longer considered acute. However, establishing treatment goals with a patient who has already received opioid therapy for 3 months would defer this discussion well past the point of

initiation of opioid therapy for chronic pain. Clinicians often write prescriptions for long-term use in 30-day increments, and opioid prescriptions written for ≥ 30 days are likely to represent initiation or continuation of long-term opioid therapy. Before writing an opioid prescription for ≥ 30 days, clinicians should establish treatment goals with patients. Clinicians seeing new patients already receiving opioids should establish treatment goals for continued opioid therapy. Although the clinical evidence review did not find studies evaluating the effectiveness of written agreements or treatment plans (KQ4), clinicians and patients who set a plan in advance will clarify expectations regarding how opioids will be prescribed and monitored, as well as situations in which opioids will be discontinued or doses tapered (e.g., if treatment goals are not met, opioids are no longer needed, or adverse events put the patient at risk) to improve patient safety.

Experts thought that goals should include improvement in both pain relief and function (and therefore in quality of life). However, there are some clinical circumstances under which reductions in pain without improvement in physical function might be a more realistic goal (e.g., diseases typically associated with progressive functional impairment or catastrophic injuries such as spinal cord trauma). Experts noted that function can include emotional and social as well as physical dimensions. In addition, experts emphasized that mood has important interactions with pain and function. Experts agreed that clinicians may use validated instruments such as the three-item “Pain average, interference with Enjoyment of life, and interference with General activity” (PEG) Assessment Scale (186) to track patient outcomes. Clinically meaningful improvement has been defined as a 30% improvement in scores for both pain and function (187). Monitoring progress toward patient-centered functional goals (e.g., walking the dog or walking around the block, returning to part-time work, attending family sports or recreational activities) can also contribute to the assessment of functional improvement. Clinicians should use these goals in assessing benefits of opioid therapy for individual patients and in weighing benefits against risks of continued opioid therapy (see Recommendation 7, including recommended intervals for follow-up). Because depression, anxiety, and other psychological co-morbidities often coexist with and can interfere with resolution of pain, clinicians should use validated instruments to assess for these conditions (see Recommendation 8) and ensure that treatment for these conditions is optimized. If patients receiving opioid therapy for chronic pain do not experience meaningful improvements in both pain and function compared with prior to initiation of opioid therapy, clinicians should consider working with patients to taper and discontinue opioids (see Recommendation 7) and should use nonpharmacologic and

nonopioid pharmacologic approaches to pain management (see Recommendation 1).

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy (recommendation category: A, evidence type: 3).

The clinical evidence review did not find studies evaluating effectiveness of patient education or opioid treatment plans as risk-mitigation strategies (KQ4). However, the contextual evidence review found that many patients lack information about opioids and identified concerns that some clinicians miss opportunities to effectively communicate about safety. Given the substantial evidence gaps on opioids, uncertain benefits of long-term use, and potential for serious harms, patient education and discussion before starting opioid therapy are critical so that patient preferences and values can be understood and used to inform clinical decisions. Experts agreed that essential elements to communicate to patients before starting and periodically during opioid therapy include realistic expected benefits, common and serious harms, and expectations for clinician and patient responsibilities to mitigate risks of opioid therapy.

Clinicians should involve patients in decisions about whether to start or continue opioid therapy. Given potentially serious risks of long-term opioid therapy, clinicians should ensure that patients are aware of potential benefits of, harms of, and alternatives to opioids before starting or continuing opioid therapy. Clinicians are encouraged to have open and honest discussions with patients to inform mutual decisions about whether to start or continue opioid therapy. Important considerations include the following:

- Be explicit and realistic about expected benefits of opioids, explaining that while opioids can reduce pain during short-term use, there is no good evidence that opioids improve pain or function with long-term use, and that complete relief of pain is unlikely (clinical evidence review, KQ1).
- Emphasize improvement in function as a primary goal and that function can improve even when pain is still present.
- Advise patients about serious adverse effects of opioids, including potentially fatal respiratory depression and development of a potentially serious lifelong opioid use disorder that can cause distress and inability to fulfill major role obligations.
- Advise patients about common effects of opioids, such as constipation, dry mouth, nausea, vomiting, drowsiness, confusion, tolerance, physical dependence, and withdrawal symptoms when stopping opioids. To prevent constipation associated with opioid use, advise patients to increase

hydration and fiber intake and to maintain or increase physical activity. Stool softeners or laxatives might be needed.

- Discuss effects that opioids might have on ability to safely operate a vehicle, particularly when opioids are initiated, when dosages are increased, or when other central nervous system depressants, such as benzodiazepines or alcohol, are used concurrently.
- Discuss increased risks for opioid use disorder, respiratory depression, and death at higher dosages, along with the importance of taking only the amount of opioids prescribed, i.e., not taking more opioids or taking them more often.
- Review increased risks for respiratory depression when opioids are taken with benzodiazepines, other sedatives, alcohol, illicit drugs such as heroin, or other opioids.
- Discuss risks to household members and other individuals if opioids are intentionally or unintentionally shared with others for whom they are not prescribed, including the possibility that others might experience overdose at the same or at lower dosage than prescribed for the patient, and that young children are susceptible to unintentional ingestion. Discuss storage of opioids in a secure, preferably locked location and options for safe disposal of unused opioids (188).
- Discuss the importance of periodic reassessment to ensure that opioids are helping to meet patient goals and to allow opportunities for opioid discontinuation and consideration of additional nonpharmacologic or nonopioid pharmacologic treatment options if opioids are not effective or are harmful.
- Discuss planned use of precautions to reduce risks, including use of prescription drug monitoring program information (see Recommendation 9) and urine drug testing (see Recommendation 10). Consider including discussion of naloxone use for overdose reversal (see Recommendation 8).
- Consider whether cognitive limitations might interfere with management of opioid therapy (for older adults in particular) and, if so, determine whether a caregiver can responsibly co-manage medication therapy. Discuss the importance of reassessing safer medication use with both the patient and caregiver.

Given the possibility that benefits of opioid therapy might diminish or that risks might become more prominent over time, it is important that clinicians review expected benefits and risks of continued opioid therapy with patients periodically, at least every 3 months (see Recommendation 7).

Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids (recommendation category: A, evidence type: 4).

ER/LA opioids include methadone, transdermal fentanyl, and extended-release versions of opioids such as oxycodone, oxymorphone, hydrocodone, and morphine. The clinical evidence review found a fair-quality study showing a higher risk for overdose among patients initiating treatment with ER/LA opioids than among those initiating treatment with immediate-release opioids (77). The clinical evidence review did not find evidence that continuous, time-scheduled use of ER/LA opioids is more effective or safer than intermittent use of immediate-release opioids or that time-scheduled use of ER/LA opioids reduces risks for opioid misuse or addiction (KQ3).

In 2014, the FDA modified the labeling for ER/LA opioid pain medications, noting serious risks and recommending that ER/LA opioids be reserved for “management of pain severe enough to require daily, around-the-clock, long-term opioid treatment” when “alternative treatment options (e.g., nonopioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain” and not used as “as needed” pain relievers (121). FDA has also noted that some ER/LA opioids are only appropriate for opioid-tolerant patients, defined as patients who have received certain dosages of opioids (e.g., 60 mg daily of oral morphine, 30 mg daily of oral oxycodone, or equianalgesic dosages of other opioids) for at least 1 week (189). Time-scheduled opioid use can be associated with greater total average daily opioid dosage compared with intermittent, as-needed opioid use (contextual evidence review). In addition, experts indicated that there was not enough evidence to determine the safety of using immediate-release opioids for breakthrough pain when ER/LA opioids are used for chronic pain outside of active cancer pain, palliative care, or end-of-life care, and that this practice might be associated with dose escalation.

Abuse-deterrent technologies have been employed to prevent manipulation intended to defeat extended-release properties of ER/LA opioids and to prevent opioid use by unintended routes of administration, such as injection of oral opioids. As indicated in FDA guidance for industry on evaluation and labeling of abuse-deterrent opioids (190), although abuse-deterrent technologies are expected to make manipulation of opioids more difficult or less rewarding, they do not prevent

opioid abuse through oral intake, the most common route of opioid abuse, and can still be abused by nonoral routes. The “abuse-deterrent” label does not indicate that there is no risk for abuse. No studies were found in the clinical evidence review assessing the effectiveness of abuse-deterrent technologies as a risk mitigation strategy for deterring or preventing abuse. In addition, abuse-deterrent technologies do not prevent unintentional overdose through oral intake. Experts agreed that recommendations could not be offered at this time related to use of abuse-deterrent formulations.

In comparing different ER/LA formulations, the clinical evidence review found inconsistent results for overdose risk with methadone versus other ER/LA opioids used for chronic pain (KQ3). The contextual evidence review found that methadone has been associated with disproportionate numbers of overdose deaths relative to the frequency with which it is prescribed for chronic pain. In addition, methadone is associated with cardiac arrhythmias along with QT prolongation on the electrocardiogram, and it has complicated pharmacokinetics and pharmacodynamics, including a long and variable half-life and peak respiratory depressant effect occurring later and lasting longer than peak analgesic effect. Experts noted that the pharmacodynamics of methadone are subject to more inter-individual variability than other opioids. In regard to other ER/LA opioid formulations, experts noted that the absorption and pharmacodynamics of transdermal fentanyl are complex, with gradually increasing serum concentration during the first part of the 72-hour dosing interval, as well as variable absorption based on factors such as external heat. In addition, the dosing of transdermal fentanyl in mcg/hour, which is not typical for a drug used by outpatients, can be confusing. Experts thought that these complexities might increase the risk for fatal overdose when methadone or transdermal fentanyl is prescribed to a patient who has not used it previously or by clinicians who are not familiar with its effects.

Experts agreed that for patients not already receiving opioids, clinicians should not initiate opioid treatment with ER/LA opioids and should not prescribe ER/LA opioids for intermittent use. ER/LA opioids should be reserved for severe, continuous pain and should be considered only for patients who have received immediate-release opioids daily for at least 1 week. When changing to an ER/LA opioid for a patient previously receiving a different immediate-release opioid, clinicians should consult product labeling and reduce total daily dosage to account for incomplete opioid cross-tolerance. Clinicians should use additional caution with ER/LA opioids and consider a longer dosing interval when prescribing to patients with renal or hepatic dysfunction because decreased clearance of drugs among these patients can lead to accumulation of drugs to toxic levels and persistence in the

body for longer durations. Although there might be situations in which clinicians need to prescribe immediate-release and ER/LA opioids together (e.g., transitioning patients from ER/LA opioids to immediate-release opioids by temporarily using lower dosages of both), in general, avoiding the use of immediate-release opioids in combination with ER/LA opioids is preferable, given potentially increased risk and diminishing returns of such an approach for chronic pain.

When an ER/LA opioid is prescribed, using one with predictable pharmacokinetics and pharmacodynamics is preferred to minimize unintentional overdose risk. In particular, unusual characteristics of methadone and of transdermal fentanyl make safe prescribing of these medications for pain especially challenging.

- Methadone should not be the first choice for an ER/LA opioid. Only clinicians who are familiar with methadone’s unique risk profile and who are prepared to educate and closely monitor their patients, including risk assessment for QT prolongation and consideration of electrocardiographic monitoring, should consider prescribing methadone for pain. A clinical practice guideline that contains further guidance regarding methadone prescribing for pain has been published previously (191).
- Because dosing effects of transdermal fentanyl are often misunderstood by both clinicians and patients, only clinicians who are familiar with the dosing and absorption properties of transdermal fentanyl and are prepared to educate their patients about its use should consider prescribing it.

5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥ 50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥ 90 MME/day or carefully justify a decision to titrate dosage to ≥ 90 MME/day (recommendation category: A, evidence type: 3).

Benefits of high-dose opioids for chronic pain are not established. The clinical evidence review found only one study (84) addressing effectiveness of dose titration for outcomes related to pain control, function, and quality of life (KQ3). This randomized trial found no difference in pain or function between a more liberal opioid dose escalation strategy and maintenance of current dosage. (These groups were prescribed average dosages of 52 and 40 MME/day, respectively, at the end of the trial.) At the same time, risks for serious harms

related to opioid therapy increase at higher opioid dosage. The clinical evidence review found that higher opioid dosages are associated with increased risks for motor vehicle injury, opioid use disorder, and overdose (KQ2). The clinical and contextual evidence reviews found that opioid overdose risk increases in a dose-response manner, that dosages of 50–<100 MME/day have been found to increase risks for opioid overdose by factors of 1.9 to 4.6 compared with dosages of 1–<20 MME/day, and that dosages ≥ 100 MME/day are associated with increased risks of overdose 2.0–8.9 times the risk at 1–<20 MME/day. In a national sample of Veterans Health Administration patients with chronic pain who were prescribed opioids, mean prescribed opioid dosage among patients who died from opioid overdose was 98 MME (median 60 MME) compared with mean prescribed opioid dosage of 48 MME (median 25 MME) among patients not experiencing fatal overdose (127).

The contextual evidence review found that although there is not a single dosage threshold below which overdose risk is eliminated, holding dosages <50 MME/day would likely reduce risk among a large proportion of patients who would experience fatal overdose at higher prescribed dosages. Experts agreed that lower dosages of opioids reduce the risk for overdose, but that a single dosage threshold for safe opioid use could not be identified. Experts noted that daily opioid dosages close to or greater than 100 MME/day are associated with significant risks, that dosages <50 MME/day are safer than dosages of 50–100 MME/day, and that dosages <20 MME/day are safer than dosages of 20–50 MME/day. One expert thought that a specific dosage at which the benefit/risk ratio of opioid therapy decreases could not be identified. Most experts agreed that, in general, increasing dosages to 50 or more MME/day increases overdose risk without necessarily adding benefits for pain control or function and that clinicians should carefully reassess evidence of individual benefits and risks when considering increasing opioid dosages to ≥ 50 MME/day. Most experts also agreed that opioid dosages should not be increased to ≥ 90 MME/day without careful justification based on diagnosis and on individualized assessment of benefits and risks.

When opioids are used for chronic pain outside of active cancer, palliative, and end-of-life care, clinicians should start opioids at the lowest possible effective dosage (the lowest starting dosage on product labeling for patients not already taking opioids and according to product labeling guidance regarding tolerance for patients already taking opioids). Clinicians should use additional caution when initiating opioids for patients aged ≥ 65 years and for patients with renal or hepatic insufficiency because decreased clearance of drugs in these patients can result in accumulation of drugs to toxic levels. Clinicians should use caution when increasing opioid dosages and increase dosage by the smallest practical

amount because overdose risk increases with increases in opioid dosage. Although there is limited evidence to recommend specific intervals for dosage titration, a previous guideline recommended waiting at least five half-lives before increasing dosage and waiting at least a week before increasing dosage of methadone to make sure that full effects of the previous dosage are evident (31). Clinicians should re-evaluate patients after increasing dosage for changes in pain, function, and risk for harm (see Recommendation 7). Before increasing total opioid dosage to ≥ 50 MME/day, clinicians should reassess whether opioid treatment is meeting the patient's treatment goals (see Recommendation 2). If a patient's opioid dosage for all sources of opioids combined reaches or exceeds 50 MME/day, clinicians should implement additional precautions, including increased frequency of follow-up (see Recommendation 7) and considering offering naloxone and overdose prevention education to both patients and the patients' household members (see Recommendation 8). Clinicians should avoid increasing opioid dosages to ≥ 90 MME/day or should carefully justify a decision to increase dosage to ≥ 90 MME/day based on individualized assessment of benefits and risks and weighing factors such as diagnosis, incremental benefits for pain and function relative to harms as dosages approach 90 MME/day, other treatments and effectiveness, and recommendations based on consultation with pain specialists. If patients do not experience improvement in pain and function at ≥ 90 MME/day, or if there are escalating dosage requirements, clinicians should discuss other approaches to pain management with the patient, consider working with patients to taper opioids to a lower dosage or to taper and discontinue opioids (see Recommendation 7), and consider consulting a pain specialist. Some states require clinicians to implement clinical protocols at specific dosage levels. For example, before increasing long-term opioid therapy dosage to >120 MME/day, clinicians in Washington state must obtain consultation from a pain specialist who agrees that this is indicated and appropriate (30). Clinicians should be aware of rules related to MME thresholds and associated clinical protocols established by their states.

Established patients already taking high dosages of opioids, as well as patients transferring from other clinicians, might consider the possibility of opioid dosage reduction to be anxiety-provoking, and tapering opioids can be especially challenging after years on high dosages because of physical and psychological dependence. However, these patients should be offered the opportunity to re-evaluate their continued use of opioids at high dosages in light of recent evidence regarding the association of opioid dosage and overdose risk. Clinicians should explain in a nonjudgmental manner to patients already taking high opioid dosages (≥ 90 MME/day) that there is

now an established body of scientific evidence showing that overdose risk is increased at higher opioid dosages. Clinicians should empathically review benefits and risks of continued high-dosage opioid therapy and should offer to work with the patient to taper opioids to safer dosages. For patients who agree to taper opioids to lower dosages, clinicians should collaborate with the patient on a tapering plan (see Recommendation 7). Experts noted that patients tapering opioids after taking them for years might require very slow opioid tapers as well as pauses in the taper to allow gradual accommodation to lower opioid dosages. Clinicians should remain alert to signs of anxiety, depression, and opioid use disorder (see Recommendations 8 and 12) that might be unmasked by an opioid taper and arrange for management of these co-morbidities. For patients agreeing to taper to lower opioid dosages as well as for those remaining on high opioid dosages, clinicians should establish goals with the patient for continued opioid therapy (see Recommendation 2), maximize pain treatment with nonpharmacologic and nonopioid pharmacologic treatments as appropriate (see Recommendation 1), and consider consulting a pain specialist as needed to assist with pain management.

6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed (recommendation category: A, evidence type: 4).

The clinical evidence review found that opioid use for acute pain (i.e., pain with abrupt onset and caused by an injury or other process that is not ongoing) is associated with long-term opioid use, and that a greater amount of early opioid exposure is associated with greater risk for long-term use (KQ5). Several guidelines on opioid prescribing for acute pain from emergency departments (192–194) and other settings (195,196) have recommended prescribing ≤ 3 days of opioids in most cases, whereas others have recommended ≤ 7 days (197) or < 14 days (30). Because physical dependence on opioids is an expected physiologic response in patients exposed to opioids for more than a few days (contextual evidence review), limiting days of opioids prescribed also should minimize the need to taper opioids to prevent distressing or unpleasant withdrawal symptoms. Experts noted that more than a few days of exposure to opioids significantly increases hazards, that each day of unnecessary opioid use increases likelihood of physical dependence without adding benefit, and that prescriptions

with fewer days' supply will minimize the number of pills available for unintentional or intentional diversion.

Experts agreed that when opioids are needed for acute pain, clinicians should prescribe opioids at the lowest effective dose and for no longer than the expected duration of pain severe enough to require opioids to minimize unintentional initiation of long-term opioid use. The lowest effective dose can be determined using product labeling as a starting point with calibration as needed based on the severity of pain and on other clinical factors such as renal or hepatic insufficiency (see Recommendation 8). Experts thought, based on clinical experience regarding anticipated duration of pain severe enough to require an opioid, that in most cases of acute pain not related to surgery or trauma, a ≤ 3 days' supply of opioids will be sufficient. For example, in one study of the course of acute low back pain (not associated with malignancies, infections, spondylarthropathies, fractures, or neurological signs) in a primary care setting, there was a large decrease in pain until the fourth day after treatment with paracetamol, with smaller decreases thereafter (198). Some experts thought that because some types of acute pain might require more than 3 days of opioid treatment, it would be appropriate to recommend a range of ≤ 3 –5 days or ≤ 3 –7 days when opioids are needed. Some experts thought that a range including 7 days was too long given the expected course of severe acute pain for most acute pain syndromes seen in primary care.

Acute pain can often be managed without opioids. It is important to evaluate the patient for reversible causes of pain, for underlying etiologies with potentially serious sequelae, and to determine appropriate treatment. When the diagnosis and severity of nontraumatic, nonsurgical acute pain are reasonably assumed to warrant the use of opioids, clinicians should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids, often 3 days or less, unless circumstances clearly warrant additional opioid therapy. More than 7 days will rarely be needed. Opioid treatment for post-surgical pain is outside the scope of this guideline but has been addressed elsewhere (30). Clinicians should not prescribe additional opioids to patients “just in case” pain continues longer than expected. Clinicians should re-evaluate the subset of patients who experience severe acute pain that continues longer than the expected duration to confirm or revise the initial diagnosis and to adjust management accordingly. Given longer half-lives and longer duration of effects (e.g., respiratory depression) with ER/LA opioids such as methadone, fentanyl patches, or extended release versions of opioids such as oxycodone, oxymorphone, or morphine, clinicians should not prescribe ER/LA opioids for the treatment of acute pain.

7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids (recommendation category: A, evidence type: 4).

Although the clinical evidence review did not find studies evaluating the effectiveness of more frequent monitoring intervals (KQ4), it did find that continuing opioid therapy for 3 months substantially increases risk for opioid use disorder (KQ2); therefore, follow-up earlier than 3 months might be necessary to provide the greatest opportunity to prevent the development of opioid use disorder. In addition, risk for overdose associated with ER/LA opioids might be particularly high during the first 2 weeks of treatment (KQ3). The contextual evidence review found that patients who do not have pain relief with opioids at 1 month are unlikely to experience pain relief with opioids at 6 months. Although evidence is insufficient to determine at what point within the first 3 months of opioid therapy the risks for opioid use disorder increase, reassessment of pain and function within 1 month of initiating opioids provides an opportunity to minimize risks of long-term opioid use by discontinuing opioids among patients not receiving a clear benefit from these medications. Experts noted that risks for opioid overdose are greatest during the first 3–7 days after opioid initiation or increase in dosage, particularly when methadone or transdermal fentanyl are prescribed; that follow-up within 3 days is appropriate when initiating or increasing the dosage of methadone; and that follow-up within 1 week might be appropriate when initiating or increasing the dosage of other ER/LA opioids.

Clinicians should evaluate patients to assess benefits and harms of opioids within 1 to 4 weeks of starting long-term opioid therapy or of dose escalation. Clinicians should consider follow-up intervals within the lower end of this range when ER/LA opioids are started or increased or when total daily opioid dosage is ≥ 50 MME/day. Shorter follow-up intervals (within 3 days) should be strongly considered when starting or increasing the dosage of methadone. At follow up, clinicians should assess benefits in function, pain control, and quality of life using tools such as the three-item “Pain average, interference with Enjoyment of life, and interference with General activity” (PEG) Assessment Scale (186) and/or asking patients about progress toward functional goals that have meaning for them (see Recommendation 2). Clinicians should also ask patients about common adverse effects such as

constipation and drowsiness (see Recommendation 3), as well as asking about and assessing for effects that might be early warning signs for more serious problems such as overdose (e.g., sedation or slurred speech) or opioid use disorder (e.g., craving, wanting to take opioids in greater quantities or more frequently than prescribed, or difficulty controlling use). Clinicians should ask patients about their preferences for continuing opioids, given their effects on pain and function relative to any adverse effects experienced.

Because of potential changes in the balance of benefits and risks of opioid therapy over time, clinicians should regularly reassess all patients receiving long-term opioid therapy, including patients who are new to the clinician but on long-term opioid therapy, at least every 3 months. At reassessment, clinicians should determine whether opioids continue to meet treatment goals, including sustained improvement in pain and function, whether the patient has experienced common or serious adverse events or early warning signs of serious adverse events, signs of opioid use disorder (e.g., difficulty controlling use, work or family problems related to opioid use), whether benefits of opioids continue to outweigh risks, and whether opioid dosage can be reduced or opioids can be discontinued. Ideally, these reassessments would take place in person and be conducted by the prescribing clinician. In practice contexts where virtual visits are part of standard care (e.g., in remote areas where distance or other issues make follow-up visits challenging), follow-up assessments that allow the clinician to communicate with and observe the patient through video and audio could be conducted, with in-person visits occurring at least once per year. Clinicians should re-evaluate patients who are exposed to greater risk of opioid use disorder or overdose (e.g., patients with depression or other mental health conditions, a history of substance use disorder, a history of overdose, taking ≥ 50 MME/day, or taking other central nervous system depressants with opioids) more frequently than every 3 months. If clinically meaningful improvements in pain and function are not sustained, if patients are taking high-risk regimens (e.g., dosages ≥ 50 MME/day or opioids combined with benzodiazepines) without evidence of benefit, if patients believe benefits no longer outweigh risks or if they request dosage reduction or discontinuation, or if patients experience overdose or other serious adverse events (e.g., an event leading to hospitalization or disability) or warning signs of serious adverse events, clinicians should work with patients to reduce opioid dosage or to discontinue opioids when possible. Clinicians should maximize pain treatment with nonpharmacologic and nonopioid pharmacologic treatments as appropriate (see Recommendation 1) and consider consulting a pain specialist as needed to assist with pain management.

Considerations for Tapering Opioids

Although the clinical evidence review did not find high-quality studies comparing the effectiveness of different tapering protocols for use when opioid dosage is reduced or opioids are discontinued (KQ3), tapers reducing weekly dosage by 10%–50% of the original dosage have been recommended by other clinical guidelines (199), and a rapid taper over 2–3 weeks has been recommended in the case of a severe adverse event such as overdose (30). Experts noted that tapers slower than 10% per week (e.g., 10% per month) also might be appropriate and better tolerated than more rapid tapers, particularly when patients have been taking opioids for longer durations (e.g., for years). Opioid withdrawal during pregnancy has been associated with spontaneous abortion and premature labor.

When opioids are reduced or discontinued, a taper slow enough to minimize symptoms and signs of opioid withdrawal (e.g., drug craving, anxiety, insomnia, abdominal pain, vomiting, diarrhea, diaphoresis, mydriasis, tremor, tachycardia, or piloerection) should be used. A decrease of 10% of the original dose per week is a reasonable starting point; experts agreed that tapering plans may be individualized based on patient goals and concerns. Experts noted that at times, tapers might have to be paused and restarted again when the patient is ready and might have to be slowed once patients reach low dosages. Tapers may be considered successful as long as the patient is making progress. Once the smallest available dose is reached, the interval between doses can be extended. Opioids may be stopped when taken less frequently than once a day. More rapid tapers might be needed for patient safety under certain circumstances (e.g., for patients who have experienced overdose on their current dosage). Ultrarapid detoxification under anesthesia is associated with substantial risks, including death, and should not be used (200). Clinicians should access appropriate expertise if considering tapering opioids during pregnancy because of possible risk to the pregnant patient and to the fetus if the patient goes into withdrawal. Patients who are not taking opioids (including patients who are diverting all opioids they obtain) do not require tapers. Clinicians should discuss with patients undergoing tapering the increased risk for overdose on abrupt return to a previously prescribed higher dose. Primary care clinicians should collaborate with mental health providers and with other specialists as needed to optimize nonopioid pain management (see Recommendation 1), as well as psychosocial support for anxiety related to the taper. More detailed guidance on tapering, including management of withdrawal symptoms has been published previously (30,201). If a patient exhibits signs of opioid use disorder, clinicians should offer or arrange for treatment of opioid use disorder (see Recommendation 12) and consider offering naloxone for overdose prevention (see Recommendation 8).

Assessing Risk and Addressing Harms of Opioid Use

8. **Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥ 50 MME/day), or concurrent benzodiazepine use, are present (recommendation category: A, evidence type: 4).**

The clinical evidence review found insufficient evidence to determine how harms of opioids differ depending on patient demographics or patient comorbidities (KQ2). However, based on the contextual evidence review and expert opinion, certain risk factors are likely to increase susceptibility to opioid-associated harms and warrant incorporation of additional strategies into the management plan to mitigate risk. Clinicians should assess these risk factors periodically, with frequency varying by risk factor and patient characteristics. For example, factors that vary more frequently over time, such as alcohol use, require more frequent follow up. In addition, clinicians should consider offering naloxone, re-evaluating patients more frequently (see Recommendation 7), and referring to pain and/or behavioral health specialists when factors that increase risk for harm, such as history of overdose, history of substance use disorder, higher dosages of opioids (≥ 50 MME/day), and concurrent use of benzodiazepines with opioids, are present.

Patients with Sleep-Disordered Breathing, Including Sleep Apnea

Risk factors for sleep-disordered breathing include congestive heart failure, and obesity. Experts noted that careful monitoring and cautious dose titration should be used if opioids are prescribed for patients with mild sleep-disordered breathing. Clinicians should avoid prescribing opioids to patients with moderate or severe sleep-disordered breathing whenever possible to minimize risks for opioid overdose (contextual evidence review).

Pregnant Women

Opioids used in pregnancy might be associated with additional risks to both mother and fetus. Some studies have shown an association of opioid use in pregnancy with stillbirth, poor fetal growth, pre-term delivery, and birth defects (contextual evidence review). Importantly, in some cases, opioid use during pregnancy leads to neonatal opioid withdrawal syndrome. Clinicians and patients together should carefully weigh risks and benefits when making decisions

about whether to initiate opioid therapy for chronic pain during pregnancy. In addition, before initiating opioid therapy for chronic pain for reproductive-age women, clinicians should discuss family planning and how long-term opioid use might affect any future pregnancy. For pregnant women already receiving opioids, clinicians should access appropriate expertise if considering tapering opioids because of possible risk to the pregnant patient and to the fetus if the patient goes into withdrawal (see Recommendation 7). For pregnant women with opioid use disorder, medication-assisted therapy with buprenorphine or methadone has been associated with improved maternal outcomes and should be offered (202) (see Recommendation 12). Clinicians caring for pregnant women receiving opioids for pain or receiving buprenorphine or methadone for opioid use disorder should arrange for delivery at a facility prepared to monitor, evaluate for, and treat neonatal opioid withdrawal syndrome. In instances when travel to such a facility would present an undue burden on the pregnant woman, it is appropriate to deliver locally, monitor and evaluate the newborn for neonatal opioid withdrawal syndrome, and transfer the newborn for additional treatment if needed. Neonatal toxicity and death have been reported in breast-feeding infants whose mothers are taking codeine (contextual evidence review); previous guidelines have recommended that codeine be avoided whenever possible among mothers who are breast feeding and, if used, should be limited to the lowest possible dose and to a 4-day supply (203).

Patients with Renal or Hepatic Insufficiency

Clinicians should use additional caution and increased monitoring (see Recommendation 7) to minimize risks of opioids prescribed for patients with renal or hepatic insufficiency, given their decreased ability to process and excrete drugs, susceptibility to accumulation of opioids, and reduced therapeutic window between safe dosages and dosages associated with respiratory depression and overdose (contextual evidence review; see Recommendations 4, 5, and 7).

Patients Aged ≥ 65 Years

Inadequate pain treatment among persons aged ≥ 65 years has been documented (204). Pain management for older patients can be challenging given increased risks of both nonopioid pharmacologic therapies (see Recommendation 1) and opioid therapy in this population. Given reduced renal function and medication clearance even in the absence of renal disease, patients aged ≥ 65 years might have increased susceptibility to accumulation of opioids and a smaller therapeutic window between safe dosages and dosages associated with respiratory depression and overdose (contextual evidence review). Some older adults suffer from cognitive impairment, which can

increase risk for medication errors and make opioid-related confusion more dangerous. In addition, older adults are more likely than younger adults to experience co-morbid medical conditions and more likely to receive multiple medications, some of which might interact with opioids (such as benzodiazepines). Clinicians should use additional caution and increased monitoring (see Recommendations 4, 5, and 7) to minimize risks of opioids prescribed for patients aged ≥ 65 years. Experts suggested that clinicians educate older adults receiving opioids to avoid risky medication-related behaviors such as obtaining controlled medications from multiple prescribers and saving unused medications. Clinicians should also implement interventions to mitigate common risks of opioid therapy among older adults, such as exercise or bowel regimens to prevent constipation, risk assessment for falls, and patient monitoring for cognitive impairment.

Patients with Mental Health Conditions

Because psychological distress frequently interferes with improvement of pain and function in patients with chronic pain, using validated instruments such as the Generalized Anxiety Disorder (GAD)-7 and the Patient Health Questionnaire (PHQ)-9 or the PHQ-4 to assess for anxiety, post-traumatic stress disorder, and/or depression (205), might help clinicians improve overall pain treatment outcomes. Experts noted that clinicians should use additional caution and increased monitoring (see Recommendation 7) to lessen the increased risk for opioid use disorder among patients with mental health conditions (including depression, anxiety disorders, and PTSD), as well as increased risk for drug overdose among patients with depression. Previous guidelines have noted that opioid therapy should not be initiated during acute psychiatric instability or uncontrolled suicide risk, and that clinicians should consider behavioral health specialist consultation for any patient with a history of suicide attempt or psychiatric disorder (31). In addition, patients with anxiety disorders and other mental health conditions are more likely to receive benzodiazepines, which can exacerbate opioid-induced respiratory depression and increase risk for overdose (see Recommendation 11). Clinicians should ensure that treatment for depression and other mental health conditions is optimized, consulting with behavioral health specialists when needed. Treatment for depression can improve pain symptoms as well as depression and might decrease overdose risk (contextual evidence review). For treatment of chronic pain in patients with depression, clinicians should strongly consider using tricyclic or SNRI antidepressants for analgesic as well as antidepressant effects if these medications are not otherwise contraindicated (see Recommendation 1).

Patients with Substance Use Disorder

Illicit drugs and alcohol are listed as contributory factors on a substantial proportion of death certificates for opioid-related overdose deaths (contextual evidence review). Previous guidelines have recommended screening or risk assessment tools to identify patients at higher risk for misuse or abuse of opioids. However, the clinical evidence review found that currently available risk-stratification tools (e.g., Opioid Risk Tool, Screener and Opioid Assessment for Patients with Pain Version 1, SOAPP-R, and Brief Risk Interview) show insufficient accuracy for classification of patients as at low or high risk for abuse or misuse (KQ4). Clinicians should always exercise caution when considering or prescribing opioids for any patient with chronic pain outside of active cancer, palliative, and end-of-life care and should not overestimate the ability of these tools to rule out risks from long-term opioid therapy.

Clinicians should ask patients about their drug and alcohol use. Single screening questions can be used (206). For example, the question “How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?” (with an answer of one or more considered positive) was found in a primary care setting to be 100% sensitive and 73.5% specific for the detection of a drug use disorder compared with a standardized diagnostic interview (207). Validated screening tools such as the Drug Abuse Screening Test (DAST) (208) and the Alcohol Use Disorders Identification Test (AUDIT) (209) can also be used. Clinicians should use PDMP data (see Recommendation 9) and drug testing (see Recommendation 10) as appropriate to assess for concurrent substance use that might place patients at higher risk for opioid use disorder and overdose. Clinicians should also provide specific counseling on increased risks for overdose when opioids are combined with other drugs or alcohol (see Recommendation 3) and ensure that patients receive effective treatment for substance use disorders when needed (see Recommendation 12).

The clinical evidence review found insufficient evidence to determine how harms of opioids differ depending on past or current substance use disorder (KQ2), although a history of substance use disorder was associated with misuse. Similarly, based on contextual evidence, patients with drug or alcohol use disorders are likely to experience greater risks for opioid use disorder and overdose than persons without these conditions. If clinicians consider opioid therapy for chronic pain outside of active cancer, palliative, and end-of-life care for patients with drug or alcohol use disorders, they should discuss increased risks for opioid use disorder and overdose with patients, carefully consider whether benefits of opioids outweigh increased risks, and incorporate strategies to mitigate risk into

the management plan, such as considering offering naloxone (see Offering Naloxone to Patients When Factors That Increase Risk for Opioid-Related Harms Are Present) and increasing frequency of monitoring (see Recommendation 7) when opioids are prescribed. Because pain management in patients with substance use disorder can be complex, clinicians should consider consulting substance use disorder specialists and pain specialists regarding pain management for persons with active or recent past history of substance abuse. Experts also noted that clinicians should communicate with patients’ substance use disorder treatment providers if opioids are prescribed.

Patients with Prior Nonfatal Overdose

Although studies were not identified that directly addressed the risk for overdose among patients with prior nonfatal overdose who are prescribed opioids, based on clinical experience, experts thought that prior nonfatal overdose would substantially increase risk for future nonfatal or fatal opioid overdose. If patients experience nonfatal opioid overdose, clinicians should work with them to reduce opioid dosage and to discontinue opioids when possible (see Recommendation 7). If clinicians continue opioid therapy for chronic pain outside of active cancer, palliative, and end-of-life care in patients with prior opioid overdose, they should discuss increased risks for overdose with patients, carefully consider whether benefits of opioids outweigh substantial risks, and incorporate strategies to mitigate risk into the management plan, such as considering offering naloxone (see Offering Naloxone to Patients When Factors That Increase Risk for Opioid-Related Harms Are Present) and increasing frequency of monitoring (see Recommendation 7) when opioids are prescribed.

Offering Naloxone to Patients When Factors That Increase Risk for Opioid-Related Harms Are Present

Naloxone is an opioid antagonist that can reverse severe respiratory depression; its administration by lay persons, such as friends and family of persons who experience opioid overdose, can save lives. Naloxone precipitates acute withdrawal among patients physically dependent on opioids. Serious adverse effects, such as pulmonary edema, cardiovascular instability, and seizures, have been reported but are rare at doses consistent with labeled use for opioid overdose (210). The contextual evidence review did not find any studies on effectiveness of prescribing naloxone for overdose prevention among patients prescribed opioids for chronic pain. However, there is evidence for effectiveness of naloxone provision in preventing opioid-related overdose death at the community level through community-based distribution (e.g., through overdose education and naloxone distribution programs in community service agencies) to persons at risk for overdose

(mostly due to illicit opiate use), and it is plausible that effectiveness would be observed when naloxone is provided in the clinical setting as well. Experts agreed that it is preferable not to initiate opioid treatment when factors that increase risk for opioid-related harms are present. Opinions diverged about the likelihood of naloxone being useful to patients and the circumstances under which it should be offered. However, most experts agreed that clinicians should consider offering naloxone when prescribing opioids to patients at increased risk for overdose, including patients with a history of overdose, patients with a history of substance use disorder, patients taking benzodiazepines with opioids (see Recommendation 11), patients at risk for returning to a high dose to which they are no longer tolerant (e.g., patients recently released from prison), and patients taking higher dosages of opioids (≥ 50 MME/day). Practices should provide education on overdose prevention and naloxone use to patients receiving naloxone prescriptions and to members of their households. Experts noted that naloxone co-prescribing can be facilitated by clinics or practices with resources to provide naloxone training and by collaborative practice models with pharmacists. Resources for prescribing naloxone in primary care settings can be found through Prescribe to Prevent at <http://prescribetoprevent.org>.

9. Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months (recommendation category: A, evidence type: 4).

PDMPs are state-based databases that collect information on controlled prescription drugs dispensed by pharmacies in most states and, in select states, by dispensing physicians as well. In addition, some clinicians employed by the federal government, including some clinicians in the Indian Health Care Delivery System, are not licensed in the states where they practice, and do not have access to PDMP data. Certain states require clinicians to review PDMP data prior to writing each opioid prescription (see state-level PDMP-related policies on the National Alliance for Model State Drug Laws website at <http://www.namsdl.org/prescription-monitoring-programs.cfm>). The clinical evidence review did not find studies evaluating the effectiveness of PDMPs on outcomes related to overdose, addiction, abuse, or misuse (KQ4). However, even though evidence is limited on the effectiveness of PDMP implementation at the state level on prescribing and mortality

outcomes (28), the contextual evidence review found that most fatal overdoses were associated with patients receiving opioids from multiple prescribers and/or with patients receiving high total daily opioid dosages; information on both of these risk factors for overdose are available to prescribers in the PDMP. PDMP data also can be helpful when patient medication history is not otherwise available (e.g., for patients from other locales) and when patients transition care to a new clinician. The contextual evidence review also found that PDMP information could be used in a way that is harmful to patients. For example, it has been used to dismiss patients from clinician practices (211), which might adversely affect patient safety.

The contextual review found variation in state policies that affect timeliness of PDMP data (and therefore benefits of reviewing PDMP data) as well as time and workload for clinicians in accessing PDMP data. In states that permit delegating access to other members of the health care team, workload for prescribers can be reduced. These differences might result in a different balance of benefits to clinician workload in different states. Experts agreed that PDMPs are useful tools that should be consulted when starting a patient on opioid therapy and periodically during long-term opioid therapy. However, experts disagreed on how frequently clinicians should check the PDMP during long-term opioid therapy, given PDMP access issues and the lag time in reporting in some states. Most experts agreed that PDMP data should be reviewed every 3 months or more frequently during long-term opioid therapy. A minority of experts noted that, given the current burden of accessing PDMP data in some states and the lack of evidence surrounding the most effective interval for PDMP review to improve patient outcomes, annual review of PDMP data during long-term opioid therapy would be reasonable when factors that increase risk for opioid-related harms are not present.

Clinicians should review PDMP data for opioids and other controlled medications patients might have received from additional prescribers to determine whether a patient is receiving high total opioid dosages or dangerous combinations (e.g., opioids combined with benzodiazepines) that put him or her at high risk for overdose. Ideally, PDMP data should be reviewed before every opioid prescription. This is recommended in all states with well-functioning PDMPs and where PDMP access policies make this practicable (e.g., clinician and delegate access permitted), but it is not currently possible in states without functional PDMPs or in those that do not permit certain prescribers to access them. As vendors and practices facilitate integration of PDMP information into regular clinical workflow (e.g., data made available in electronic health records), clinicians' ease of access in reviewing PDMP data is expected to improve.

In addition, improved timeliness of PDMP data will improve their value in identifying patient risks.

If patients are found to have high opioid dosages, dangerous combinations of medications, or multiple controlled substance prescriptions written by different clinicians, several actions can be taken to augment clinicians' abilities to improve patient safety:

- Clinicians should discuss information from the PDMP with their patient and confirm that the patient is aware of the additional prescriptions. Occasionally, PDMP information can be incorrect (e.g., if the wrong name or birthdate has been entered, the patient uses a nickname or maiden name, or another person has used the patient's identity to obtain prescriptions).
- Clinicians should discuss safety concerns, including increased risk for respiratory depression and overdose, with patients found to be receiving opioids from more than one prescriber or receiving medications that increase risk when combined with opioids (e.g., benzodiazepines) and consider offering naloxone (see Recommendation 8).
- Clinicians should avoid prescribing opioids and benzodiazepines concurrently whenever possible. Clinicians should communicate with others managing the patient to discuss the patient's needs, prioritize patient goals, weigh risks of concurrent benzodiazepine and opioid exposure, and coordinate care (see Recommendation 11).
- Clinicians should calculate the total MME/day for concurrent opioid prescriptions to help assess the patient's overdose risk (see Recommendation 5). If patients are found to be receiving high total daily dosages of opioids, clinicians should discuss their safety concerns with the patient, consider tapering to a safer dosage (see Recommendations 5 and 7), and consider offering naloxone (see Recommendation 8).
- Clinicians should discuss safety concerns with other clinicians who are prescribing controlled substances for their patient. Ideally clinicians should first discuss concerns with their patient and inform him or her that they plan to coordinate care with the patient's other prescribers to improve the patient's safety.
- Clinicians should consider the possibility of a substance use disorder and discuss concerns with their patient (see Recommendation 12).
- If clinicians suspect their patient might be sharing or selling opioids and not taking them, clinicians should consider urine drug testing to assist in determining whether opioids can be discontinued without causing withdrawal (see Recommendations 7 and 10). A negative drug test for prescribed opioids might indicate the patient is not taking prescribed opioids, although clinicians should

consider other possible reasons for this test result (see Recommendation 10).

Experts agreed that clinicians should not dismiss patients from their practice on the basis of PDMP information. Doing so can adversely affect patient safety, could represent patient abandonment, and could result in missed opportunities to provide potentially lifesaving information (e.g., about risks of opioids and overdose prevention) and interventions (e.g., safer prescriptions, nonopioid pain treatment [see Recommendation 1], naloxone [see Recommendation 8], and effective treatment for substance use disorder [see Recommendation 12]).

10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs (recommendation category: B, evidence type: 4).

Concurrent use of opioid pain medications with other opioid pain medications, benzodiazepines, or heroin can increase patients' risk for overdose. Urine drug tests can provide information about drug use that is not reported by the patient. In addition, urine drug tests can assist clinicians in identifying when patients are not taking opioids prescribed for them, which might in some cases indicate diversion or other clinically important issues such as difficulties with adverse effects. Urine drug tests do not provide accurate information about how much or what dose of opioids or other drugs a patient took. The clinical evidence review did not find studies evaluating the effectiveness of urine drug screening for risk mitigation during opioid prescribing for pain (KQ4). The contextual evidence review found that urine drug testing can provide useful information about patients assumed not to be using unreported drugs. Urine drug testing results can be subject to misinterpretation and might sometimes be associated with practices that might harm patients (e.g., stigmatization, inappropriate termination from care). Routine use of urine drug tests with standardized policies at the practice or clinic level might destigmatize their use. Although random drug testing also might destigmatize urine drug testing, experts thought that truly random testing was not feasible in clinical practice. Some clinics obtain a urine specimen at every visit, but only send it for testing on a random schedule. Experts noted that in addition to direct costs of urine drug testing, which often are not covered fully by insurance and can be a burden for patients, clinician time is needed to interpret, confirm, and communicate results.

Experts agreed that prior to starting opioids for chronic pain and periodically during opioid therapy, clinicians should

use urine drug testing to assess for prescribed opioids as well as other controlled substances and illicit drugs that increase risk for overdose when combined with opioids, including nonprescribed opioids, benzodiazepines, and heroin. There was some difference of opinion among experts as to whether this recommendation should apply to all patients, or whether this recommendation should entail individual decision making with different choices for different patients based on values, preferences, and clinical situations. While experts agreed that clinicians should use urine drug testing before initiating opioid therapy for chronic pain, they disagreed on how frequently urine drug testing should be conducted during long-term opioid therapy. Most experts agreed that urine drug testing at least annually for all patients was reasonable. Some experts noted that this interval might be too long in some cases and too short in others, and that the follow-up interval should be left to the discretion of the clinician. Previous guidelines have recommended more frequent urine drug testing in patients thought to be at higher risk for substance use disorder (30). However, experts thought that predicting risk prior to urine drug testing is challenging and that currently available tools do not allow clinicians to reliably identify patients who are at low risk for substance use disorder.

In most situations, initial urine drug testing can be performed with a relatively inexpensive immunoassay panel for commonly prescribed opioids and illicit drugs. Patients prescribed less commonly used opioids might require specific testing for those agents. The use of confirmatory testing adds substantial costs and should be based on the need to detect specific opioids that cannot be identified on standard immunoassays or on the presence of unexpected urine drug test results. Clinicians should be familiar with the drugs included in urine drug testing panels used in their practice and should understand how to interpret results for these drugs. For example, a positive “opiates” immunoassay detects morphine, which might reflect patient use of morphine, codeine, or heroin, but this immunoassay does not detect synthetic opioids (e.g., fentanyl or methadone) and might not detect semisynthetic opioids (e.g., oxycodone). However, many laboratories use an oxycodone immunoassay that detects oxycodone and oxymorphone. In some cases, positive results for specific opioids might reflect metabolites from opioids the patient is taking and might not mean the patient is taking the specific opioid for which the test was positive. For example, hydromorphone is a metabolite of hydrocodone, and oxymorphone is a metabolite of oxycodone. Detailed guidance on interpretation of urine drug test results, including which tests to order and expected results, drug detection time in urine, drug metabolism, and other considerations has been published previously (30). Clinicians should not test for substances

for which results would not affect patient management or for which implications for patient management are unclear. For example, experts noted that there might be uncertainty about the clinical implications of a positive urine drug test for tetrahydrocannabinol (THC). In addition, restricting confirmatory testing to situations and substances for which results can reasonably be expected to affect patient management can reduce costs of urine drug testing, given the substantial costs associated with confirmatory testing methods. Before ordering urine drug testing, clinicians should have a plan for responding to unexpected results. Clinicians should explain to patients that urine drug testing is intended to improve their safety and should also explain expected results (e.g., presence of prescribed medication and absence of drugs, including illicit drugs, not reported by the patient). Clinicians should ask patients about use of prescribed and other drugs and ask whether there might be unexpected results. This will provide an opportunity for patients to provide information about changes in their use of prescribed opioids or other drugs. Clinicians should discuss unexpected results with the local laboratory or toxicologist and with the patient. Discussion with patients prior to specific confirmatory testing can sometimes yield a candid explanation of why a particular substance is present or absent and obviate the need for expensive confirmatory testing on that visit. For example, a patient might explain that the test is negative for prescribed opioids because she felt opioids were no longer helping and discontinued them. If unexpected results are not explained, a confirmatory test using a method selective enough to differentiate specific opioids and metabolites (e.g., gas or liquid chromatography/mass spectrometry) might be warranted to clarify the situation.

Clinicians should use unexpected results to improve patient safety (e.g., change in pain management strategy [see Recommendation 1], tapering or discontinuation of opioids [see Recommendation 7], more frequent re-evaluation [see Recommendation 7], offering naloxone [see Recommendation 8], or referral for treatment for substance use disorder [see Recommendation 12], all as appropriate). If tests for prescribed opioids are repeatedly negative, confirming that the patient is not taking the prescribed opioid, clinicians can discontinue the prescription without a taper. Clinicians should not dismiss patients from care based on a urine drug test result because this could constitute patient abandonment and could have adverse consequences for patient safety, potentially including the patient obtaining opioids from alternative sources and the clinician missing opportunities to facilitate treatment for substance use disorder.

11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently

whenever possible (recommendation category: A, evidence type: 3).

Benzodiazepines and opioids both cause central nervous system depression and can decrease respiratory drive. Concurrent use is likely to put patients at greater risk for potentially fatal overdose. The clinical evidence review did not address risks of benzodiazepine co-prescription among patients prescribed opioids. However, the contextual evidence review found evidence in epidemiologic series of concurrent benzodiazepine use in large proportions of opioid-related overdose deaths, and a case-cohort study found concurrent benzodiazepine prescription with opioid prescription to be associated with a near quadrupling of risk for overdose death compared with opioid prescription alone (212). Experts agreed that although there are circumstances when it might be appropriate to prescribe opioids to a patient receiving benzodiazepines (e.g., severe acute pain in a patient taking long-term, stable low-dose benzodiazepine therapy), clinicians should avoid prescribing opioids and benzodiazepines concurrently whenever possible. In addition, given that other central nervous system depressants (e.g., muscle relaxants, hypnotics) can potentiate central nervous system depression associated with opioids, clinicians should consider whether benefits outweigh risks of concurrent use of these drugs. Clinicians should check the PDMP for concurrent controlled medications prescribed by other clinicians (see Recommendation 9) and should consider involving pharmacists and pain specialists as part of the management team when opioids are co-prescribed with other central nervous system depressants. Because of greater risks of benzodiazepine withdrawal relative to opioid withdrawal, and because tapering opioids can be associated with anxiety, when patients receiving both benzodiazepines and opioids require tapering to reduce risk for fatal respiratory depression, it might be safer and more practical to taper opioids first (see Recommendation 7). Clinicians should taper benzodiazepines gradually if discontinued because abrupt withdrawal can be associated with rebound anxiety, hallucinations, seizures, delirium tremens, and, in rare cases, death (contextual evidence review). A commonly used tapering schedule that has been used safely and with moderate success is a reduction of the benzodiazepine dose by 25% every 1–2 weeks (213,214). CBT increases tapering success rates and might be particularly helpful for patients struggling with a benzodiazepine taper (213). If benzodiazepines prescribed for anxiety are tapered or discontinued, or if patients receiving opioids require treatment for anxiety, evidence-based psychotherapies (e.g., CBT) and/or specific anti-depressants or other nonbenzodiazepine medications approved for anxiety should be offered. Experts emphasized that clinicians should communicate with mental health professionals managing the

patient to discuss the patient's needs, prioritize patient goals, weigh risks of concurrent benzodiazepine and opioid exposure, and coordinate care.

12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder (recommendation category: A, evidence type: 2).

Opioid use disorder (previously classified as opioid abuse or opioid dependence) is defined in the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5) as a problematic pattern of opioid use leading to clinically significant impairment or distress, manifested by at least two defined criteria occurring within a year (<http://pcssmat.org/wp-content/uploads/2014/02/5B-DSM-5-Opioid-Use-Disorder-Diagnostic-Criteria.pdf>) (20).

The clinical evidence review found prevalence of opioid dependence (using DSM-IV diagnosis criteria) in primary care settings among patients with chronic pain on opioid therapy to be 3%–26% (KQ2). As found in the contextual evidence review and supported by moderate quality evidence, opioid agonist or partial agonist treatment with methadone maintenance therapy or buprenorphine has been shown to be more effective in preventing relapse among patients with opioid use disorder (151–153). Some studies suggest that using behavioral therapies in combination with these treatments can reduce opioid misuse and increase retention during maintenance therapy and improve compliance after detoxification (154,155); behavioral therapies are also recommended by clinical practice guidelines (215). The cited studies primarily evaluated patients with a history of illicit opioid use, rather than prescription opioid use for chronic pain. Recent studies among patients with prescription opioid dependence (based on DSM-IV criteria) have found maintenance therapy with buprenorphine and buprenorphine-naloxone effective in preventing relapse (216,217). Treatment need in a community is often not met by capacity to provide buprenorphine or methadone maintenance therapy (218), and patient cost can be a barrier to buprenorphine treatment because insurance coverage of buprenorphine for opioid use disorder is often limited (219). Oral or long-acting injectable formulations of naltrexone can also be used as medication-assisted treatment for opioid use disorder in nonpregnant adults, particularly for highly motivated persons (220,221). Experts agreed that clinicians prescribing opioids should identify treatment resources for opioid use disorder in the community and should work together to ensure sufficient treatment capacity for opioid use disorder at the practice level.

If clinicians suspect opioid use disorder based on patient concerns or behaviors or on findings in prescription drug monitoring program data (see Recommendation 9) or from urine drug testing (see Recommendation 10), they should discuss their concern with their patient and provide an opportunity for the patient to disclose related concerns or problems. Clinicians should assess for the presence of opioid use disorder using DSM-5 criteria (20). Alternatively, clinicians can arrange for a substance use disorder treatment specialist to assess for the presence of opioid use disorder. For patients meeting criteria for opioid use disorder, clinicians should offer or arrange for patients to receive evidence-based treatment, usually medication-assisted treatment with buprenorphine or methadone maintenance therapy in combination with behavioral therapies. Oral or long-acting injectable naltrexone, a long-acting opioid antagonist, can also be used in non-pregnant adults. Naltrexone blocks the effects of opioids if they are used but requires adherence to daily oral therapy or monthly injections. For pregnant women with opioid use disorder, medication-assisted therapy with buprenorphine (without naloxone) or methadone has been associated with improved maternal outcomes and should be offered (see Recommendation 8). Clinicians should also consider offering naloxone for overdose prevention to patients with opioid use disorder (see Recommendation 8). For patients with problematic opioid use that does not meet criteria for opioid use disorder, experts noted that clinicians can offer to taper and discontinue opioids (see Recommendation 7). For patients who choose to but are unable to taper, clinicians may reassess for opioid use disorder and offer opioid agonist therapy if criteria are met.

Physicians not already certified to provide buprenorphine in an office-based setting can undergo training to receive a waiver from the Substance Abuse and Mental Health Services Administration (SAMHSA) that allows them to prescribe buprenorphine to treat patients with opioid use disorder. Physicians prescribing opioids in communities without sufficient treatment capacity for opioid use disorder should strongly consider obtaining this waiver. Information about qualifications and the process to obtain a waiver are available from SAMHSA (222). Clinicians do not need a waiver to offer naltrexone for opioid use disorder as part of their practice.

Additional guidance has been published previously (215) on induction, use, and monitoring of buprenorphine treatment (see Part 5) and naltrexone treatment (see Part 6) for opioid use disorder and on goals, components of, and types of effective psychosocial treatment that are recommended in conjunction with pharmacological treatment of opioid use disorder (see Part 7). Clinicians unable to provide treatment themselves should arrange for patients with opioid use disorder to receive

care from a substance use disorder treatment specialist, such as an office-based buprenorphine or naltrexone treatment provider, or from an opioid treatment program certified by SAMHSA to provide supervised medication-assisted treatment for patients with opioid use disorder. Clinicians should assist patients in finding qualified treatment providers and should arrange for patients to follow up with these providers, as well as arranging for ongoing coordination of care. Clinicians should not dismiss patients from their practice because of a substance use disorder because this can adversely affect patient safety and could represent patient abandonment. Identification of substance use disorder represents an opportunity for a clinician to initiate potentially life-saving interventions, and it is important for the clinician to collaborate with the patient regarding their safety to increase the likelihood of successful treatment. In addition, although identification of an opioid use disorder can alter the expected benefits and risks of opioid therapy for pain, patients with co-occurring pain and substance use disorder require ongoing pain management that maximizes benefits relative to risks. Clinicians should continue to use nonpharmacologic and nonopioid pharmacologic pain treatments as appropriate (see Recommendation 1) and consider consulting a pain specialist as needed to provide optimal pain management.

Resources to help with arranging for treatment include SAMHSA's buprenorphine physician locator (http://buprenorphine.samhsa.gov/bwns_locator); SAMHSA's Opioid Treatment Program Directory (<http://dpt2.samhsa.gov/treatment/directory.aspx>); SAMHSA's Provider Clinical Support System for Opioid Therapies (<http://pcss-o.org>), which offers extensive experience in the treatment of substance use disorders and specifically of opioid use disorder, as well as expertise on the interface of pain and opioid misuse; and SAMHSA's Provider's Clinical Support System for Medication-Assisted Treatment (<http://pcssmat.org>), which offers expert physician mentors to answer questions about assessment for and treatment of substance use disorders.

Conclusions and Future Directions

Clinical guidelines represent one strategy for improving prescribing practices and health outcomes. Efforts are required to disseminate the guideline and achieve widespread adoption and implementation of the recommendations in clinical settings. CDC will translate this guideline into user-friendly materials for distribution and use by health systems, medical professional societies, insurers, public health departments, health information technology developers, and clinicians and engage in dissemination efforts. CDC has provided a

checklist for prescribing opioids for chronic pain (<http://stacks.cdc.gov/view/cdc/38025>), additional resources such as fact sheets (<http://www.cdc.gov/drugoverdose/prescribing/resources.html>), and will provide a mobile application to guide clinicians in implementing the recommendations. CDC will also work with partners to support clinician education on pain management options, opioid therapy, and risk mitigation strategies (e.g., urine drug testing). Activities such as development of clinical decision support in electronic health records to assist clinicians' treatment decisions at the point of care; identification of mechanisms that insurers and pharmacy benefit plan managers can use to promote safer prescribing within plans; and development of clinical quality improvement measures and initiatives to improve prescribing and patient care within health systems have promise for increasing guideline adoption and improving practice. In addition, policy initiatives that address barriers to implementation of the guidelines, such as increasing accessibility of PDMP data within and across states, e-prescribing, and availability of clinicians who can offer medication-assisted treatment for opioid use disorder, are strategies to consider to enhance implementation of the recommended practices. CDC will work with federal partners and payers to evaluate strategies such as payment reform and health care delivery models that could improve patient health and safety. For example, strategies might include strengthened coverage for nonpharmacologic treatments, appropriate urine drug testing, and medication-assisted treatment; reimbursable time for patient counseling; and payment models that improve access to interdisciplinary, coordinated care.

As highlighted in the forthcoming report on the National Pain Strategy, an overarching federal effort that outlines a comprehensive population-level health strategy for addressing pain as a public health problem, clinical guidelines complement other strategies aimed at preventing illnesses and injuries that lead to pain. A draft of the National Pain Strategy has been published previously (180). These strategies include strengthening the evidence base for pain prevention and treatment strategies, reducing disparities in pain treatment, improving service delivery and reimbursement, supporting professional education and training, and providing public education. It is important that overall improvements be made in developing the workforce to address pain management in general, in addition to opioid prescribing specifically. This guideline also complements other federal efforts focused on addressing the opioid overdose epidemic including prescriber training and education, improving access to treatment for opioid use disorder, safe storage and disposal programs, utilization management mechanisms, naloxone distribution programs, law enforcement and supply reduction efforts, prescription drug

monitoring program improvements, and support for community coalitions and state prevention programs.

This guideline provides recommendations that are based on the best available evidence that was interpreted and informed by expert opinion. The clinical scientific evidence informing the recommendations is low in quality. To inform future guideline development, more research is necessary to fill in critical evidence gaps. The evidence reviews forming the basis of this guideline clearly illustrate that there is much yet to be learned about the effectiveness, safety, and economic efficiency of long-term opioid therapy. As highlighted by an expert panel in a recent workshop sponsored by the National Institutes of Health on the role of opioid pain medications in the treatment of chronic pain, "evidence is insufficient for every clinical decision that a provider needs to make about the use of opioids for chronic pain" (223). The National Institutes of Health panel recommended that research is needed to improve our understanding of which types of pain, specific diseases, and patients are most likely to be associated with benefit and harm from opioid pain medications; evaluate multidisciplinary pain interventions; estimate cost-benefit; develop and validate tools for identification of patient risk and outcomes; assess the effectiveness and harms of opioid pain medications with alternative study designs; and investigate risk identification and mitigation strategies and their effects on patient and public health outcomes. It is also important to obtain data to inform the cost feasibility and cost-effectiveness of recommended actions, such as use of nonpharmacologic therapy and urine drug testing. Research that contributes to safer and more effective pain treatment can be implemented across public health entities and federal agencies (4). Additional research can inform the development of future guidelines for special populations that could not be adequately addressed in this guideline, such as children and adolescents, where evidence and guidance is needed but currently lacking. CDC is committed to working with partners to identify the highest priority research areas to build the evidence base. Yet, given that chronic pain is recognized as a significant public health problem, the risks associated with long-term opioid therapy, the availability of effective nonpharmacological and nonopioid pharmacologic treatment options for pain, and the potential for improvement in the quality of health care with the implementation of recommended practices, a guideline for prescribing is warranted with the evidence that is currently available. The balance between the benefits and the risks of long-term opioid therapy for chronic pain based on both clinical and contextual evidence is strong enough to support the issuance of category A recommendations in most cases.

CDC will revisit this guideline as new evidence becomes available to determine when evidence gaps have been sufficiently closed to warrant an update of the guideline. Until this research is conducted, clinical practice guidelines will have to be based on the best available evidence and expert opinion. This guideline is intended to improve communication between clinicians and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder, overdose, and death. CDC is committed to evaluating the guideline to identify the impact of the recommendations on clinician and patient outcomes, both intended and unintended, and revising the recommendations in future updates when warranted.

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TABLE 1. Grading of Recommendations Assessment, Development and Evaluation (GRADE) clinical evidence review ratings of the evidence for the key clinical questions regarding effectiveness and risks of long-term opioid therapy for chronic pain

Outcome	Studies	Limitations	Inconsistency	Imprecision	Type of evidence	Other factors	Estimates of effect/findings
Effectiveness and comparative effectiveness (KQ1)							
Effectiveness of long-term opioid therapy versus placebo or no opioid therapy for long-term (≥1 year) outcomes							
Pain, function, and quality of life	None	—†	—	—	Insufficient	—	No evidence
Harms and adverse events (KQ2)							
Risks of opioids versus placebo or no opioids on opioid abuse, addiction, and related outcomes; overdose; and other harms							
Abuse or addiction	1 cohort study (n = 568,640)	Serious limitations	Unknown (1 study)	No imprecision	3	None identified	One retrospective cohort study found long-term use of prescribed opioids associated with an increased risk of abuse or dependence diagnosis versus no opioid use (adjusted OR ranged from 14.9 to 122.5, depending on dose).
Abuse or addiction	10 uncontrolled studies (n = 3,780)	Very serious limitations	Very serious inconsistency	No imprecision	4	None identified	In primary care settings, prevalence of opioid abuse ranged from 0.6% to 8% and prevalence of dependence from 3% to 26%. In pain clinic settings, prevalence of misuse ranged from 8% to 16% and addiction from 2% to 14%. Prevalence of aberrant drug-related behaviors ranged from 6% to 37%.
Overdose	1 cohort study (n = 9,940)	Serious limitations	Unknown (1 study)	Serious imprecision	3	None identified	Current opioid use associated with increased risk of any overdose events (adjusted HR 5.2, 95% CI = 2.1–12) and serious overdose events (adjusted HR 8.4, 95% CI = 2.5–28) versus current nonuse.
Fractures	1 cohort study (n = 2,341) and 1 case-control study (n = 21,739 case patients)	Serious limitations	No inconsistency	No imprecision	3	None identified	Opioid use associated with increased risk of fracture in 1 cohort study (adjusted HR 1.28, 95% CI = 0.99–1.64) and 1 case-control study (adjusted OR 1.27, 95% CI = 1.21–1.33).
Myocardial infarction	1 cohort study (n = 426,124) and 1 case-control study (n = 11,693 case patients)	No limitations	No inconsistency	No imprecision	3	None identified	Current opioid use associated with increased risk of myocardial infarction versus nonuse (adjusted HR 1.28, 95% CI = 1.19–1.37 and incidence rate ratio 2.66, 95% CI = 2.30–3.08).
Endocrinologic harms	1 cross-sectional study (n = 11,327)	Serious limitations	Unknown (1 study)	No imprecision	3	None identified	Long-term opioid use associated with increased risk for use of medications for erectile dysfunction or testosterone replacement versus nonuse (adjusted OR 1.5, 95% CI = 1.1–1.9).
How do harms vary depending on the opioid dose used?							
Abuse or addiction	1 cohort study (n = 568,640)	Serious limitations	Unknown (1 study)	No imprecision	3	None identified	One retrospective cohort study found higher doses of long-term opioid therapy associated with increased risk of opioid abuse or dependence than lower doses. Compared to no opioid prescription, the adjusted odds ratios were 15 (95% CI = 10–21) for 1 to 36 MME/day, 29 (95% CI = 20–41) for 36 to 120 MME/day, and 122 (95% CI = 73–205) for ≥120 MME/day.
Overdose	1 cohort study (n = 9,940) and 1 case-control study (n = 593 case patients in primary analysis)	Serious limitations	No inconsistency	No imprecision	3	Magnitude of effect, dose response relationship	Versus 1 to <20 MME/day, one cohort study found an adjusted HR for an overdose event of 1.44 (95% CI = 0.57–3.62) for 20 to <50 MME/day that increased to 8.87 (95% CI = 3.99–19.72) at ≥100 MME/day; one case-control study found an adjusted OR for an opioid-related death of 1.32 (95% CI = 0.94–1.84) for 20 to 49 MME/day that increased to 2.88 (95% CI = 1.79–4.63) at ≥200 MME/day.
Fractures	1 cohort study (n = 2,341)	Serious limitations	Unknown (1 study)	Serious imprecision	3	None identified	Risk of fracture increased from an adjusted HR of 1.20 (95% CI = 0.92–1.56) at 1 to <20 MME/day to 2.00 (95% CI = 1.24–3.24) at ≥50 MME/day; the trend was of borderline statistical significance.

See table footnotes on page 47.

TABLE 1. (Continued) Grading of Recommendations Assessment, Development and Evaluation (GRADE) clinical evidence review ratings of the evidence for the key clinical questions regarding effectiveness and risks of long-term opioid therapy for chronic pain

Outcome	Studies	Limitations	Inconsistency	Imprecision	Type of evidence	Other factors	Estimates of effect/findings
Myocardial infarction	1 cohort study (n = 426,124)	Serious limitations	Unknown (1 study)	No imprecision	3	None identified	Relative to a cumulative dose of 0 to 1,350 MME during a 90-day period, the incidence rate ratio for myocardial infarction for 1350 to <2700 MME was 1.21 (95% CI = 1.02–1.45), for 2,700 to <8,100 MME was 1.42 (95% CI = 1.21–1.67), for 8,100 to <18,000 MME was 1.89 (95% CI = 1.54–2.33), and for ≥18,000 MME was 1.73 (95% CI = 1.32–2.26).
Motor vehicle crash injuries	1 case–control study (n = 5,300 case patients)	No limitations	Unknown (1 study)	No imprecision	3	None identified	No association between opioid dose and risk of motor vehicle crash injuries even though opioid doses >20 MME/day were associated with increased odds of road trauma among drivers.
Endocrinologic harms	1 cross-sectional study (n = 11,327) New for update: 1 additional cross-sectional study (n=1,585)	Serious limitations	Consistent	No imprecision	3	None identified	Relative to 0 to <20 MME/day, the adjusted OR for ≥120 MME/day for use of medications for erectile dysfunction or testosterone replacement was 1.6 (95% CI = 1.0–2.4). One new cross-sectional study found higher-dose long-term opioid therapy associated with increased risk of androgen deficiency among men receiving immediate-release opioids (adjusted OR per 10 MME/day 1.16, 95% CI = 1.09–1.23), but the dose response was very weak among men receiving ER/LA opioids.
Dosing strategies (KQ3)							
Comparative effectiveness of different methods for initiating opioid therapy and titrating doses							
Pain	3 randomized trials (n = 93)	Serious limitations	Serious inconsistency	Very serious imprecision	4	None identified	Trials on effects of titration with immediate-release versus ER/LA opioids reported inconsistent results and had additional differences between treatment arms in dosing protocols (titrated versus fixed dosing) and doses of opioids used.
Overdose	New for update: 1 cohort study (n = 840,606)	Serious limitations	Unknown (1 study)	No imprecision	4	None identified	One new cross-sectional study found initiation of therapy with an ER/LA opioid associated with increased risk of overdose versus initiation with an immediate-release opioid (adjusted HR 2.33, 95% CI = 1.26–4.32).
Comparative effectiveness of different ER/LA opioids							
Pain and function	3 randomized trials (n = 1,850)	Serious limitations	No inconsistency	No imprecision	3	None identified	No differences
All-cause mortality	1 cohort study (n = 108,492) New for update: 1 cohort study (n = 38,756)	Serious limitations	Serious inconsistency	No imprecision	4	None identified	One cohort study found methadone to be associated with lower all-cause mortality risk than sustained-release morphine in a propensity-adjusted analysis (adjusted HR 0.56, 95% CI = 0.51–0.62) and one cohort study among Tennessee Medicaid patients found methadone to be associated with higher risk of all-cause mortality than sustained-release morphine (adjusted HR 1.46, 95% CI = 1.17–1.73).
Abuse and related outcomes	1 cohort study (n = 5,684)	Serious limitations	Unknown (1 study)	Serious imprecision	4	None identified	One cohort study found some differences between ER/LA opioids in rates of adverse outcomes related to abuse, but outcomes were nonspecific for opioid-related adverse events, precluding reliable conclusions.
ER/LA versus immediate-release opioids							
Endocrinologic harms	New for update: 1 cross-sectional study (n = 1,585)	Serious limitations	Unknown (1 study)	No imprecision	4	None identified	One cross-sectional study found ER/LA opioids associated with increased risk of androgen deficiency versus immediate-release opioids (adjusted OR 3.39, 95% CI = 2.39–4.77).

See table footnotes on page 47.

TABLE 1. (Continued) Grading of Recommendations Assessment, Development and Evaluation (GRADE) clinical evidence review ratings of the evidence for the key clinical questions regarding effectiveness and risks of long-term opioid therapy for chronic pain

Outcome	Studies	Limitations	Inconsistency	Imprecision	Type of evidence	Other factors	Estimates of effect/findings
Dose escalation versus dose maintenance or use of dose thresholds							
Pain, function, or withdrawal due to opioid misuse	1 randomized trial (n = 140)	Serious limitations	Unknown (1 study)	Very serious imprecision	3	None identified	No difference between more liberal dose escalation versus maintenance of current doses in pain, function, or risk of withdrawal due to opioid misuse, but there was limited separation in opioid doses between groups (52 versus 40 MME/day at the end of the trial).
Immediate-release versus ER/LA opioids; immediate-release plus ER/LA opioids versus ER/LA opioids alone; scheduled and continuous versus as-needed dosing of opioids; or opioid rotation versus maintenance of current therapy							
Pain, function, quality of life, and outcomes related to abuse	None	—	—	—	Insufficient	—	No evidence
Effects of decreasing or tapering opioid doses versus continuation of opioid therapy							
Pain and function	1 randomized trial (n = 10)	Very serious limitations	Unknown (1 study)	Very serious imprecision	4	None identified	Abrupt cessation of morphine was associated with increased pain and decreased function compared with continuation of morphine.
Comparative effectiveness of different tapering protocols and strategies							
Opioid abstinence	2 nonrandomized trials (n = 150)	Very serious limitations	No inconsistency	Very serious imprecision	4	None identified	No clear differences between different methods for opioid discontinuation or tapering in likelihood of opioid abstinence after 3–6 months
Risk assessment and risk mitigation strategies (KQ4)							
Diagnostic accuracy of instruments for predicting risk for opioid overdose, addiction, abuse, or misuse among patients with chronic pain being considered for long-term opioid therapy							
Opioid risk tool	3 studies of diagnostic accuracy (n = 496) New for update: 2 studies of diagnostic accuracy (n = 320)	Serious limitations	Very serious inconsistency	Serious imprecision	4	None identified	Based on a cutoff score of >4 (or unspecified), five studies (two fair-quality, three poor-quality) reported sensitivity that ranged from 0.20 to 0.99 and specificity that ranged from 0.16 to 0.88.
Screeener and Opioid Assessment for Patients with Pain, Version 1	2 studies of diagnostic accuracy (n = 203)	Very serious limitations	No inconsistency	Serious imprecision	3	None identified	Based on a cutoff score of ≥8, sensitivity was 0.68 and specificity was 0.38 in one study, for a positive likelihood ratio of 1.11 and a negative likelihood ratio of 0.83. Based on a cutoff score of >6, sensitivity was 0.73 in one study.
Screeener and Opioid Assessment for Patients with Pain-Revised	New for update: 2 studies of diagnostic accuracy (n = 320)	Very serious limitations	No inconsistency	Serious imprecision	3	None identified	Based on a cutoff score of >3 or unspecified, sensitivity was 0.25 and 0.53 and specificity was 0.62 and 0.73 in two studies, for likelihood ratios close to 1.
Brief Risk Interview	New for update: 2 studies of diagnostic accuracy (n = 320)	Very serious limitations	No inconsistency	Serious imprecision	3	None identified	Based on a “high risk” assessment, sensitivity was 0.73 and 0.83 and specificity was 0.43 and 0.88 in two studies, for positive likelihood ratios of 1.28 and 7.18 and negative likelihood ratios of 0.63 and 0.19.

See table footnotes on page 47.

TABLE 1. (Continued) Grading of Recommendations Assessment, Development and Evaluation (GRADE) clinical evidence review ratings of the evidence for the key clinical questions regarding effectiveness and risks of long-term opioid therapy for chronic pain

Outcome	Studies	Limitations	Inconsistency	Imprecision	Type of evidence	Other factors	Estimates of effect/findings
Effectiveness of risk prediction instruments on outcomes related to overdose, addiction, abuse, or misuse in patients with chronic pain							
Outcomes related to abuse	None	—	—	—	Insufficient	—	No evidence
Effectiveness of risk mitigation strategies, including opioid management plans, patient education, urine drug screening, use of prescription drug monitoring program data, use of monitoring instruments, more frequent monitoring intervals, pill counts, and use of abuse-deterrent formulations, on outcomes related to overdose, addiction, abuse, or misuse							
Outcomes related to abuse	None	—	—	—	Insufficient	—	No evidence
Effectiveness of risk prediction instruments on outcomes related to overdose, addiction, abuse, or misuse in patients with chronic pain							
Outcomes related to abuse	None	—	—	—	Insufficient	—	No evidence
Effectiveness of risk mitigation strategies, including opioid management plans, patient education, urine drug screening, use of prescription drug monitoring program data, use of monitoring instruments, more frequent monitoring intervals, pill counts, and use of abuse-deterrent formulations, on outcomes related to overdose, addiction, abuse, or misuse							
Outcomes related to abuse	None	—	—	—	Insufficient	—	No evidence
Comparative effectiveness of treatment strategies for managing patients with addiction to prescription opioids							
Outcomes related to abuse	None	—	—	—	Insufficient	—	No evidence
Effects of opioid therapy for acute pain on long-term use (KQ5)							
Long-term opioid use	New for update: 2 cohort studies (n = 399,852)	Serious limitations	No inconsistency	No imprecision	3	None identified	One study found use of opioids within 7 days of low-risk surgery associated with increased likelihood of opioid use at 1 year (adjusted OR 1.44, 95% CI = 1.39–1.50), and one study found use of opioids within 15 days of onset of low back pain among workers with a compensation claim associated with increased risk of late opioid use (adjusted OR 2.08, 95% CI = 1.55–2.78 for 1 to 140 MME/day and OR 6.14, 95% CI = 4.92–7.66 for ≥450 MME/day).

Abbreviations: CI = confidence interval; ER/LA = extended release/long-acting; HR = hazard ratio; MME = morphine milligram equivalents; OR = odds ratio.
 *Ratings were made per GRADE quality assessment criteria; “no limitations” indicates that limitations assessed through the GRADE method were not identified.
 † Not applicable as no evidence was available for rating.

TABLE 2. Morphine milligram equivalent (MME) doses for commonly prescribed opioids

Opioid	Conversion factor*
Codeine	0.15
Fentanyl transdermal (in mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone	
1–20 mg/day	4
21–40 mg/day	8
41–60 mg/day	10
≥61–80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3
Tapentadol†	0.4

Source: Adapted from Von Korff M, Saunders K, Ray GT, et al. Clin J Pain 2008;24:521–7 and Washington State Interagency Guideline on Prescribing Opioids for Pain (<http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf>).

* Multiply the dose for each opioid by the conversion factor to determine the dose in MMEs. For example, tablets containing hydrocodone 5 mg and acetaminophen 300 mg taken four times a day would contain a total of 20 mg of hydrocodone daily, equivalent to 20 MME daily; extended-release tablets containing oxycodone 10mg and taken twice a day would contain a total of 20mg of oxycodone daily, equivalent to 30 MME daily. The following cautions should be noted: 1) All doses are in mg/day except for fentanyl, which is mcg/hr. 2) Equianalgesic dose conversions are only estimates and cannot account for individual variability in genetics and pharmacokinetics. 3) Do not use the calculated dose in MMEs to determine the doses to use when converting opioid to another; when converting opioids the new opioid is typically dosed at substantially lower than the calculated MME dose to avoid accidental overdose due to incomplete cross-tolerance and individual variability in opioid pharmacokinetics. 4) Use particular caution with methadone dose conversions because the conversion factor increases at higher doses. 5) Use particular caution with fentanyl since it is dosed in mcg/hr instead of mg/day, and its absorption is affected by heat and other factors.

† Tapentadol is a mu receptor agonist and norepinephrine reuptake inhibitor. MMEs are based on degree of mu-receptor agonist activity, but it is unknown if this drug is associated with overdose in the same dose-dependent manner as observed with medications that are solely mu receptor agonists.

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Reducing Opioid Overdose and Misuse

CDC Guideline for Opioid Prescribing

The U.S. Centers for Disease Control and Prevention has published a [CDC Guideline for Prescribing Opioids for Chronic Pain](#), along with [Guideline Resources](#).

The guideline includes recommendations to improve patient safety and care for those with chronic pain, and address the ongoing prescription opioid overdose epidemic.



Related Resources

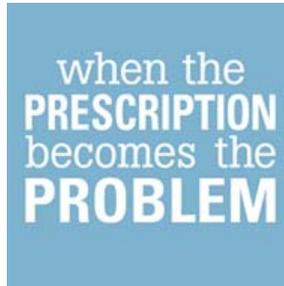
- [Addictions and Mental Health Services](#)
- [Oregon Prescription Drug Monitoring Program](#)
- [Prescription Drug Overdose Epidemic \(CDC\)](#)
- [Opioid Facts \(SAMHSA\)](#)

Contact Us

[Email us](#)

Oregon has one of the highest rates of prescription opioid misuse in the nation.

In Oregon, more drug poisoning deaths involve prescription opioids than any other type of drug, including alcohol, methamphetamines, heroin and cocaine. An average of 3 Oregonians die every week from prescription opioid overdose, and many more develop opioid use disorder.



[Partners](#) across Oregon are working to reduce this epidemic. We have made recent progress, but there is more work to be done.

- [What you should know about opioid pain medication](#)
- [Naloxone can save a life](#)
- [For health care professionals and CCOs](#)

Getting help for opioid use disorder

Opioid use disorder can be treated. Talk to your health care provider or visit the links below for treatment resources.



- [Substance use helpline: 1-800-923-4357](#)
- [Opioid treatment program directory](#)
- [Southern Oregon community treatment resources](#)
- [Addictions and Mental Health services](#)

Pain management resources

- [Chronic disease self-management programs](#)
- [How to manage your pain safely and effectively \(CDC website\)](#)
- [Understanding pain and what to do about it \(video from the Department of Defense and Veterans Health Administration\)](#)
- [Southern Oregon Pain Guidance website](#)

Our work

- [Publications](#)
- [Prescribing and Overdose Data Dashboard for Oregon](#)
- [Oregon Prescription Drug Monitoring Program website](#)

Partners

Addressing the opioid epidemic involves many local, state and national partners. In Oregon, our Opioid Initiative Partnership includes the following groups:

In Oregon

- [Coordinated Care Organizations](#)
- Emergency Departments
- [Local Public Health Departments](#)
- [Opioid Treatment Programs in Oregon](#)
- [Oregon Chapter of the American College of Emergency Physicians](#)
- [Oregon Coalition for the Responsible Use of Medications](#)
- [Oregon Health Leadership Council](#)
- [Oregon High-Intensity Drug Trafficking Areas Program](#)
- [Oregon Pain Advisors](#)
- [Oregon Pain Management Commission](#)
- Pain Management Clinics
- Public Safety

National partners

- [Centers for Disease Control and Prevention \(CDC\)](#)
- [Substance Abuse and Mental Health Services Administration \(SAMHSA\)](#)



Home

IF YOU NEED A PASSWORD RESET, PLEASE CALL THE PRESCRIPTION DRUG MONITORING PROGRAM HELP DESK AT: 866-205-1222 OR EMAIL THEM AT: ORPDMP-INFO@HIDESIGNS.COM

Oregon Prescription Drug Monitoring Program

The Oregon Prescription Drug Monitoring Program (PDMP) is a tool to help healthcare providers and pharmacists provide patients better care in managing their prescriptions. It contains information provided by Oregon-licensed retail pharmacies.

Pharmacies submit prescription data to the PDMP system for all [Schedules II, III and IV controlled substances](#) dispensed to Oregon residents. The protected health information is collected and stored securely.

Oregon-licensed healthcare providers and pharmacists and their staff may be authorized for an account to access information from the PDMP system. Bordering state licensed healthcare providers may also be authorized for access accounts. By law their access is limited to patients under their care.

The program was started to support the appropriate use of prescription drugs. The information is intended to help people work with their healthcare providers and pharmacists to determine what medications are best for them.

For more information, questions or concerns, browse the website and [Fact Sheet](#) or email or call the PDMP staff.

New PDMP Legislation

[Senate Bill 71](#) was passed during the 2015 Oregon legislative session and signed into law June 18, 2015:

- Pharmacies are required to electronically report data no later than 72 hours after dispensing a prescription drug that is subject to the prescription monitoring program.

[Senate Bill 470](#) was passed during the 2013 Oregon legislative session. The bill authorizes the following changes effective January 1, 2014:

- Permits the PDMP to collect additional data (patient sex, days supplied, and refill data)
 - Permits prescribers and pharmacists to authorize delegate access to members of staff
 - Permits prescribers to review prescriptions dispensed under their own DEA number
 - Allows the State Medical Examiner and designees to access PDMP information for autopsies and death investigations
 - Authorizes prescribers in neighboring states (WA, ID, and CA) and who treat Oregonians to access the Oregon PDMP
 - Allows public health authorities to use de-identified PDMP data
 - Makes additional PDMP information exempt from public records disclosure
-

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Prescription Drug Monitoring Program - IPE | PO Box 14450

Portland, OR 97293-0450 Phone: 971-673-0741 | Fax: 971-673-0990

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TTY: 971-673-0372

Oregon Prescription Drug Monitoring Program

Basic Facts

- Approximately 7,000,000 prescription records are uploaded into the PDMP system annually.
- Greater than 99 percent of pharmacies required to participate are reporting.
- More than 8,200 practitioners and pharmacists have PDMP accounts.
- In 2013, more than 621,000 queries were made by practitioners and pharmacists.
- 78 percent of the prescriptions in the PDMP are prescribed by a cohort of 4,000 practitioners; 67 percent of these prescribers have PDMP accounts.
- Opioids account for 54 percent of the prescriptions in the PDMP data system.
- Opioids are the class of medication that has the highest potential for overdose, misuse, dependence, and abuse.
- Benzodiazepines are the second-most-often-prescribed class of medication in the PDMP data system.
- Opioids combined with benzodiazepines increase the risk of overdose.

What is the PDMP?

The Oregon Prescription Drug Monitoring Program (PDMP) is a Web-based data system that contains information on controlled substance prescription medications dispensed by Oregon-licensed retail pharmacies. The PDMP became operational on September 1, 2011; pharmacies began reporting data on June 1, 2011. Oregon law requires pharmacies to submit data weekly for all Schedule II – IV controlled substances dispensed. Controlled substances reported include opioids, benzodiazepines, sedative hypnotics, stimulants, and other drugs. PDMP legislation was passed in 2009 and amended in 2013.

What is its purpose?

The PDMP is a tool practitioners and pharmacists can use to improve patient safety and health outcomes. Patients who use these medications are at risk for: overdose, side effects and increased effect when combined with alcohol and/or other drugs, risk for physical dependence, and risk for developing patterns of drug abuse. The PDMP provides practitioners and pharmacists a means to identify and assess these problems.

How does it work?

Authorized system users can logon to the PDMP Web-based system and request a report of the controlled substance medications dispensed to their patients. The patient report is a line list of prescriptions dispensed. Prescription records include information on the dispenser, prescriber, and drug (i.e. name, quantity, days supplied, and refill information).

Who can access PDMP information?

Access to PDMP information is regulated by law—ORS 431.966. Entities that can access system information once authorized include: Oregon-licensed practitioners and pharmacists and their delegated and authorized office staff, licensed and authorized practitioners in bordering states, and the State Medical

Examiner and designees. Other entities may submit request forms to obtain a PDMP report. Other entities include patients, health care regulatory boards, and law enforcement agencies. In addition to the prescription record, patient reports include a list of anyone who queried a patient's information to ensure proper access. Law enforcement requests must be pursuant to a valid court order. Executive directors of health care boards must certify the request is part of an active investigation.

How is patient privacy protected?

PDMP patient information is protected by law—ORS 431.966.

Top 12 Prescriptions, JUN 2011—SEPT 2014		
Drug	Number of Rx*	% of all Rx
Hydrocodone	6,098,70	27.5%
Oxycodone	3,684,53	16.6%
Zolpidem	1,629,69	7.4%
Lorazepam	1,356,99	6.1%
Alprazolam	1,199,65	5.4%
Clonazepam	1,060,81	4.8%
Amphet ASP/ AMPHET/ D- AMPHET	834,090	3.8%
Morphine	750,332	3.4%
Methylphenidate	738,005	3.3%
Diazepam	587,039	2.6%
Methadone	385,765	1.7%
Acetaminophen with Codeine	332,710	1.5%

*Prescriptions

For more information:

Go to www.orpdmp.com

Program Contact:

Lisa Millet
Lisa.M.Millet@state.or.us

In this newsletter:

- New: Prescriber Dashboard
- Delegate Accounts
- Prescribing and Overdose Data
- System Use Suggestions
- For password resets and uploader technical support please call 866-205-1222.
- For all other PDMP related questions: 971-673-0741

Prescriber Dashboard

A new feature, a prescriber dashboard, has been added to the provider portal. This dashboard provides prescribers a report of patients they have prescribed Schedule II-IV medications in the last 6 months which meet one or more metrics for an increased risk of a possible overdose, or substance use disorder. This dashboard includes 5 thresholds:

- Threshold 1 - Recipient is receiving opioids at greater than 120 mg MED (Morphine Equivalent Dose) daily
MED calculated : (quantity/days of supply) x strength per unit x MME conversion factor
- Threshold 2 - Recipient is receiving methadone at greater than 40 mg dose daily
- Threshold 3 - Recipient is receiving opioids for longer than 90 consecutive days
- Threshold 4 - Recipient is concurrently receiving opioids and benzodiazepines
- Threshold 5 - Recipient is being prescribed medications by 4 or more prescribers and being dispensed medications by 4 or more pharmacies

Within this report you can select a single patient's to view more detailed information. That information is presented in easy to utilize tables that correspond to each threshold with dates and information on the prescription, prescriber, and pharmacy.

*Table used for MED calculation can be found at:

http://www.pdmpassist.org/pdf/bja_performance_measure_aid_mme_conversion_tool.pdf

Delegate accounts save prescribers time.

Prescribers can save valuable time by having office staff, medical assistants, pharmacy technicians, and other non-prescribing staff register for a delegate account.

- Please have office staff visit our page at www.orpdmp.com and follow the instructions to register for a new account.
- To Link a Delegate: sign into your account through the PDMP Provider Portal: <https://orpdmp-ph.hidinc.com>
 - Select "User Management" from the option menu from the top of the screen. Select "Delegate Accounts".
 - Select the name(s) of your delegate(s) and select "Link Account".
 - Now your delegate account holders will be able to look up patient records.
- Once your delegates are linked to your account they can create, print, or save patient reports. They cannot query patients without being linked and may be linked to as many prescribers as they need to be. You can also have as many delegates as you need.

Suggested times to use the PDMP:

- When seeing a new patient.
- When writing a new prescription for a controlled substance.
- When writing a renewal prescription for a controlled substance.
- At annual exams.
- Whenever a patient asks for an early refill.
- If a patient exhibits signs of difficulty related to substance use.

What indicators that a patient may be exhibiting signs of difficulties related to substance use to look for:

- Is your patient receiving medications you were not aware of?
- Dosages that look out of the ordinary.
- Drug combinations that might be dangerous.
- Multiple prescribers and/or multiple pharmacies over several months.
- Over 90 consecutive days of opioids.
- Methadone greater than 40mg daily dose.

Prescribing and Overdose Data for Oregon: Are you interested in data for your county or the state? An I interactive tool has been created to view statewide data on prescribing measures, drug overdose hospitalization, and drug overdose death.

To view this interactive information please visit: <https://public.health.oregon.gov/PreventionWellness/SubstanceUse/Opioids/Pages/data.aspx>

Coming in April to our prescriber and pharmacist account holders - a PDMP Satisfaction Survey.

Prescription Drug Monitoring Year-to-Date Report

Jan 2015–Dec 2015, Issue 23,
year 5

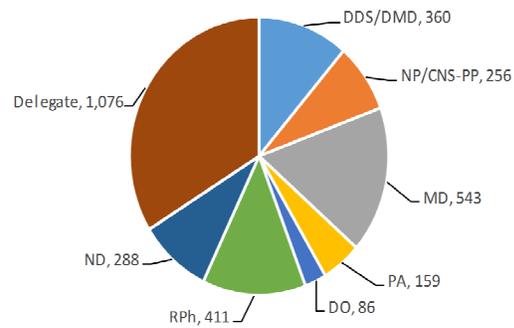
<http://public.health.oregon.gov/DISEASES/CONDITIONS/INJURYFATALITYDATA/Pages/index.aspx>

Oregon Injury and Violence Prevention Program Information Sheet

BASIC FACTS JAN 15–DEC 15:

- Account requests: 9 per day
 - Prescriptions: 7,576,703
 - Queries: 414,416 by health care providers, 480,731 by pharmacists, 266,300 by delegates**
 - Special requests: 152 patient record requests, 333 health care board requests, 4 law enforcement requests
 - Web site hits: 192,393
- *Percent is based on pharmacies required to report.
**Delegate access began 1/1/14.

System Accounts by Discipline, Jan. - Dec. 2015, n = 3,179



Key to Abbreviations: DDS/DMD: Dentist, DO: Doctor of Osteopathy, MD: Medical Doctor, ND: Naturopath, NP/CNS-PP: Nurse, OD: Doctor of Optometry, PA: Physician Assistant, RPh: Pharmacist

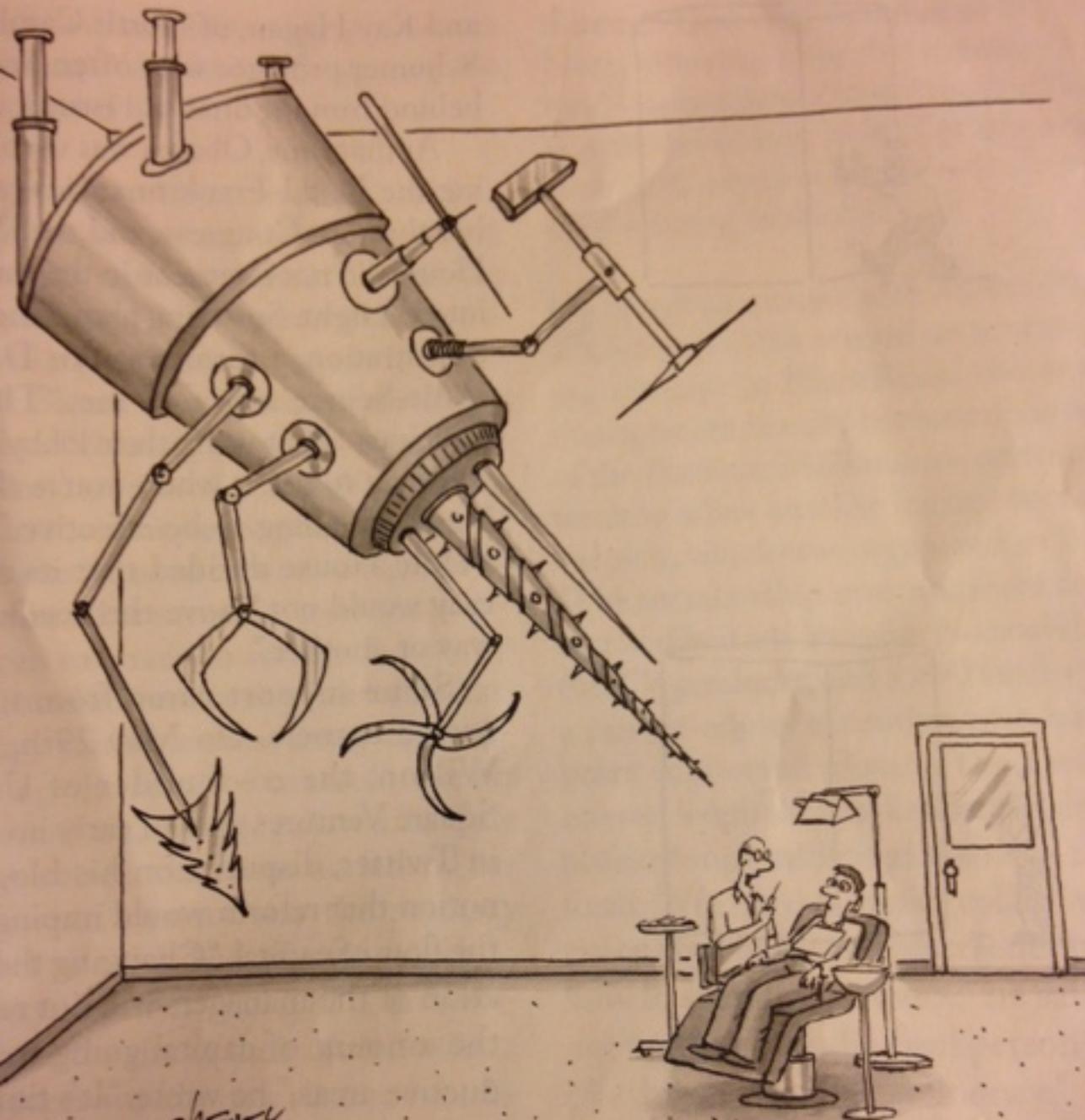
Top 12 Prescriptions, JAN 2015–DEC 2015

Drug	Number of Rx	% of all Rx
Hydrocodone	1,686,507	22.3%
Oxycodone	1,254,287	16.6%
Zolpidem	432,049	5.7%
Lorazepam	428,672	5.7%
Tramadol	410,576	5.4%
Alprazolam	359,098	4.7%
Amphet ASP/AMPHET/ D-AMPHET	341,853	4.5%
Clonazepam	327,102	4.3%
Methylphenidate	260,789	3.4%
Pseudoephedrine	259,661	3.4%
Morphine	252,955	3.3%
Diazepam	173,871	2.3%

*All dosages, quantities

Estimated Number of Health Care Providers Who Registered for an Account by County, Between Jan 2015–Dec 2015

County	Number of providers with accounts	County	Number of providers with accounts
Baker	8	Lake	1
Benton	81	Lane	371
Clackamas	191	Lincoln	28
Clatsop	18	Linn	53
Columbia	7	Malheur	10
Coos	64	Marion	117
Crook	3	Morrow	1
Curry	8	Multnomah	695
Deschutes	136	Polk	26
Douglas	65	Sherman	0
Gilliam	2	Tillamook	8
Grant	4	Umatilla	32
Harney	12	Union	29
Hood River	12	Wallowa	9
Jackson	286	Wasco	15
Jefferson	10	Washington	218
Josephine	65	Wheeler	0
Klamath	34	Yamhill	53



CHENEY

"First, let's get you nice and numb for this procedure."

LICENSE RATIFICATION

16. RATIFICATION OF LICENSES

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

DENTAL HYGIENISTS

H7144	WENDY JEAN FOXE, R.D.H.	2/12/2016
H7145	MAKAHLA ROSE HUFF, R.D.H.	2/12/2016
H7146	KELSEY DAWN WHITAKER, R.D.H.	2/25/2016
H7147	NICOLE LYNN TIFFANY, R.D.H.	2/26/2016
H7148	CARISSA MARIE HOPPIE, R.D.H.	2/26/2016
H7149	BRIANNE TRACI ELLIOTT, R.D.H.	3/2/2016
H7150	JOHN ROSS EDWARD ERICKSON, R.D.H.	3/2/2016
H7151	ELIZABETH ASHLEY PELLOW, R.D.H.	3/3/2016
H7152	MOLYNDA MC KIBBEN, R.D.H.	3/3/2016
H7153	KATIE J SOBER, R.D.H.	3/10/2016
H7154	INESSA ILLINICHNA TEREKHIN, R.D.H.	3/10/2016
H7155	STEPHANIE MARIE NELSON, R.D.H.	3/10/2016
H7156	ANGELIA C SPIEGEL, R.D.H.	3/23/2016
H7157	KENNEDY GABRIELLE HILGERS, R.D.H.	4/6/2016
H7158	JOHN V RUSSO, R.D.H.	4/6/2016
H7159	TRICIA L MONTEZ, R.D.H.	4/6/2016

DENTISTS

D10396	NICOLE CONNORS SMITH, D.M.D.	2/12/2016
D10397	STEVEN J WORLEY, D.D.S.	2/22/2016
D10398	NATHAN D LENOX, D.M.D.	2/25/2016
D10399	SEAN P HENRIE, D.M.D.	2/25/2016
D10400	JONATHAN C GARCIA, D.D.S.	2/25/2016
D10401	ANA K PUENTE, D.D.S.	2/26/2016
D10402	MICHAEL J LONGLET, D.D.S.	2/26/2016
D10403	ERICA GOSS, D.D.S.	2/26/2016
D10404	CHELSEA MARIE LONGLET, D.D.S.	3/2/2016
D10405	VICTOR RONALD MANCUSO, D.D.S.	3/10/2016
D10406	DAVID MARK DE CILLIS, D.D.S.	3/10/2016
D10407	STEPHEN I CAMPBELL, D.D.S.	3/10/2016
D10408	COLIN STUART GRASER, D.M.D.	3/14/2016
D10409	TESS A SIMMONS, D.D.S.	3/23/2016
D10410	DIEU-HIEN V HUYNH, D.M.D.	4/6/2016
D10411	THOMAS LEE MOSLEY, D.M.D.	4/6/2016
D10412	ADAM T FOX, D.M.D.	4/6/2016
D10413	NIOUSHA SAGHAFI, D.D.S.	4/6/2016

DENTAL FACULTY

DF0035	HIDEHIKO WATANABE	3/2/2016
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**LICENSE, PERMIT
&
CERTIFICATION**

Nothing to report under this tab

**STRATEGIC
PLANNING
SESSION**



NOTICE OF STRATEGIC PLANNING SESSION MEETING

PLACE: Marriott Hotel- Downtown Portland
1401 SW Naito Pkwy
Portland, Or 97201
Pearl Conference Room

DATE: April 23, 2016

TIME: 8:00 a.m. – 4:30 p.m.

8:00 Breakfast

8:30 Session opening and welcome
Agenda review and Session Working Agreements

Presentation: *Collective view of the strategic landscape, based on interview results*

Discussion and additions to the landscape

9:00 “Three Critical Conversations”

- *Complexity and Caseload / Process Improvement and New Technology:*
 - *How is the volume and complexity of OBD trending?*
 - *What are some examples of volume/complexity trends from the recent past?*
 - *How might we anticipate and mitigate the stress from these trends on the OBD? Are there process improvements or new technology that could be transformational?*
- *Attrition and Succession:*
 - *What impacts will upcoming attrition have on the OBD?*
 - *What needs to be done to retain critical OBD institutional memory and capabilities?*
 - *What new capabilities should be considered in succession planning?*
- *Adapting the OBD Mission for the Future:*
 - *What else should the Board have on its radar screen that could either enhance, or detract from, OBD’s ability to “protect the public”?*

11:30 Open Discussion: *Other factors to carry forward into strategic planning*

Notes:

(1) A working lunch will be served for Board members at approximately 12:00 p.m.

(2) The meeting location is accessible to persons with disabilities. A request for an interpreter for the hearing impaired or for other accommodations for persons with disabilities should be made at least 48 hours before the meeting to Stephen Prisky at (971)673-3200.

(3) The Board may from time to time throughout the meeting enter into Executive Session to discuss matters on the agenda for any of the reasons specified in ORS 192.660.

Prior to entering into Executive Session, the Board President will announce the nature of and authority for holding the Executive Session. No final action will be taken in Executive Session.

Noon

Lunch

1:00

Environmental Scan

***Breaks as
needed***

- *Issues, trends, opportunities, challenges on the five-year horizon.*
- *Budget and legislative impact.*
- *Impact assessment.*

Mission Alignment

- What are the mission critical elements of the OBD's work?
- Within OBD's resources how can be best align with our mission?

Strategic Objectives & Priorities 2017 – 2020

- Establish priorities.
- Anticipated milestones.
- Measures of success

4:15

Session Summary

4:30

Session Closing

Notes:

(1) A working lunch will be served for Board members at approximately 12:00 p.m.

(2) The meeting location is accessible to persons with disabilities. A request for an interpreter for the hearing impaired or for other accommodations for persons with disabilities should be made at least 48 hours before the meeting to Stephen Prisky at (971)673-3200.

(3) The Board may from time to time throughout the meeting enter into Executive Session to discuss matters on the agenda for any of the reasons specified in ORS 192.660.

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The Oregon Board of Dentistry's 2007 Strategic Plan

MISSION STATEMENT AND STATUTORY AUTHORITY

The mission of the Oregon Board of Dentistry is to assure that the citizens of the state receive the highest possible quality of oral health care.

The authority and responsibilities of the Board are contained in Oregon Revised Statutes Chapter 679 (Dentists), Chapter 680.010 to 680.205 (Dental Hygienists), and Oregon Administrative Rules, Chapter 818. These statutes charge the Board of Dentistry with the responsibility to regulate the practice of dentistry and dental hygiene by enforcing the standards of practice established in statute and rule. The statutes define the practice of dentistry and dental hygiene and require that any person practicing either of those professions do so only while holding a license duly issued by the Board. The statutes require that the Board examine and license dentists, dental instructors and dental hygienists; establish and enforce regulations regarding sedation in dental offices; investigate complaints regarding the practice of dentistry and dental hygiene; discipline licensees found to have violated the provisions of the Dental Practice Act; regulate and monitor continuing education requirements for licensees; and establish training, examination and certification standards for dental auxiliaries.

OTHER STATUTORY MANDATES:

ORS 676.160 – Complaint investigations.

These statutes require that upon receipt of a complaint filed by any person against a licensee or applicant the Board shall (1) assign an investigator, (2) the investigator shall collect evidence and interview witnesses; (3) the investigator shall prepare a report that describes the evidence gathered, results of witness interviews and any other information considered in preparing the report and (4) the investigator shall make a report to the Board within 120 days of receipt of the complaint. This statute also declares that investigatory information gathered by the agency is exempt from public disclosure.

ORS 676.345 – Registration program for health care professionals claiming liability limitation

This statute requires several health licensing Boards, including the Board of Dentistry, to maintain a registration program for health practitioners who provide health care services without compensation and who wish to be subject to the liability limitation provided by ORS 676.340.

SB 786 (Oregon Law, Chapter 973, 2001) –Cultural diversity in regulated health professions

This law, effective January 1, 2002 requires that health-licensing boards establish programs to increase the representation of people of color and bilingual people on the boards and in the professions that they represent. Programs

are required to promote the education, recruitment and professional practice of members of these targeted populations. The law also requires that each health professional regulatory board maintain records of the racial and ethnic makeup of applicants and professionals regulated by the board. This information is to be reported to the Legislative Assembly biennially

AGENCY PLANS

The Agency Strategic Plan was adopted in 1999 and is reviewed periodically to assess progress toward goals and to adjust goals to reflect current and projected needs. The Board of Dentistry's short and long-range plan is directed by its mandate to protect the health, safety and welfare of Oregonians and by its mission to assure that citizens receive the highest possible quality oral health care. The Board strives to ensure that its activities fulfill its mission within the resources allocated by the Legislature and effectively provides appropriate public protection.

Oregon Benchmarks

The Board of Dentistry has no Primary Links to the Oregon Benchmarks; however, Board activities support the following Benchmarks as secondary links:

#29 Skills Training: Percentage of Oregonians in the labor force who received at least 20 hours of skills training in the past year.

Licensees of the Board are required to complete continuing education requirements biennially in order to renew their professional licenses (40 hours for dentists; 36 hours for dental hygienists holding Limited Access Permits; and 24 hours for all other dental hygienists). In addition to this mandatory requirement, most licensees voluntarily participate in study clubs and take courses that enhance their professional skills. Many continuing education courses are available via the Internet and are an effective means of receiving training.

#30 Volunteerism: Percentage of Oregonians who volunteer at least 50 hours of their time per year to civic, community or nonprofit activities.

The Board supports volunteerism by encouraging uncompensated dental and dental hygiene care provided through various non-profit and community based clinics. In cases where unacceptable patient care is not an issue, the Board frequently requires uncompensated services as a part of settlement agreements in disciplinary cases. Feedback from practitioners has been positive and many continue their volunteer relationship with the dental clinic after the Board's requirements have been fulfilled.

In January of 2005 in cooperation with the Oregon Dental Association and Dentists Benefits Insurance Company the Board created a Volunteer Dentist/Dental Hygiene license designation program. As of August 1, 2006 eight dentists currently have a volunteer dentist licensee designation

A dentist who maintains an Oregon license but is retired from active practice may obtain liability insurance through the Department of Administrative Services in order to provide uncompensated dental services through nonprofit corporations offering community services and dental services to low-income patients. (ORS 679.510).

The Board maintains a registry of dentists and dental hygienists who provide dental and dental hygiene services without compensation in accordance with ORS 676.340. By registering with the Board annually, licensees providing uncompensated health care are not liable for any injury, death or other loss arising out of the provision of the services unless the injury, death or other loss results from the gross negligence of the practitioner.

Every member of the Board (six dentists, two dental hygienists and one public member) are volunteers and collectively donate hundreds of hours of time to Board work, through Board meetings, committee meetings, Legislative appearances, public appearances and speaking engagements, serving as examiners for regional clinical dental and dental hygiene examinations, and representing the State of Oregon at national meetings germane to the licensure, examination and regulation of the two professions under its jurisdiction..

#44 Adult Non-smokers: Percentage of Oregonians, 18 and older, who smoke cigarettes.

#52 Substance Use During Pregnancy: Percentage of pregnant women who abstain from using: a. alcohol; b. tobacco.

The Board recognizes that tobacco use prevention and cessation are an important part of oral health and directly related to the prevention of other health conditions. In 1988, the Board issued its position statement on the health hazards associated with tobacco and determined that the prescribing of drugs such as Nicorette, Nicoderm, and Zyban were within the scope of practice of dentistry. The Board supports and encourages dental professionals to educate their patients on the dangers of tobacco use. The Board of Dentistry maintains a smoke-free workplace and all meetings of the Board are smoke free in accordance with Oregon Public Meetings Law and agency policy.

#50 Child Abuse or Neglect: Number of children, per 1,000 persons under 18, who are: a. neglected/abused; b. at a substantial risk of being neglected/abused.

Under ORS 419B.005, dentists are required to report suspected incidents of child abuse or neglect. The Board regularly publishes in its newsletter information on the requirement to report, symptoms and physical indications of abuse, and contact numbers for reporting in various areas of the state.

2007-2013 SIX-YEAR PLAN

The Board of Dentistry's strategic plan was originally completed in 1999 and is reviewed periodically for progress towards meeting established goals, adjusting goals to reflect current or projected needs and to re-assess priorities. The Board of Dentistry's long- and short-range plan is directed by both its mission to assure that Oregonians receive high quality dental care and by its statutory mandate to protect the health, safety and welfare of the citizens of Oregon. The Board strives to ensure that its goals and objectives are realistic and within the resources allocated by the Legislature.

Goal 1: Assure that licensees are qualified and competent to practice safely.

Benchmark/High-Level Outcome

Agency mission.

Intermediate Outcomes:

- Licenses will only be granted to applicants possessing the appropriate requirements for education and examination.
- Examinations for licensure will be valid and reliable.
- National FBI Criminal Background checks will be conducted for all applicants by submitting fingerprints to the Oregon State Police and inquiries of the National Practitioners Data Bank and the Healthcare Integrity and Protection Data Bank.
- All licensees will complete required hours of verifiable continuing education related to clinical patient care.
- Licensees with performance or substance abuse issues will be remediated and monitored during their recovery and remediation process.
- Licensees under disciplinary sanction will be actively monitored to ensure compliance with terms of probation, and to restore them to active, useful service to Oregon's citizens whenever appropriate.
- Maintain a network of consultants and evaluation/treatment facilities capable of meeting the need and scope of expertise required to assist the Board in its mission to rehabilitate licensees in need of assistance.

Performance Measures:

1. Licenses will be issued or renewed within 7 business days of receipt of completed paperwork.
2. 100% of all applicants will have background checks.
3. Compliance with continuing education requirements will be audited for 15% of all licensees each year.
4. 100% of licensees who are under consent orders for substance abuse issues will appear before the Board at least annually.
5. 85% of licensees on monitoring status will complete the terms of disciplinary sanctions within original time frames established in their order.

Goal 2: Promote access to oral care.

Benchmark/High-Level Outcome

Benchmark #30; Agency mission.

Intermediate Outcomes:

- Promote volunteerism.
- Review scopes of practice of dental hygienists and dental assistants to provide broader scope where appropriate.
- Provide for reasonable access to education and testing in rural areas; i.e. long distance learning.
- Support increased funding for education of dental, dental hygiene and dental assisting.
- Partner with communities of interest to provide incentives to enter dental health care careers.
- Participate in workforce studies to determine the extent of the workforce problems and identify possible solutions.
- Support community prevention activities; i.e. Early Childhood Caries Prevention Project, and statewide fluoridation efforts.

Performance Measures:

1. At least 90% of licenses disciplined for continuing education noncompliance or practicing without a license will be required to provide volunteer dental services.
2. Encourage Dentists and Dental Hygienists to join the Boards Volunteer License Designation Program.
3. Dental Hygiene and Dental Assisting rules will be reviewed each annually.

Goal 3: Standards of practice, statutes and regulations will be realistic, understandable and applied appropriately

Benchmark/High-Level Outcome

Benchmark #29 and #30, Agency Mission, Legislative mandate

Intermediate Outcomes:

- Investigate allegations of unprofessional conduct, unacceptable patient care or other violations of the Dental Practice Act in a fair, prompt, objective and thorough manner.
- Take an active stance in preventing practice problems that endanger patients through educational outreach.
- Where unacceptable care is identified, Board emphasis will be on remediation through education and restitution to patients when appropriate.
- Continue to support a confidential diversion program for licensees with substance abuse disorders.
- Disciplinary issues will be mediated and resolved through mutual agreements to the greatest extent possible.
- Review all statutes and rules at least annually for consistency and cohesion.

Performance Measures:

1. Investigations will be completed within three months from date of receipt.
2. At least 95% of disciplinary actions will be settled through negotiated consent agreements rather than Contested Case Hearing.
3. The percent of licensees who are disciplined will decrease each biennium.

Goal 4: Communicate timely and useful information regarding the Board's mission, services, policies and standards of practice to the public and licensees.

Benchmark/High-Level Outcome

Agency Mission, Strategic Plan

Intermediate Outcomes

- Improve public awareness of the Board as a resource for, and provider of, information and services.
- Provide appropriate information regarding licensees to the extent allowed by law.
- Continue to make the Board's website a useful resource for citizens and licensees.
- Review of all potential partnerships during the planning of all board initiatives to maximize synergy and resources.
- Communicate regularly with licensees, educators, professional associations and interested community organizations regarding Board policies and expectations
- Continue to support Outreach Program/Presentation to Licensees and the Public.

Performance Measures

1. The number of pages viewed ("hits") on the Board's website.
2. Feed back provided from the Customer Services Survey posted on the website.
3. Produce and distribute two newsletters per year, mailed to all licensees, other state dental boards and professional associations, and post on the website.
4. Number of presentations made by staff and Board members to dental, dental hygiene and dental assisting students; licensees and professional organizations.

CURRICULUM OVERVIEW:	In 2015 a senate bill was passed requiring DAS to develop and provide training for new board/commission members and executive directors of a small entity. To meet the requirement of the bill, a curriculum has been developed and is available within iLearn. The curriculum contains 2 online courses and 1 classroom course. All of these courses must be completed within 6 months of the start date of a new board/commission member or the appointment as an executive director of a small entity. Only people who started or were appointed on or after 1/1/16 are required to complete the curriculum.
CLASSROOM DESCRIPTION:	<p>This is information on the classroom course and the quarterly training schedule for 2016.</p> <p>The purpose of this classroom course is to provide best practices, current issues, and allow new board and commission members and executive directors to ask the experts on topics such as government ethics, public records and meetings law, human resources, procurement, payroll, etc.</p>
AUDIENCE:	New members of a board or commission and new executive directors of a small entity.
LENGTH:	The training is a total of 4 hours of in-class time.
COST:	Free
TOPICS:	<ul style="list-style-type: none">• Public Sector Ethics• Public Meetings and Records• Overview of Rulemaking• Diversity and Inclusion• HR and Payroll• Finance and Procurement
REGISTRATION:	To register, log into iLearnOregon at https://ilearn.oregon.gov . In the course catalog search for B&C.
QUESTIONS:	If you have any questions about the program, please contact Brandy Meng at chro.training@oregon.gov or 503-378-2209.

SCHEDULE FOR 2016

LOCATION:	Employment Department 875 Union St. NE Salem, OR 97311
OPTION 1 DATE/TIME:	1. March 8, 2016 8am – Noon
OPTION 2 DATE/TIME:	2. March 8, 2016 1pm – 5pm

LOCATION:	ODOT 123 NW Flanders Portland, OR 97209
OPTION 1 DATE/TIME:	1. June 7, 2016 8am – Noon
OPTION 2 DATE/TIME:	2. June 7, 2016 1pm – 5pm

LOCATION:	Webinar You'll need a computer with an internet connection.
OPTION 1 DATE/TIME:	1. June 14, 2016 8am – Noon
OPTION 2 DATE/TIME:	2. June 14, 2016 1pm – 5pm

LOCATION:	University of Oregon – Ford Alumni Center 1720 East 13th Ave. Eugene, OR 97403
OPTION 1 DATE/TIME:	October 4, 2016 8am – Noon
OPTION 2 DATE/TIME:	October 4, 2016 1pm – 5pm

LOCATION:	Employment Department 875 Union St. NE Salem, OR 97311
OPTION 1 DATE/TIME:	1. December 6, 2016 8am – Noon
OPTION 2 DATE/TIME:	2. December 6, 2016 1pm – 5pm

Overview of Boards, Commissions, & Small Entities

Online Training

Introduction

Welcome to the online training for new board and commission members and executive directors.

This training does not and cannot override state law, rules, policies, or procedures. While the intent is to periodically update the material to comply with applicable laws it is incumbent upon the user to use the current and effective laws, rules, policies, and procedures. Where in conflict, the applicable law, rule, policy, or procedure takes precedence over information contained in this training.

Most major state agencies are headed by policy-making boards or commissions appointed by the Governor. Many additional boards and commissions establish policy in given areas or serve in advisory roles.

The board system contributes to the success of Oregon state government. It is key to bringing local citizens' talent and interest to the state level, keeping government innovative and responsive and improving state performance.

For purposes of this training we will be using the term board to include boards, commissions, or small entities, board member will be used to include board and commission members, and director to include administrator and executive directors.

A public official is defined as any person who is serving the state of Oregon or any of its political subdivisions or any other public body as an elected official, appointed official, employee or agent.

Board members are not employees unless they are in an actual salaried position. Board members are public officials and in their official capacity act on behalf of Oregon state government. If you are an administrator or executive director of a board, commission, or small entity you are an employee of Oregon state government and you are also considered a public official.

As a steward of public resources, you are held to a higher standard of conduct than a private citizen. Any actions of public officials are open to critical examination. As public officials, board members and directors are required to abide by the laws and policies of the state.

This course will cover the following topics:

1. Overview of Oregon State Government
2. Overview of Boards, Commissions, and Small Entities
3. General Activities of Boards, Commissions, and Small Entities
4. Operations and Management of Boards, Commissions, and Small Entities

Module 1 – Overview of Oregon State Government

This module provides a high-level overview of Oregon state government.

Branches of Government

Overview of Boards, Commissions, & Small Entities

Online Training

Governmental authority and functions in the state rest in 3 branches of government. Separate functions and powers are assigned to each of the three branches of government.

- The legislative branch makes laws.
- The executive branch carries out the laws.
- The judicial branch interprets the laws the legislative branch makes.

Legislative Branch

The Senate and the House of Representatives are responsible for making or changing laws. The legislature consists of 30 Senators and 60 Representatives. Representatives are elected for 2 year terms. Senators are elected for 4 year terms. Elections are held in even-numbered years.

The Legislature convenes annually in February. Sessions may not exceed 35 days in even-numbered years and 160 days in odd-numbered years. The Legislative Assembly convenes on the second Monday in January, to swear-in newly elected officials, elect legislative leaders, adopt rules, organize and appoint committees, and begin introducing bills. The leader of the Senate is the President of the Senate and the leader of the House is the Speaker of the House.

Executive Branch

Five statewide officials are elected to manage the executive branch of government. The officials are the Governor, the Secretary of State, the Treasurer, the Attorney General, and the Commissioner of Labor and Industries.

The Governor is the leader and is responsible for planning and coordinating the executive branch. The executive branch is commonly grouped into 8 program areas including:

1. Economic & Community Development;
2. Education;
3. Human Services;
4. Natural Resources;
5. Public Safety;
6. Transportation;
7. Administration; and
8. Consumer & Business Services.

All executive branch agencies fall within one of these program areas.

Judicial Branch

Oregon's judicial branch is made up of different courts. They are responsible for interpreting and enforcing the laws the legislative branch makes.

The Judicial Branch consists of the following courts:

- The Supreme Court has the most authority and they regulate the lower courts in Oregon. The Supreme

Overview of Boards, Commissions, & Small Entities

Online Training

Court makes sure all laws follow Oregon's Constitution.

- The Court of Appeals has jurisdiction to review appeals of most civil and criminal cases and most state administrative agency actions.
- The Tax Court is the only court able to make decisions in cases involving tax issues such as income tax and property tax.
- The Circuit Courts are the state trial courts.

Legislative Process

Now that we've covered the 3 branches of government let's take a look at the different types of measures and how they go through the legislative process.

A bill is a proposed law. All statutes, except those initiated by the people, must be enacted through a bill.

Bills from state agencies must have the Governor's approval before they are introduced.

There are 6 types of measures: a bill, a joint resolution, a concurrent resolution, a resolution, a joint memorial, and a memorial.

The legislative process is governed by rules, laws and procedures, making it somewhat mechanical in nature. Although the legislative process is long and complex, all laws begin as ideas.

An idea for a law can come from anyone; an individual or group of citizens, a legislator or legislative committee, the executive or judicial branch, or a lobbyist.

A bill, the most common type of measure, is a proposal for a law.

In order for a bill to become law, it must be passed by both houses in the identical form. A bill may be introduced in either the Senate or the House with the exception of revenue bills which must originate in the House.

Module 2 – Overview of Boards, Commissions, and Small Entities

Now that we've had an overview of Oregon state government, let's do an overview of boards, commissions, and small entities.

It is important to keep in mind all members have been appointed to the board to serve the public at large. The concerns and points of view of all interested parties must be represented and considered, but ultimately, the primary responsibility of every board member is to protect the health, safety and welfare of the general public.

If you were recommended by a professional association or special interest group, board members are expected to provide the board with their technical expertise, and to bring the point of view of the group to the board. However, they are not appointed to serve only as the representative of a specific group.

Overview of Boards, Commissions, & Small Entities

Online Training

When the group's interest conflicts with the general public, their primary responsibility is to the public. All board members must work for the benefit of the public first.

Authority

Some of the basic operating rules in state government are different from those in the private sector. One of these rules relates to authority.

A private citizen may do anything the law does not prohibit.

However, a board may only do what the law authorizes. Thus, a board has no inherent authority to act. A board may take an action only if the law provides authority for the intended action. A single board member acting alone has no authority unless specifically granted, as in the case of a chair, and an individual cannot take action to bind.

Make sure to have an understanding of what your board has authority for. Understanding and interpreting the laws that grant your board authority is vital to your decision-making. You should carefully review your enabling laws. Litigation frequently results when a board takes action based on authority that is unclear or implied. It is important to remember if a board acts without authority, the action does not bind the state. Actions taken without authority may be overturned and, in some circumstances, the person taking the unauthorized action may be personally liable for the consequences of the action. For these reasons, we recommend you consult with DOJ legal counsel when you have any questions about you or your board's authority to act.

Law Structure

Public officials and boards get their authority from Statutes, Administrative Rules, policies, and procedures.

- Oregon Revised Statutes are laws passed by the legislature. They must be followed by the people and institutions under their jurisdiction. Oregon Revised Statutes are the umbrella laws for all rules, policies, and procedures. Statutes are state laws which define what public agencies must do, can do, and cannot do.
- Oregon Administrative Rules further articulate the statutes and provide additional guidance to boards. OARs are written or adopted by state agencies to provide guidelines or process requirements for actions impacting the public. Rules may be more restrictive than statutes, but not more lenient.
- Policies and procedures are guidelines to assist internal operations of the individual board.

Types of Boards

The purpose and scope of each board are determined by the state law or executive order that created it. There are four main types of boards. Each is created to meet a specific need in the management of state government, so it is important to understand the distinctions between each type.

Policy Making Boards are given statutory power by the legislature to make policy decisions and enforce regulations. Policy is developed by interpreting legislative intent as outlined in the board's governing

Overview of Boards, Commissions, & Small Entities

Online Training

statutes or in officially adopted administrative rules, and by implementing procedures to carry out those laws or rules. Members of policy making boards are generally final decision makers, accountable directly through the Governor to the public.

Some policy making boards are also Governing Boards, responsible for directing a state agency or appointing the agency director.

Advisory Boards may be created by the Governor, the legislature, state agencies, or existing boards. They serve as advisors on policy matters to their appointing authority who is responsible for the management and administration of the policy. These boards study existing policy and make recommendations for change or implementation. Although they do not have final authority to make or enforce rules, their research and advice to decision makers contribute to effective changes in state government.

Licensing Boards examine and license members of a profession or occupation to practice in Oregon. Some also have the power to discipline members of the regulated profession or occupation, and to suspend or revoke licenses.

Judgment Boards are created by the legislature as review and appeals boards which hear and rule on individual cases. The decisions made by most of these and all other boards may be appealed to a higher court.

Bylaws

Boards should have a set of bylaws to direct and clarify its actions, procedures and organization. Bylaws are the guidelines by which a board functions. They should include expectations of members and cover issues such as attendance, responsibilities and discipline.

Administrative Help

Most boards work within an agency or have access to assistance and advice from the agencies. Typically, if a board works within an agency, certain central support services are provided to manage internal business. Some boards have their own staff to perform their day to day administrative functions.

Most often, the primary role of board staff is to carry out the rules, policies and programs developed by the board. Board staff also bring to the attention of the board issues of importance, prepare meeting agendas, and compile background information for board study.

Key Agencies

These agencies may affect your board and they also provide some support services.

Department of Administrative Services

The Director of DAS, who also serves as the State Chief Operating Officer, is appointed by the Governor. DAS was established to administer the Governor's programs and to provide policy direction and support services to boards. Most state agencies report to the Governor through DAS' Director.

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Department of Justice

DOJ is the state's law firm, headed by the attorney general. DOJ provides most of the same services as do private law firms, but with a few important differences. By statute, the attorney general and lawyers within DOJ are the sole providers of legal advice and representation to agencies and officials. DOJ acts as a legal adviser at meetings, and is an advocate for the state in hearings, trials and appeals. Each board is assigned at least one assistant attorney general who specializes in the area of law affecting the agency. DOJ helps identify any legal problems posed by existing or proposed agency policies or actions. Your attorney is there to facilitate your policy choices by pointing out potential problems and evaluating the legal effect of other policy options to accomplish the desired goal more easily. If you act on the advice of counsel, DOJ will defend you in court and any liability will be assumed by the state. Acting without consulting your lawyer, or acting contrary to their advice, may result in personal liability.

Secretary of State

The Secretary of State is an elected official who serves as the state's chief elections and public records officer, the auditor of public accounts and the administrator of the State Archives. There are 2 divisions within the Secretary of State's office boards will work with regularly. The Audits Division performs fiscal, performance, and compliance audits of all boards. The Archives Division preserves permanent government records and establishes retention schedules for public records of all boards. Boards must follow the guidelines established by the division on the care, accessibility, storage and destruction of its public records. No official records may be destroyed without the approval of the division.

Governor's Office

Most agencies are relatively independent within their areas of responsibility. Overall policy guidance and direction are provided by the governor, as the state's chief executive officer, and by the legislature, which writes laws and appropriates operating funds. To provide an overall management structure, the governor uses DAS. The governor coordinates the activities of agencies; actively participates in the design, development and approval of state agency budgets; appoints many agency directors, board members and other officials; and approves or disapproves all legislation affecting agencies. Board activities are subject to both legislative and executive oversight. Actions by the governor and the legislature may result in revision of a board's authority or changes in appropriations. Many board members have some involvement with the legislature during their period of service.

Legislature

Many boards work with the legislature in changing and developing state law. Your board may propose legislation and track bills relating to the work and concerns of your board. As a board member, you may also testify before legislative committees and advise legislators on issues concerning your board. The knowledge and expertise provided by boards can be very helpful to the legislature. Be careful to not represent yourself as a spokesperson for your board without the board's and the governor's prior consent and approval.

Module 3 – General Activities of Boards, Commissions, and Small Entities

Now let's take a look at general activities boards may participate in.

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Budget Process

Oregon's budget is a tool to carry out the state's law and policy decisions. It allocates the state's General Fund, Federal Funds, and Other Funds.

The budget also sets limits on other types of revenues and state positions.

Oregon's budget must be balanced.

Each board's budget is called an appropriations bill which authorizes the budget, specifies the maximum amount a board can spend, and allows the board to spend money.

The budget covers two fiscal years, which is called a biennium.

The budget runs from July 1 of an odd-numbered year to June 30 of the next odd-numbered year.

Approval of the budget is one of the principal issues of the legislature. The Oregon Constitution does not allow the state to spend money in excess of its revenues.

The Joint Committee on Ways and Means conducts hearings and receives testimony on the Governor's Recommended Budget.

The budget is then reviewed and approved by both houses of the legislature and approved by the Governor. Upon signature or effective date, the budget bill becomes law.

A budget specifies the maximum amount a board can spend. A board's revenue comes primarily from three sources:

- The General Fund is primarily from taxes and fees. General Fund money is generally used for programs dealing with health, education, public welfare, correctional institutions, legislative and judicial functions, general governmental administrative functions, or for programs without a dedicated revenue source.
- Some boards are funded in whole or in part by federal funds. Boards must get permission to apply for this money. Budget approval for a board financed with federal funds establishes the maximum amount of money it can spend from its income source. This is called an expenditure limitation.
- Most boards get their funds from Other funds which come from fees, tuition, or sales of services or commodities. Generally, these sources are established by the legislature specifically to support the board or program.

Regardless of revenue source, authority for all board expenditures rests with the legislature.

The budget process starts early in even-numbered years to develop the agency request budget. This lays out finances and policies for consideration. Boards send their budget request to the Chief Financial Office by September 1.

The governor and the CFO review the budget request. They use the governor's priorities, budget policies
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and current law to make budget decisions. The governor's recommended budget document summarizes those decisions. It gives data on all the state's revenues, expenditures, and information on each agency's budget.

The governor presents the recommended budget to the legislature when it meets at the start of the next calendar year. Legislative committees review the proposed budget. They hold public hearings to hear from each agency and the public. Each budget bill has a budget report presenting the committee recommendations. The legislature votes on each budget bill. The budget bills enacted into law make up the legislatively adopted budget. Agencies carry out, or execute, the budget over the two year budget period.

Rulemaking

To carry out prescribed duties and responsibilities, your board may need to prepare and adopt administrative directives.

Generally speaking, there are 3 types of directives:

- Rules
- Policies
- Procedural statements

A rule is a general administrative directive, standard, regulation or statement implementing, interpreting or prescribing law. It may set forth standards and expectations in general terms or may specifically deal with day to day objectives. A rule is adopted when the subject matter affects the public or another agency, or when a statute directs a rule be adopted. Once established, a rule has the force of law and all persons or entities to whom the rule applies must adhere to it.

Boards may engage in rulemaking only if the legislature has specifically delegated authority in the board's enabling statute. Most boards have the authority to pass rules and regulations necessary to implement their own statutory powers. The board cannot pass rules which go beyond the scope of its statute, because rules are generally intended to provide interpretive support for the statutes.

Because rules affect the public, they must be adopted in compliance with the requirements of the Administrative Procedures Act (ORS Chapter 183) unless specifically exempted by statute.

A policy sets forth minimum standards and directives concerning internal management which do not substantially affect the interests of the public. They are generally issued by the board's administrative officer or appointing authority. They have the same status within the board as a rule, and all persons to whom a policy applies must adhere to it.

Policy development and adoption are not subject to statutory mandate or the requirements of the APA. However, to protect the interests of the board members, staff and other parties affected by the proposed policies, it is wise to develop a systematic procedure for policy making. Staff and other affected persons should always be given an opportunity to make suggestions or ask questions before final adoption.

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Procedural statements give the specific details of the day to day processes for carrying out policies and rules. They are issued by the board administrative officer, govern all persons affected, and have the same status within the board or agency as rules.

Regulatory Board Activities

Many boards engage in regulatory activities. The philosophy of government regulation assumes the public would suffer physical, emotional or financial injury if the state did not exercise some oversight or control. Occupational and professional regulation is intended to ensure people engaged in those activities having an impact on the public's health, safety or welfare, provide Oregon citizens with honest and competent service. In addition, the regulation system provides a means for the public to provide input through a fair and objective process.

Members of regulatory boards help to set policy and give guidance to the regulated industry or profession under governing statutes.

Effectively constructed and administered tests provide an important contribution to licensure. Licensing tests should be designed to ensure an applicant's education and experience have adequately prepared them to assume an occupational or professional role impacting the public's health, safety, and welfare.

A principal responsibility of licensing boards is to determine whether a person should obtain or retain a license. Licensing boards with regulatory authority establish the standards and prescribe the qualifications required for a license to practice and regulate the services provided by the licensee by enforcing compliance with those standards.

Most licensing boards may revoke, suspend or refuse to renew any license, registration or certificate they issue, and some are authorized to stay a suspension on probationary conditions.

Most boards receive complaints about licensees. Complaints are usually received from consumers of licensee services, other licensees or professionals, other regulatory agencies, or as a result of routine inspections or investigations. Each complaint must be reviewed, and every effort must be made to mediate and satisfactorily resolve all complaints.

In some cases, an administrative hearing will be held to resolve a complaint. The Administrative Procedures Act establishes specific procedures to be followed to take disciplinary actions against individuals or firms. If the board conducts a hearing required by the Administrative Procedures Act, board members should not participate in the investigative or pre-hearing complaint handling functions. They must be impartial parties to the hearing.

Individual board members should disqualify themselves if bias or significant interest prevents fair and impartial participation in the hearing. If members have any conflicts of interest or have received any communication on a fact or issue made outside the hearing during review of a case, they must place on the record a statement on the nature of the conflict or substance of the communication.

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Parliamentary Procedure

Parliamentary Procedure is a set of rules for conduct at meetings allowing everyone to be heard and to make decisions. Part of any meeting should be a systematic plan for the orderly conduct of business. The sequence in which business is taken up during a meeting is known as the “Order of Business.” The Order of Business is a blueprint for the meeting and typically has the following components.

- The presiding officer should never call the meeting to order until a quorum is present. A quorum is the number of members entitled to vote who must be present in order for business to be legally transacted. Quorum is typically defined in the governing documents. Once a quorum is present, the presiding officer calls the meeting to order by stating, “The meeting will come to order.”
- A roll call of members present is completed.
- In meetings when minutes are to be approved, the minutes are typically distributed to all members. Corrections and approval are normally done by unanimous consent. The presiding officer can ask, “Is there any objection to approving the minutes as read [or distributed].” If there is no objection, the minutes are approved.
- The first substantive item of business in meetings is typically hearing from the officers and established committees.
- The logic in this order of arrangement is to give priority to the items of business from the leadership. Typically, the presiding officer learns in advance who needs to report and only calls on those committees.
- Reports are generally for information only. In such instances, no motion is necessary following the reports unless there are recommendations to be implemented. A motion “to adopt” or “to accept” a report is seldom wise except when the report is to be issued or published in the name of the organization. On the other hand, it is common the reporting member end by making a motion if there is a specific recommendation for action.
- Unlike standing committees established in the governing documents, special committees do not have continual existence. Instead, special committees exist solely for the purpose of a specific project. For example, a special committee might be created to plan a specific function or event. Special committees typically go out of existence upon their final report.
- Unfinished business refers to matters carried over from a previous meeting. This category of business is sometime incorrectly referred to as “old business.”
- Instead, unfinished business items typically fall into one of several specific categories. For organizations meeting at least four times a year, unfinished business may include: (1) any matter pending when the previous meeting adjourned; (2) any matters on the previous meeting’s agenda not reached; or (3) matters that were postponed to the present meeting.
- The presiding officer should know if there are any items to be considered under unfinished business. As a result, the presiding officer should not ask, “Is there any unfinished business?” Instead, the presiding officer should simply state the question on the first item of business. If there is no unfinished business, the presiding officer should skip this category of business.
- Much of the work in a meeting is accomplished during new business. In this category of business, members can introduce any new item for consideration (unless there are notice requirements). In some instances, the presiding officer may be unaware of what items of business will arise under new business. The presiding officer introduces the heading of new business by asking, “Is there any new

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business?" Any member can then introduce new items of business by making a motion and obtaining a second. Following the consideration of each item, the chair repeatedly asks, "Is there any further new business?" This process continues until there are no additional business items.

- In most assemblies the presiding officer can adjourn the meeting without waiting for a motion to adjourn. If all items of business have been considered, the presiding officer can ask, "Is there any further business?" If there is no response, the presiding officer simply states, "Since there is no further business, the meeting is adjourned."
- If custom or tradition requires a motion to adjourn be made, the presiding officer can ask, "Is there a motion to adjourn?" Once the motion is made and seconded, the presiding officer can ask, "Is there any objection to adjourning the meeting? Hearing no objection, the meeting is adjourned."

Process for Making a Motion

There are 4 basic types of motions:

- **Main Motions:** The purpose of a main motion is to introduce items to the membership for their consideration. They cannot be made when any other motion is on the floor, and yield to privileged, subsidiary, and incidental motions.
- **Subsidiary Motions:** The purpose is to change or affect how a main motion is handled, and is voted on before a main motion.
- **Privileged Motions:** The purpose is to bring up items that are urgent about special or important matters unrelated to pending business.
- **Incidental Motions:** The purpose is to provide a means of questioning procedure concerning other motions and must be considered before the other motion.

Here's the typical steps for making a motion:

1. **Obtaining the Floor:** Wait until the last speaker has finished. Rise and address the Chair. Wait until the Chair recognizes you.
2. **Make Your Motion:** Speak in a clear and concise manner. Always state a motion affirmatively. Say, "I move that we ..." rather than, "I move that we do not ...". Avoid personalities and stay on your subject.
3. **Wait for Someone to Second Your Motion:** Another member will second your motion or the Chair will call for a second. If there is no second to your motion it is lost.
4. **The Chair States Your Motion:** The Chair will say, "it has been moved and seconded that we ..." Thus placing your motion before the membership for consideration and action. The membership then either debates your motion, or may move directly to a vote. Once your motion is presented to the membership by the chair it becomes "assembly property", and cannot be changed by you without the consent of the members.
5. **Expanding on Your Motion:** The time for you to speak in favor of your motion is at this point in time, rather than at the time you present it. The mover is always allowed to speak first. All comments and debate must be directed to the Chair. Keep to the established time limit for speaking. The mover may speak again only after other speakers are finished, unless called upon by the Chair.
6. **Putting the Question to the Membership:** The Chair asks, "Are you ready to vote on the question?" If there is no more discussion, a vote is taken.
7. **Voting on a Motion:** The method of vote on any motion depends on the situation and the bylaws or policy of your board. There are five methods used to vote by most boards, they are:

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- ~ **By Voice:** The Chair asks those in favor to say, "aye", those opposed to say "no". Any member may move for a exact count.
- ~ **By Roll Call:** Each member answers "yes" or "no" as their name is called. This method is used when a record of each person's vote is required.
- ~ **By General Consent:** When a motion is not likely to be opposed, the Chair says, "if there is no objection ...". The membership shows agreement by their silence, however if one member says, "I object," the objection will be recorded as long as the required majority does not object.
- ~ **By Division:** This is a slight variation of a voice vote. It does not require a count unless the Chair so desires. Members raise their hands or stand.
- ~ **By Ballot:** Members write their vote on a slip of paper, this method is used when secrecy is desired.

Public Records

With a few exceptions, all government records of any kind are considered public records. There are two definitions for public records:

ORS 192.005(5) defines public record as any information:

- Prepared, owned, used or retained by a state agency;
- Relating to an activity, transaction or function of a state agency; and
- Necessary to satisfy the fiscal, legal, administrative or historical policies, requirements or needs of the state agency.

ORS 192.410(4) states public records include any writing containing information relating to the conduct of the public's business, including but not limited to court records, mortgages, and deed records, prepared, owned, used or retained by a public body regardless of physical form or characteristics.

The public records law applies to every public body, which includes every state officer, agency, department, bureau, board and commission.

Most public records are subject to disclosure, but there are exemptions. For instance, records related to an active criminal investigation or confidential communications between public officials and lawyers. If a public body claims an exemption, it generally must show the need for confidentiality outweighs the public interest in disclosure under the particular circumstances.

Public records include any "writing" containing information relating to the conduct of the public's business. The term "writing" is broadly defined as including every type of documentation. For instance, hand written documents, photographs, computer discs, emails, instant messages, text messages, etc. Even after electronic records are deleted, they continue to exist on computer back-ups which are still public records.

Every board is required to have a written procedure on how to make a public records request. Work with your board administration to familiarize yourself with the procedure.

For more information on the public records law click on the resources tab to view DOJs Public Records and

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Meetings Manual.

Public Meetings

Oregon's public meetings law serves two purposes:

- To provide a means by which the public can be informed about the deliberations and decisions of state government; and
- To ensure governing bodies in Oregon have an open decision-making process.

A public meeting is any meeting conducted by a governing body to decide or consider any matter. For the meeting to be subject to open meeting law, a majority must be present. The public meetings law applies to the governing body of any state agency, regional government, city, county, school district, special district or municipal corporation. It also applies to any subcommittee of these public bodies.

Staff meetings generally are not covered by the public meetings law. If less than a majority is present, the meeting is not covered by the public meetings law. Public meetings may be conducted electronically, but the public must have adequate notice and access to the meeting - no matter how it is conducted. Public bodies must keep a record of their public meetings. Written minutes or audio or video recordings are acceptable. Written minutes must include the members present; all motions, resolutions and other actions; any votes taken; and the substance of any discussion.

For more information on the public meetings law click on the recourses tab to view DOJ's Public Records and Meetings manual.

Executive Sessions

A meeting can be closed to the public if a governing body goes into executive session. The law governing executive sessions is designed to allow a public body to have confidential discussions, but does not allow any decisions to be made in secret. All decisions by a governing body must be made in public. Journalists may attend most executive sessions, but cannot report or broadcast what was said.

Executive sessions should not be confused with meetings exempt from the public meetings law altogether. An executive session is a type of public meeting and must conform to all related provisions of the public meetings law.

The public meetings law provides very specific provisions allowing the governing body of a public body to convene and participate in executive sessions to discuss specific topics when certain conditions and prerequisites are met. The presiding officer must publicly announce the statutory authority or lawful basis for holding the executive session prior to convening the executive session. Topics not covered by one of the stated reasons for the executive session cannot be discussed.

Examples of topics that may be discussed in an executive session include labor negotiations, legal counsel, hiring, disciplining, or firing a public employee. For a complete listing of lawful topics refer to DOJ's Public Records and Meetings Manual in the resources section of this training.

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If you have any questions regarding appropriate topics, certain discussions or the prerequisites for executive sessions you should seek counsel from your board's DOJ attorney.

Module 4 – Operations & Management of Boards, Commissions, and Small Entities

Now let's take a look at common operations and management of a board.

Procurement Authority

A board's procurement authority comes from either its own statutory authority, from a written delegation of authority by DAS, or by DAS Administrative Rule. DAS delegates procurement authority at certain dollar thresholds to agency heads and Designated Procurement Officers. Before purchasing goods or services with taxpayer money, a written document setting out agency authority must be on file. Agencies may be permitted to sub-delegate procurement authority granted by DAS, but the responsibility for operating within the rules remains with the employee to whom authority was granted. Authority and accountability for procurements is delegated to individuals based on the knowledge, skills and abilities of staff assigned to procurement duties. The delegation of authority to procure goods and services is usually tied to thresholds outlined in the procurement statutes or in a tiered delegation assigned to an agency.

Boards must follow:

- Oregon Revised Statutes 279A, B and C;
- Oregon Administrative Rules Chapter 125 and 137; and
- The Oregon Accounting Manual.

Buy Decision Making Process

A board is allowed to enter into intergovernmental or interagency agreements without competitive bidding when it is with another board, state agency, public entity (for instance a city, county, community college, etc.), or the federal government.

If you don't use an intergovernmental or interagency agreement, you must purchase goods and services using these sources in this order.

1. Surplus provides a central repository for the collection, reutilization and, public sale of excess and surplus property and vehicles for all state agencies and public entities. This is the first place a board must look to see if the goods are available.
2. A QRF is a non-profit rehabilitation organization employing individuals with disabilities. QRFs provide services such as janitorial services, recycling services, food and beverage services, temporary staffing services, etc. Boards are required to purchase goods or services from a QRF before going out to the open market.
3. Oregon Corrections Enterprises (OCE) provides inmates full-time work or on-the-job training through the state's correctional institutions. OCE provides goods and services such as furniture, office seating, signs, park equipment, printing services, call centers, laundry services, etc. Boards are required to purchase goods or services from OCE before going out to the open market.

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4. All boards are required to purchase needed goods and services from the DAS contracted price agreements when other steps in the “Buy Decision” do not yield results. A board may purchase services or supplies from a price agreement without further competition. Most commonly used products and services are found on the price agreements.
5. This is the fifth and final source selection method. This means going out for bid or a request for proposal from private firms. Minority, Women and Emerging Small Businesses (MWESB) are included in the open market procurement process. MWESBs must be included when getting quotes for a project, but they are not given preference in award of contracts.

If a board goes out to the open market you must consider the following.

Contracts valued between \$10,000 and \$150,000 must be competitively solicited. Boards have the authority to conduct intermediate procurements for these goods and services and must advertise them using the Oregon Procurement Information Network.

Contracts with a value exceeding \$150,000 must receive legal sufficiency approval from DOJ. This review is intended to ensure contracts contain all the elements to make the agreement legally binding. Legal sufficiency review does not ensure the board is making a good business decision.

Notice of all contracts with a value exceeding \$10,000 must be provided to the Advocate for Minority, Women and Emerging Small Business which can be done through posting the solicitation on the Oregon Procurement Information Network.

Boards must submit a procurement request to DAS for personal services, trade services and commodities exceeding \$150,000 and construction contracts exceeding \$100,000.

Purchasing in the Open Market

When you need to go to the open market here are the mechanisms used to purchase goods and services.

A request for quote is an informal process used to get pricing information.

An invitation to bid is an intermediate or formally advertised solicitation. This process is intended to ensure the contract is awarded to the lowest responsible bidder.

A request for proposal is an advertised intermediate or formal solicitation. This process is intended to ensure that the contract is awarded to the most qualified company based on evaluation factors other than cost. Including negotiated Best Value contracts for information technology projects.

An emergency procurement is used when a circumstance could not reasonably be foreseen and creates a substantial risk of loss, damage, interruption of services, or threat to public health or safety. When an emergency takes place, the chief executive or another duly authorized person must prepare a written declaration. An agency must keep a written record of the competition process used to award contracts. Agencies must get quotes when possible for all procurements.

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A sole source procurement is used on very rare occasions when there is only one source or provider for the needed item or service.

Special procurements are an exempted process is used when determined competition will not be harmed and the state will realize substantial savings. The DAS Chief Procurement Officer must approve all special procurements in advance. Forms to apply for a special procurement may be found on the Oregon Procurement Information Network.

Contract Types

There are five contract types commonly used to acquire goods and services.

1. Trade services contracts are usually industry standard, easily definable skills associated with a trade. For example, an electrician, a plumber, etc.
2. Goods contracts are for consumable products, equipment, and materials; these are often found on price agreements established by DAS. For example, office supplies, computers, cars, etc.
3. Personal services contracts require specialized skills, knowledge and professional judgment. For example, a lawyer, an interpreter, etc.
4. Public improvement contracts are projects for construction, reconstruction, or major renovation on state-owned real property. Public works contracts fall under public improvements, but have separate rules and usually are used to repair or update existing structures. A public works contract does not always qualify as a public improvement project.
5. Information technology contracts are projects requiring hardware, software and associated services. Many IT projects must be reviewed by the DAS Chief Information Office prior to being implemented.

Contract Administration

Following the award of a contract, contract administration is the management actions to be taken to assure full compliance with all of the terms and conditions contained within the contract. Before administering a contract you need to determine the who, where, when and how the contract will be administered.

- You will need to determine who will provide oversight of the project, services or deliverables.
- You will need to determine who and how will the work be reviewed and progress monitored.
- You will need to determine who review and match deliverables to the contract payments.
- You will need to determine who will approve bills and invoices.
- Who and how will changes and amendments to the contract be managed.
- All actions must be documented in the procurement files. The procurement files also must be properly maintained and retained according to the retention schedule.
- You will need to determine who and how you'll perform compliance reviews.

Amendments

If you need to make any changes to a contract make sure to do the following:

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- Review the original solicitation and contract to ensure the changes are still within the scope of the procurement.
- Review prior amendments.
- Check your budget in the event there will be a fiscal impact.
- Make sure the contract is not at term and can't be amended.
- Use the amendment process to update anything in the contract needing to be addressed such as timelines or delivery schedules.
- If an amendment will alter the terms or conditions of the contract substantially, consult with DOJ prior to authorizing the amendment.
- Do not sign off on amendments unless you are sure they are in order - check with your Designated Procurement Officer before signing contract documents.

Human Resources

Authority for work is defined by statute. Each agency has an enabling statute identifying the authority and responsibility of the entity. New or significantly augmented positions or work are requested through policy option packages which are analyzed by both DAS and the Legislative Fiscal Office before they can go forward for legislative action. This analysis includes review of a written business case for the need, position descriptions, and fiscal analysis. Positions are authorized by the legislature.

OAR 105-040-0040(1) provides each agency head the authority to recruit and fill positions. According to ORS 240.015, an officer who has the power to make appointments is called an Appointing Authority. The authority to make appointments to positions comes after a position has been established.

ORS 240.400 allows an Appointing Authority to assign delegates with written notice to DAS - Chief Human Resources Office. The signature of an Appointing Authority on the position description form gives permission for the work to be done.

DAS - CHRO is governed by ORS 240 and is tasked with overseeing state agencies' human resources functions. CHRO provides enterprise-wide policy leadership. CHRO develops and maintains statewide HR policies, administrative rules, and assists state agencies with HR management. These policies apply to most executive branch agencies that are subject to ORS 240, the State Personnel Relations statutes. There are several semi-independent agencies that are excluded (ORS 182.454). CHRO provides interpretation and recommendations on application of the rules and policies.

If an agency doesn't have an internal human resources office, they can contract with DAS to provide human resource services for the agency.

Agency human resource offices are responsible for interpreting and administering state and federal human resource laws, rules, and policies for the employees of their agency. The role of HR includes strategic planning, facilitating change, encouraging learning, and integrating HR functions into the management of the agency and its programs.

DAS - CHRO has an executive recruiter who is responsible for recruiting agency directors for the executive

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branch and to support boards that are DAS clients by recruiting for executive directors for the board.

Board seats are volunteer positions and have an average expectation of approximately 10-15 hours of work per month. However, members may be eligible to receive reimbursements and per diem for the time serving on the board.

Board members, who are appointed by the Governor, are prohibited from being a paid employee by the board while serving. In addition, they are not able to be employed by that board for one year after their term expires. (ORS 236.145)

Time and Attendance

Paychecks, leave balances, and benefits depend on accurate time and attendance records. Payroll transactions are no different than any other board expenditure, requiring the same application of internal controls. Therefore, review and approval of the time records is critical.

Time records not being reviewed and authorized may introduce incorrect data into the state payroll and accounting systems and cause unauthorized expenditures of state funds. If you are responsible for reviewing and authorizing time records and fail to do so it is considered an inappropriate action and board management can apply penalties according to the Oregon Accounting Manual.

If you are expected to report your time and attendance make sure it is accurate. If any changes occur make note of it immediately so you won't forget to update your records before submitting them.

Managers are expected to review all time reported for accuracy and appropriateness. A manager's signature or time locking verifies approval of time. If there is a revision made to an employee's time by someone else, for instance payroll or their manager, the employee must be informed of the changes made.

For more information refer to the Oregon Accounting Manual Policy 45.07.00 located in the resources section of this training.

Fair Labor Standards Act

The Fair Labor Standards Act (FLSA) is a federal statute. FLSA establishes the federal minimum wage and the 40-hour work week; sets overtime to be paid at time and one-half; and regulates the exemptions to the 40-hour work week and over time rule.

The 40-hour work week is defined by state policy and the Department of Labor as a fixed, regular recurring period of 168 hours during seven consecutive 24-hour periods or days.

Certain workers are not covered by FLSA. These non-covered workers include elected officials and their staffs, political appointees and legal advisors, volunteers, independent contractors, and prison inmates. Other employees, while covered by some provisions of the FLSA, are not covered by the overtime and minimum wage requirements. They are "exempted" from such coverage.

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Non-exempt employees are paid overtime compensation when they have worked in excess of the established 40-hour work week. There are exceptions to this for jobs such as firefighters, police officers, certain hospital employees, and articles in collective bargaining agreements may be more generous. All time worked by an employee under FLSA must be paid for even if the time was not authorized by the employer.

Managers must ensure the FLSA, state wage and hour, and collective bargaining obligations are all met. If violated, FLSA penalties may include back wages, liquidated damages, civil penalties, injunctive relief, and even criminal penalties.

The Oregon Accounting Manual

The Oregon Accounting Manual (OAM) provides a comprehensive set of policies and procedures to assist with financial transactions in accordance with generally accepted accounting principles, federal regulation, and the Internal Revenue Service requirements.

When boards develop internal procedures to implement standards or guidelines contained in the OAM, those procedures should be consistent with OAM provisions. Boards may, at their discretion, adopt procedures more restrictive than the requirements of the OAM.

Internal Controls

Proper segregation of responsibilities is a necessary condition to make control procedures effective. Management should ensure adequate separation of authorization for the execution of transactions, recording of transactions, custody of assets, and periodic reconciliation of existing assets to recorded amounts.

All transactions are supported by copies of source documents such as vendor invoices, cash receipts, or time sheets. This documentation must be detailed to provide clear evidence of the transaction.

Receipts or invoices must be itemized to show specific transaction.

- A restaurant receipt must indicate the itemized purchases and not the total bill.
- A vendor invoice must have the details of the purchases.

OAM policy 10.90.00.PO sets control standards for the authorization of agency head transactions such as time reporting, travel reimbursements, and state credit card purchasing.

Mid to large sized agencies who have a deputy director or CFO position are authorized to approve agency head transactions.

Many smaller agencies do not have a deputy director or CFO position required to approve agency head transactions. In these cases, board members will be required to approve agency head transactions.

Overview of Boards, Commissions, & Small Entities

Online Training

An agency head is authorized to make expenditure decisions by statute and legislative appropriation. An agency head may delegate **expenditure decision authority** to subordinates, in writing. Any person who exercises expenditure decision authority will be legally responsible and accountable for the expenditure.

Specific individuals with expenditure authority may have limits placed on their expenditure approvals, which vary depending on agency needs. For example, an agency director and board chair may have spending authority for all fiscal transactions, mid-level management at \$50,000 and an office staff up to \$5,000.

Many agencies will have certain board members with expenditure authority, in cases where the agency head is unavailable or to sign for agency head transactions.

Stipends & Travel

Board members may be eligible to receive a stipend for attending regular board meetings and other official board activities. In addition, board members may be eligible for travel and meal reimbursements.

Stipends are outlined in state law and can vary for each board. For travel, the General Services Administration (GSA) publishes annual per diem rates for meals, lodging, and mileage.

Board members who travel on business for the state, must follow the policies set forth by the GSA, the Oregon Accounting Manual, the state travel policy, and any internal travel policies. Contact your board administration for more information.

SPOTS Card

The SPOTS card is a state-sponsored credit card boards may use to buy certain goods and services. The SPOTS card program saves the state time and money because the bank and merchants process most of the paperwork, as well as provide purchase rebates. Agency heads may appoint a SPOTS approving officer. The approving officer selects employees to use SPOTS cards and also selects a SPOTS coordinator who monitors the program within the agency.

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Introduction

This training covers the following topics:

- Key definitions
- Who is considered a public official
- Use of position or office
- Private employment of public officials
- Conflicts of interest
- Gifts
- Nepotism

This training is intended to provide public officials with an overview of the Oregon government ethics laws, it does not and cannot override state law, administrative rules, policies, or procedures. While the intent is to periodically update the material to comply with applicable laws and rules it is incumbent upon you to use the current and effective laws, rules, policies and procedures. Where in conflict, the applicable law, rule, policy or procedure takes precedence over information contained in this training.

For purposes of this training we will be using the term public entity to refer to any city, county, state agency, special district, government body, public body, public agency etc.

The provisions in the ethics laws restrict some choices, decisions or actions of a public official. The restrictions placed on public officials are different than those placed on private citizens because service in a public office is a public trust and the provisions in ORS 244 were enacted to provide one safeguard for that trust.

Overview of OGEC

The Ethics Commission is a seven-member citizen commission charged with enforcing and implementing the ethics laws.

- ORS 244 relates to the conduct of public officials prohibiting use of office for financial gain and requiring public disclosure of economic conflict of interest;
- ORS 171.125 through 171.992 relates to lobbying regulations requiring lobbyists and the entity's they represent to register and report expenditures; and
- ORS 192.660 relates to the executive session provisions in the public meetings law.

Responsibility

You might not have known, but there are approximately 200,000 public officials in Oregon. You are a public official if you are:

- Elected or appointed to an office or position with a state, county, city government, or special district.
- An employee of a state, county or city agency or special district.
- An unpaid volunteer for a state, county or city agency or special district.
- Anyone serving the State of Oregon or any of its political subdivisions, such as the State Accident

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Insurance Fund or the Oregon Health & Science University.

As a public official you are held personally responsible for complying with the provisions in the ethics laws. This means you must make a personal judgment in deciding such matters as the use of official position for financial gain, what gifts are appropriate to accept, or when to disclose conflicts of interest. If you fail to comply with the ethics laws, a violation cannot be dismissed by placing the blame on the public entity that you represent. In addition to the ethics laws your public entity may have policies and procedures that are more restrictive.

Use of Position

The ethics law prohibits you from using or attempting to use the position you hold as a public official to obtain a financial benefit, if the opportunity for the financial benefit would not otherwise be available but for the position held by you. The financial benefit prohibited can be either an opportunity for gain or to avoid an expense.

If any one of the following elements apply to a volunteer position, the person holding that volunteer position is a public official:

- Responsible for specific duties.
- The duties are performed at a scheduled time and designated place.
- The volunteer is provided with the use of the public entity's resources and equipment.
- The duties performed would have a financial impact on any person, business or organization served by the public entity.

This list is not exhaustive, contact the Ethics Commission if you have any questions.

There are provisions in the ethics law that may restrict or prohibit:

- A public official from using or attempting to use official actions of the position held to benefit a relative or household member;
- The value of financial benefits accepted by a relative or household member of the public official; and
- Require the public official to disclose the nature of a conflict of interest when a relative may receive a financial benefit.

The same sound judgment you exercise when participating in actions that could result in a financial benefit for you or your relative should be used when participating in actions that could result in a financial benefit to a business with which you or your relative is associated.

There are provisions in ORS 244 that restrict or prohibit you from using actions of the position held to benefit a business with which you or your relative is associated. The provisions may also require you to disclose the nature of a conflict of interest when a business may receive a financial benefit.

Confidential Information

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As a public official you often have access to or manage information that is confidential and not available to the general public. The ethics law specifically prohibits you from attempting to use confidential information gained because of the position you hold or by carrying out assigned duties to further your own personal gain.

The ethics law also prohibits a former public official from attempting to use confidential information for their own personal gain or others if that information was obtained while holding the position as a public official, from which access to the confidential information was obtained.

OAR 199-005-0035(5) "Confidential Information"

Actions that can be Prohibited

There are a variety of actions a public official may take or participate in that could be prohibited. The use of a position could be voting in a public meeting, placing a signature on a public entity's document, making a recommendation, making a purchase with a public entity's funds, conducting personal business on a public entity's time or resources in which you, a relative, member of your household, or business with which either are associated would receive a financial benefit that would not otherwise be available but for you holding your position as a public official.

Prohibited gains can be obtaining a financial gain or a benefit with a monetary value or avoiding an expense and they do not have to result in any cost for the public entity.

Financial Benefits

The following financial benefits are not prohibited and may be accepted some may also be accepted by your relative or a member of your household. [ORS 244.040(2)]

Official Compensation: You may accept any financial benefit that is identified by the public entity you serve as part of your official compensation package. If the public entity identifies such benefits as salary, health insurance or various paid allowances in the employment agreement or contract, those financial benefits are part of the your official compensation package. [ORS 244.040(2)(a)]

Reimbursement of Expenses: You may accept payments from your public entity for reimbursement of expenses that you personally paid for while conducting the public entity's business. [ORS 244.040(2)]

Honorarium: A payment or something of economic value given to you in exchange for services that you provide is an honorarium when the setting of the economic value has been prevented by custom or propriety. You are allowed to accept an honorarium as long as the value does not exceed \$50. Make sure you know how an honorarium is defined because there are many occasions when someone will offer you a financial benefit and call it an honorarium, but it does not meet the definition of honorarium. The services you provide may include but not be limited to speeches or other services provided in connection with an event. [ORS 244.040(2)(b)]

Awards for Professional Achievement: You may accept an award, if you did not solicit the award, and the

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award is offered to recognize a professional achievement you made. [ORS 244.040(2)(d)]

Legal Expense Trust Fund: A public official may establish a legal expense trust fund if the public official incurs or reasonably expects to incur legal expenses. Proceeds from the trust fund may be used by the public official to defray legal expenses incurred by the public official in any civil, criminal or other legal proceeding or investigation that relates to or arises from the course and scope of duties of the person as a public official. [ORS 244.205]

Gifts: You may accept gifts that do not exceed the limits specified in ORS 244.025. There are circumstances in which there are no limits on the quantity or aggregate value of gifts that you can accept. On the other hand, there are circumstances when the aggregate value of gifts you accept is restricted. There may also be reporting requirements that apply when you accept gifts.

Employment

The ethics law does not prohibit a public official from owning a private business or working for a private employer while continuing employment with or holding a position with a governing body.

Many public officials are volunteers, meaning there is little or no compensation for the public position. Other public officials may receive compensation, but choose to seek additional sources of income. Some work for a private business and others establish a private business of their own.

You are prohibited from, directly or indirectly, soliciting or accepting the promise of future employment based on the understanding that the offer is influenced by your vote, official action, or judgment. Any employer who may directly or indirectly offer employment under these conditions may also violate this provision.

In general, you may obtain employment with a private employer or engage in private income producing activity of your own. You must not use the position you hold as a public official to create the opportunity for additional personal income. You must also ensure that there is a clear distinction between the use of personal resources and time for personal income producing activity and the use of the governing body's time and resources.

The ethics law restricts the subsequent employment of certain public officials. For instance the Director of the Oregon State Lottery, Deputy Attorney General, State Treasurer. For a detailed listing and what the restrictions are, visit the Guide for Public Officials on the Resources tab in this training.

A person who no longer holds a position as a public official may not have a direct beneficial financial interest in a public contract, for two years after authorization of the contract if the contract:

- Was authorized by the public official, in their former capacity as a public official.
- Was authorized by a governing body that the former public official was a member of when the contract was authorized.

Here are guidelines to follow in order to avoid violating the ethics law when engaged in private

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employment or a personally owned business.

- Use no governing body time
- Use no governing body resources
- Take no official action that could financially impact your private enterprise
- Use no confidential information obtained through your position as a public official
- Disclose all conflicts of interest

Conflict of Interest

The difference between an actual conflict of interest and a potential conflict of interest is determined by the words “would” and “could.” You are met with an actual conflict of interest when you participate in an action that **would** affect the financial interest of yourself, your relatives, or a business with which you or your relative is associated.

You are met with a potential conflict of interest when you participate in an action that **could** affect the financial interest of yourself, your relatives, or a business with which you or your relative is associated.

Conflicts of interest have three components:

An action, decision, or recommendation made in the individual’s official capacity which causes a private financial benefit or detriment for the public official, the public official’s relatives, or a business associated with the public official or the public official’s relative.

If you or your relative has an economic interest in a business, you must be constantly aware of whether that business entity is involved in or affected by your official actions, decisions or recommendations. If such a business is directly or indirectly involved, a conflict of interest is possible.

Questions to ask when faced with a conflict of interest.

- Will the action, decision or recommendation have a financial effect on you, your relative, or a business with which either are associated?
- Is the impact of the action, decision or recommendation on your economic interest certain? Is it direct or indirect?

If you encounter an actual or potential conflict of interest you will need to disclose it. This is how the different public officials disclose a conflict of interest:

- Legislative Assembly Member: Members must announce the nature of the conflict of interest in a manner pursuant to the rules of the house in which they serve. The Oregon Attorney General has determined that only the Legislative Assembly may investigate and sanction its members for violations of conflict of interest disclosure rules.
- Judges: Judges must remove themselves from cases giving rise to the conflict of interest or advise the parties of the nature of the conflict of interest.
- Public Employees: Public employees must:
 - Provide a written notice to the person who appointed or employed them before participating in any discussion or taking any action on the matter.
 - In the notice describe the nature of the conflict of interest.

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- The written notice needs to be made on each occasion the conflict of interest is met.
- Maintain a copy of the notice in your own records. [ORS 244.120(1)(c)]
- Elected Official or Appointed Board Member: When met with a potential conflict of interest, announce publicly the nature of the potential conflict prior to taking any action in the capacity of a public official; or When met with an actual conflict of interest, announce publicly the nature of the actual conflict and refrain from participating as a public official in any discussion or debate on the issue out of which the actual conflict arises or from voting on the issue. If any public official's vote is necessary to meet a requirement of a minimum number of votes to take official action, be eligible to vote, but not to participate as a public official in any discussion or debate on the issue out of which the actual conflict arises.

If you are a manager or appointing authority for a public entity and you receive notice of a conflict of interest you must make sure the notice is recorded in the public entity's official records. You must respond to the written conflict of interest notice by either assigning someone else to that task or by instructing the person on how to take care of the matter. This response should be in writing.

Gifts

In some circumstances there are restrictions on the monetary value of gifts you are allowed to receive. The ethics law establishes a framework of conditions for you to apply when you, your relatives, or members of your household are offered gifts. If offered a gift, you must analyze the offer and decide if "something of value" can be accepted with or without restrictions. In addition to the ethics laws your public entity may have policies and procedures that are more restrictive on whether or not gifts may be accepted.

You are directly and personally responsible for understanding the circumstances when the aggregate value of gifts may be restricted.

In order to determine if the ethics law places restrictions on a particular gift, you must know:

- Whether the gift meets the definition of a gift as defined in ORS 244.020(6)(a);
- Whether the gift meets any of the exceptions defined in ORS 244.020(6)(b);
- Who is the source of the gift; and
- If that source has any legislative or administrative interest in the public official.

If the source of a gift has a legislative or administrative interest, any gift offered to you, your relative, or a member of your household, may only be offered and accepted under certain conditions. If however the source of a gift does not have a legislative or administrative interest, gifts are not restricted or prohibited. ORS 244.020 identifies 16 exceptions for certain kinds of gifts that are allowed without limit under specific conditions. Make sure to look at the statute before accepting any gifts.

With regard to gifts, the phrase "distinct from that of the general public" refers to a distinct economic interest held by the source of a gift. That economic interest is in the financial gain or loss that could result from any votes cast or decisions made by a public official. If the source of a gift could reasonably be expected to realize a financial gain or detriment from a vote or decision of a public official, that source

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has an economic interest in that public official.

1. First, make sure you know the identity of the source of the gift. Remember, the source of a gift is the person or entity that made the ultimate payment for the gift's expense.
2. Second, determine if the source of the gift has an economic interest in decisions or votes you make in your official capacity as a public official. If that economic interest is distinct from the interest held by members of the general public it is a legislative or administrative interest.
 - a. If the source does not have a legislative or administrative interest, gifts from that source are not prohibited or limited as to value or quantity.
 - b. If the source has a legislative or administrative interest, you must answer the following questions:
 - c. Is the gift offered under the conditions that would allow you to accept the gift because it is excluded from what is defined as a "gift"?
 - d. What is the value of the gift? Remember, you can accept gifts from a single source when the aggregate value of gifts from that source does not exceed \$50 in a calendar year.

Annual Verified Statement of Economic Interest

There are approximately 5,500 Oregon public officials who must file an Annual Verified Statement of Economic Interest with the Ethics Commission by April 15 of each calendar year. Refer to ORS 244.050 to determine if your specific position requires you to file.

Nepotism

Public officials cannot participate in any personnel action taken by the governing body that would impact the employment of a relative or member of the public official's household. This includes appointing, employing, promoting, discharging, firing, demoting, or interviewing.

If you are assigned duties that include performing "ministerial acts" related to any stage of a relative's or member of your households employment you are not prohibited from performing such acts. "Ministerial acts" would include mailing or filing forms or correspondence, taking and relaying messages, scheduling appointments or preparing documents and minutes for public meetings.

If you have a relative or a member of your household who has applied to be or serves as an unpaid volunteer, you may participate in any personnel action that involves the relative or member of the household.

Closing

This training covered key definitions, who is considered a public official, use of position or office, conflicts of interest, how determine what gifts can and cannot be accepted, nepotism, and private employment of public officials.

Boards and Commissions Best Practices Measure

1. What's this about?

Department of Administrative Services (DAS) and the Legislative Fiscal Office (LFO) were given a joint budget note for 2005-07 asking them to develop best management practices performance measures to be applied to governance boards and commissions. A recommendation was submitted to and approved by JLAC in July, 2006. In 2007-09 the Legislature added it to all governing Boards and Commissions.

2. What's the measure?

The approved measure is "percent of total best practices met by the board." The measure is calculated as the percent of "yes" responses provided in a self-assessment of best practices. The Self-assessment Guidance that lists 15 best practices is provided in the recommendation. Applicable boards/commissions will need to conduct annual self-evaluations to gather information to report on the measure.

3. Who is impacted?

The requirement is being applied to boards and commissions that meet the following criteria:

- The board/commission has an independent state budget or is included in another state agency's budget.
- The board/commission hires the agency or board's executive director.

These criteria focus on governing boards/commissions. A complete list of applicable boards/commissions is provided in the recommendation.

4. How often do we report on this measure?

Yearly

Standard Measure – Percent of best practices met by the Board and/or Commission

Self-Assessment/Best Practices Criteria

1. Executive Director's performance expectations are current.
2. Executive Director receives annual performance feedback.
3. The agency's mission and high-level goals are current and applicable.
4. The board reviews the *Annual Performance Progress Report*.
5. The board is appropriately involved in review of agency's key communications.
6. The board is appropriately involved in policy-making activities.
7. The agency's policy option packages are aligned with their mission and goals.
8. The board reviews all proposed budgets (likely occurs every other year).
9. The board periodically reviews key financial information and audit findings.
10. The board is appropriately accounting for resources.
11. The agency adheres to accounting rules and other relevant financial controls.
12. Board members act in accordance with their roles as public representatives.
13. The board coordinates with others where responsibilities and interests overlap.
14. The board members identify and attend appropriate training sessions.
15. The board reviews its management practices to ensure best practices are utilized.
16. Others

Totals

Percentage of Total

bestpracticetraining_2008-1.ppt [Read-Only] [Compatibility Mode] - Microsoft PowerPoint

File Home Insert Design Transitions Animations Slide Show Review View PDF Architect Acrobat

Clipboard Slides Font Paragraph Drawing Editing

Overview of Best Practices

Self Assessment Best Practices List

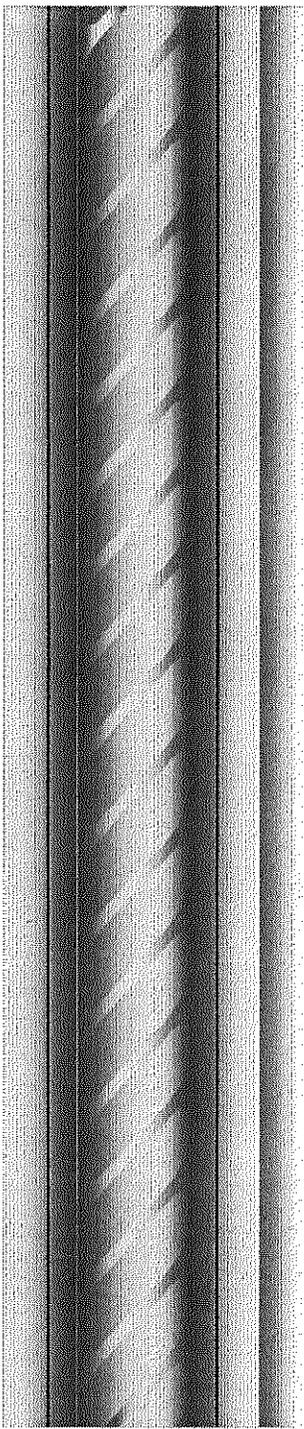
Best Practices Criteria	Yes	No
1. Executive Director's performance expectations are current.		
2. Executive Director receives annual performance feedback.		
3. The agency's mission and high-level goals are current and applicable.		
4. The board reviews the <i>Annual Performance Progress Report</i> .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

Slide 4 of 11 Layers 111%

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

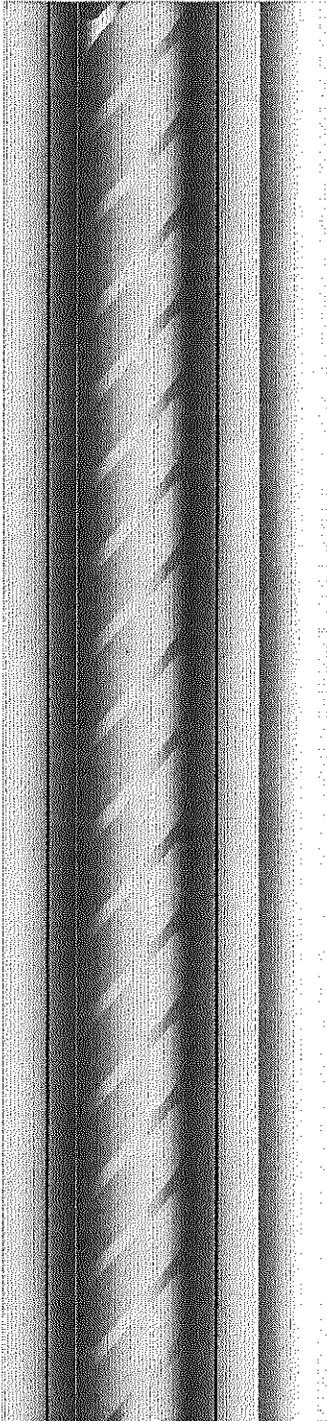
Best Practices Criteria
<p>1. Executive Director’s performance expectations are current.</p> <ul style="list-style-type: none"> • Goals and expectations for the Executive Director are reviewed annually.
<p>2. Executive Director receives annual performance feedback.</p> <ul style="list-style-type: none">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

<p>12. Board members act in accordance with their roles as public representatives.</p> <ul style="list-style-type: none"> • Board members appropriately recuse themselves from cases which create an actual or potential conflict of interest. • The Board follows public meetings and records laws. • The Board uses good judgment in upholding the Board’s Mission Statement of Protecting the Citizens of Oregon.
<p>13. The Board coordinates with others where responsibilities and interest overlap.</p> <ul style="list-style-type: none"> • Board members and staff participate in appropriate professional associations. • The OBD works with the OHSU School of Dentistry on certain issues. • The OBD works with the ODA, ODHA and ODAA and DBIC to present important practice related issues to members. • The OBD is actively involved in the American Association of Dental Board (AADB) and regional testing agencies.
<p>14. The Board members identify and attend appropriate training sessions.</p> <ul style="list-style-type: none"> • New Board members attend new Board member orientation presented by OBD Staff. • Board members utilize the Governor’s Board Training.
<p>15. The Board reviews its management practices to ensure best practices are utilized.</p> <ul style="list-style-type: none"> • On an annual basis.



Board Member Role

- **Review information objectively**
- **Potential and actual conflicts;**
- **Put them on the record/minutes**
- **Recusal; cannot be objective or a perception of non objectivity**
- **Better safe than sorry; recuse!**
- **Not play favorites; or out to get someone**



Board Member Role

- **Outcomes; licensee can make an issue in a case and cause agency liability;**
- **Don't talk to the Licensee even if you are recused; can create issue for agency**
- **Remember; you are the final decision maker not the investigator**

Your Job is Public Protection, NOT Professional Protectionism

No. _____

In the Supreme Court of the United States

THE NORTH CAROLINA STATE BOARD
OF DENTAL EXAMINERS,

Petitioner,

v.

FEDERAL TRADE COMMISSION.

Respondent.

On Petition For A Writ Of Certiorari
To The United States Court Of Appeals
For The Fourth Circuit

PETITION FOR A WRIT OF CERTIORARI

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Avoid Any Financial Gain From Your Position As a Board Member.

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3 Former Portland parking manager Ellis McCoy pleads guilty in public corruption case

By Bryan Denson | bdenson@oregonian.com
Email the author | Follow on Twitter
on August 29, 2012 at 10:30 AM, updated August 29, 2012 at 12:37 PM

10 Tweets



Photo: Mike Hooten/The Oregonian 2012

Former Portland parking manager Ellis McCoy pleaded guilty Thursday morning in a downtown courtroom to taking bribes, filing false income tax returns and conspiring to pay and accept bribes.

McCoy admitted to U.S. District Judge Marco Hernandez that he steered multimillion-dollar city contracts to executives at two parking meter companies as a senior executive at one of the outfits paid for him to vacation in Las Vegas and Pebble Beach, Calif.

The judge accepted McCoy's guilty plea.

The former parking manager, who oversaw day-to-day operations of the city's smart-meter parking program, also faced allegations that he accepted partially or fully paid

The Pact



Can faith and football lead two friends out of a rough Portland neighborhood?

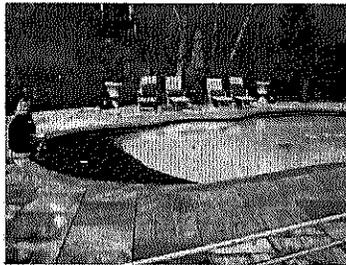
- Now 2,000 miles apart, former Roosevelt High School football stars' bond remains strong
- Jacoby Ellsbury, Darin Ainge among famous Moscow athletes to come out of Oregon high schools
- Tongans in Portland are close-knit and enthusiastic, but face stark realities

Don't Speak or Act on Behalf of the Board, Unless Specifically Board Approved

14 Bundy family fights West Linn to keep their backyard pool

By Eborsten Bailey Jr. | ebailey@oregonian.com
 Email the author | Follow on Twitter
 on Apr. 08, 2011 at 6:05 PM, updated April 09, 2011 at 7:05 PM

- 11
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Eborsten Bailey Jr./The Oregonian
 Gina Bundy (inset) and her husband Troy, of West Linn, say the city is asking her to remove their swimming pool because it's built in a wetland area. The Bundys said they tried to build the pool in 2009, without a city permit, after then-mayor Paul Galle told them it was OK to do so.

WEST LINN -- A local family's decision to install a swimming pool in their backyard has led to an almost two-year dispute with the city over wetland protection.

Troy and Gina Bundy, of Ninth St. in West Linn, say the city insists that they remove their 1,100-square-foot pool and patio and other associated backyard improvements because their property sits between two wetland areas.

They said they installed the pool in 2009 without a city permit after being told by then-mayor

Paul Galle that it would be all right. They said they intended to get the permit after the fact, considering it a formality.

When they applied for the permit, however, both the city planner director and city council denied the application.

The Land Use Board of Appeals upheld the city's decision in March. The Bundys have recently taken their grievance to Oregon Court of Appeals and say they are considering suing the city.

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Michael Bamesberger, The Oregonian

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West Linn Essentials



My West Linn' public blog

A place to connect, inform, celebrate and engage your neighbors. Write your post west linn. West Linn Resources



Understand and respect limits of Board's authority. Just because it's a good idea for the public doesn't automatically mean it's within this Board's authority.



Model Code of Conduct

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Model Code of Conduct for Board Members of the Licensed Professions

At its Leadership Conference in July 1998, which focused on ethics, the Federation of Associations of Regulatory Boards (FARB) noted that many professions have developed ethical codes for their practitioners. However, the Conference also noted the absence of any parallel document guiding the work of the regulators of those professions. Therefore, the leadership of FARB authorized the drafting of a model code of ethics for members of regulatory boards for the licensed professions.

Since the idea was generated by the attending representatives of the Federation of Chiropractic Licensing Boards (FCLB), that organization was requested to take the lead on the model code project. The FCLB member boards adopted a working version of the *Model Code of Ethics for Members of Regulatory Boards for the Licensed Professions* in April 1999 at their annual meeting.

Subsequently, the document was presented to FARB's November 2000 Attorney Certification program for input from representatives from the regulatory community's legal team from the offices of the attorneys general for a number of US jurisdictions. Continued presentations to FARB's regulatory constituency are ongoing, to ensure that the final published document will reflect the most current legal and ethical standards.

As a model, the Code is intended to be considered for adoption or adaptation by individual regulatory boards or their umbrella agencies and for use by the governors or other appointing bodies as they consider appointments to regulatory boards.

The purpose of the Code is to instill and assure the public's trust and confidence in its regulatory boards for the licensed professions.

That trust must embrace the integrity of the people who serve on those boards, including the qualifications for public service that attracted their appointment.

At its essence, the Code is a set of expectations held by the regulatory authority for each profession that can help guide individual board members in their decision-making. It can also support the recruitment and selection of members for the regulatory boards by providing a mechanism for rating nominees to a board. Conversely, the Code can also provide a rationale for the removal of board members whose service does not meet expectations or is otherwise unacceptable.

In general, while in and of itself such a code does not carry the force of law, it may be used to provide practical detail to law, rules or regulations that address ethics and other areas pertinent to board service.

For any code to attract widespread understanding and acceptance, it must be founded on clear elements that unequivocally define and further its purpose. Given the purpose of the Code as assuring public trust in professional regulation, the following principles are presented as a foundation on which the Code was drafted and from which it may be modified to reflect changing circumstances.

Founding Principles

- The mission of a regulatory board for a licensed profession is to ensure that the public will have access to competent, safe, and ethical practitioners in the profession.
- Members of a regulatory board must familiarize themselves with the laws, rules, regulations, policies, and procedures that govern their service on the board.
- The work of regulatory boards for the licensed professions is public service, not private interest or group advocacy.
- Performance of public service is a bestowed privilege, not an earned or inherited right, thus, all who serve do so at the pleasure of their appointing authority.
- Regardless of whether a member of a regulatory board for a licensed profession is a licensee in that or some other profession, a consumer, or any other type of member, it is essential for each board member to represent the public; that is, all of the people.
- Members of regulatory boards must strive beyond the norm to avoid any actual or perceived conflict of interest that may compromise the integrity of the board.
- Members of regulatory boards must strive beyond the norm to avoid any relationship, activity or position that may influence, directly or indirectly, the performance of his or her official duties as a board member.

The Code presents expectations for public service by members of regulatory boards for the licensed professions in four areas:

- 1) Personal Qualities
- 2) Board Decisions and Actions
- 3) External Activities and Relationships
- 4) Accountability

1) Personal Qualities:

Personal qualities form the composite qualities of any group. Therefore, the recruitment and selection of group members is tantamount to the group's fulfillment of its purpose. Members of regulatory boards must personify a set of qualities particularly and conspicuously consistent with public service.

This section of the Code describes that set of personal qualities identified by regulators as those most likely to instill and assure the public's trust and confidence in its regulatory boards for the licensed professions.

2) Board Decisions and Actions:

Board decisions and actions must always be in the interest of the public; that is, for the common good, not just for the good of some.

A board whose decisions and actions benefit the profession at the expense of the consumer or other groups cannot sustain public trust or confidence in its work. Eventually, the purpose of such a board will be revealed, not as protection of the public, but as protection of the profession. Actual or perceived, such a purpose is not merely inappropriate for a public regulatory body, but may be in violation of statutes governing the activity of such bodies.

Also, the processes by which regulatory boards make their decisions and take their actions should be matters of public record and, in many jurisdictions, are subject to open meetings laws.

This section sets forth expectations that may reasonably be held by the public for the activities of its regulatory boards for the licensed profession.

3) External Activities and Relationships:

In most cases, the external activities and relationships of members of any group have the potential for enriching the contributions of the group's members. However, governmental bodies constituted in law for the good of the general public must function in accordance with their statutory purpose. Moreover, their ability to function must be free from any influence external to the group, be it personal, financial, or otherwise that may conflict with the achievement of the statutory purpose.

As governmental bodies constituted for public protection, regulatory boards for the licensed professions must exercise uncommon caution to avoid, declare and reconcile any actual or apparent conflicts of interest or affiliations of their members. In this regard, members of regulatory boards for the licensed profession are held to a higher standard of service than members of many other groups.

This section outlines the areas of potential conflict of interest for board members as well as the actions the public can reasonably expect a board to take in order to avoid, declare or reconcile such conflicts.

4) Accountability:

Ethical boards are accountable to those they serve. A dedicated and purposeful effort must be made to seek out the ideas and concerns of the public and the licensees. Secondly, but also important, feedback and involvement must be solicited from the appointing or electing authority, legislature, and the regulated profession.

This section outlines some areas which should be evaluated periodically by the regulatory board.

It is the sincere hope of the Federation of Associations of Regulatory Boards that this document contributes to promoting the highest standards for selection of and service by the members of regulatory boards for all licensed professions.

Our vision is that this Code may play a part in enhancing the public trust in those boards, and ultimately, in ensuring that all citizens will have access to competent, safe, and ethical practitioners in seeking the professional services they need.

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Personal Qualities

Introduction

A human organization cannot function with ethical integrity unless the people at its core are themselves fundamentally ethical. Core persons in an organization set the tone, create the leadership direction, and personify the organization's messages heard by everyone, internally and externally.

People at the core of government organizations on a democracy have an added responsibility regarding ethical integrity: they are elected or appointed to uphold public trust. Those persons so elected or appointed assume the lofty and highly visible responsibilities of public servants. The fiduciary relationship that characterizes public service exists between the public and all of the people and their organizations equally.

Therefore, regulatory boards for the profession should be constituted to represent:

1. ***The general consumer population of the regulated jurisdiction*** to the extent possible, including gender, race, ethnicity, religion, disability status, geography, socioeconomic level, and military service, and any other group historically under-represented in the particular professions to ensure that the services of the profession are accessible to all;
2. ***The profession and its practices***, including specialization practice areas, philosophical bases, practice settings, professional education programs, membership organizations, and research to ensure that regulatory decisions and actions take into consideration the full context of the profession, not just part of it; and
3. ***The electing or appointing authority*** as a public regulatory body carrying out the designated mission of ensuring the public health, safety, and welfare.

An election or appointment to a regulatory board should be based on broad and open recruitment of individuals whose conduct personifies those qualities identified as particularly suited to public service. The personal qualities of an individual that constitute appropriate attributes for public service on a regulatory board for a profession are fairly uniform across professions and jurisdictional boundaries. Identification of those qualities by electing or appointing authorities is essential to ensuring the integrity of the body whose members conduct the work of regulating the professions in the interest of public health, safety and welfare.

To assist electing and appointing authorities in their efforts to identify qualified individuals, this section of the Code describes those personal qualities deemed most likely to instill and ensure the public trust and confidence in its boards and their members who regulate the licensed professions.

Personal Qualities of Members of Regulatory Boards

I. Integrity

- A. Has no criminal professional misconduct record, nor is under current investigation of charges or complaints, and has an acceptable malpractice history.
- B. Possesses sound moral principles, e.g. is upright, honest, sincere.
- C. Has courage of convictions to withstand pressures to be swayed from public protection agenda.
- D. Is honest about personal agendas and leaves them outside the boardroom.
- E. Reveals any actual or perceived conflicts of interest to appropriately recuse self from decisions or actions in those areas of interest.
- F. Maintains confidentiality associated with examinations, disciplinary proceedings, and other pertinent matters.

II. Service

- A. Seeks and finds personal gratification through service to others.
- B. Is available for all regulatory activities, to be called on short notice, to travel, to be flexible in scheduling commitment and handling cancellations, and is not over-booked with other obligations.
- C. Provides accurate and timely submissions of reports, vouchers and other documentation associated with board service.

III. Sacrifice

- A. Tolerates inconvenience, frustration, and scheduling conflicts to be available for board service.
- B. Subjugates own need gratification to the greater good and, consequently, postpones, minimizes or forgoes it altogether.
- C. Rises above temptation for personal gain and avoids mutual benefit transactions available to private sector leaders that would pose conflicts of interest in the public sector.

IV. Vision

- A. Uses knowledge of regulatory history, concepts and rationale, including law, rule, regulation, and administrative policy, to articulate ideas and plans for refining, enhancing and developing measures of public protection, standards of licensure and practice, and systems for regulating practitioners of a profession.
- B. Acts as a role model for the profession and general public by discussing and presenting Board mission and function in the community whenever appropriate.
- C. Encourages public awareness of the standards and legal requirements of professional credentials, practices and conduct.

V. Commitment

- A. Understands and embraces the central mission of the regulatory board as protecting the public, not advocating for the profession.
- B. Demonstrates interest and ability in learning about administering law, rule, regulation, policy and the necessary protocols and procedures.
- C. Abides by the legal and ethical responsibilities associated with board membership.
- D. Remains current with cross-professional issues and trends inside and outside the jurisdiction.

VI. Consumer Advocacy

- A. Has experience in consumer advocacy and/or civic or public service organizations.
- B. Actively seeks to provide relevant information about professional practice and regulation to the consumer public and its organizations, including the soliciting of consumer concerns and ideas.
- C. Provides appropriate nominations of individuals qualified to be consumer members of the board.

VII. Diversity and Inclusiveness

- A. Values diversity of board membership representative of the general population in the jurisdiction.
- B. Actively promotes representative diversity in the profession with the understanding that such diversity not only ensures inclusive and comprehensive decisions and actions by the board, but also maximizes the opportunity for all people to be able to access needed services of the profession.

- C. Operates primarily on the basis of consensus-building, cooperation, conflict resolution and team efforts, not individualism, egotism, factionalism, charisma or confrontation
- D. Accepts conflicts as they arise in the normal course of events and approaches them as opportunities for greater understanding, team-building and improved functioning

VIII. Fairness and Balance

- A. Is deliberative, not quick to judge, and approaches the work of the board without bias, dispassionately, disinterested, and dissociated from positions on partisan issues
- B. Respects the rights of all parties
- C. Is mindful of standards and strives to interpret them to be as inclusive as possible, not exclusionary
- D. Understands the difference between high and minimally acceptable standards of competence and practice
- E. Understands and applies processes and procedures uniformly to all

Board Decisions and Actions

Introduction

Board recommendations, decisions, and disciplinary actions constitute almost all publicly visible and legally scrutinized regulatory activity. Consequently, all such activity needs to meet with the highest standard of ethical conduct possible. Boards whose recommendations, decisions, and disciplinary actions benefit the profession at the expense of the consumer cannot sustain the public trust, and violate their ethical and legal charge to protect the public.

In a democratic society, the public business must be performed in an open and public manner. The citizens must be fully aware of and able to observe the performance of public officials, and attend and listen to the deliberations that go into the making of public policy. The people must be able to be informed if they are to retain control over those who are their public servants. The welfare of the citizenry depends on a healthy government to operate for the benefit of those who created it.

This section of the Code outlines the general considerations forming the boundaries of regulation, and discusses the important roles boards undertake in issuing recommendations, decisions, and disciplinary actions.

The first of the following four sections, General Considerations, must be understood and referenced through the remaining three sections.

I. General Considerations

- A. **Overall principle:** Ethical conduct begins with each regulatory board meticulously following all laws which govern its recommendations, decisions and disciplinary actions.
- B. **Jurisdictions:** All regulatory boards function under laws, rules, regulations written within their respective jurisdictions and/or “umbrella agencies”
- C. **Scope:** Such laws may be:
- International
 - Federal or national
 - State, province, territory, commonwealth, district
 - County, parish
 - Municipal
- D. **Sources:** Such laws may be found in different sections of each jurisdiction’s codes, and must be reviewed frequently:
- R.I.C.O., racketeering, or anti-trust
 - Bribery or corrupt influence
 - Criminal
 - Administrative procedures or other “umbrella” agency
 - Ethics
 - Conflict of interest codes or guidelines
 - Equal opportunity
 - Americans with disabilities Act
- E. **Manner of conflict:** All board recommendations decisions, and actions must be conducted in as fair, equitable, impartial, and non-partisan manner as possible. It must also be noted that each board’s reputation is largely created by the staff who first encounter the public and the profession.
- Board members and staff must represent the highest standards of ethical and professional conduct
 - All board activity must be carefully documented and well organized for future reference and scrutiny
 - Board members must ensure that both the professional and public members of the board are equal partners with unique perspectives, who value one another’s insights, comment, and experiences
 - Board members must not serve as spokespersons for the board unless properly designated by the board

II. Board Recommendations

A. ***Advice on legality and propriety:*** Licensees will occasionally query boards about the legality and propriety of certain procedures and activities. Whenever possible, boards should define clearly what is acceptable and unacceptable. Boards, must at the same time, refrain from pre-forming, pre-judging, or freely giving legal opinion or advice. Information can be communicated to the public through:

- Rules and Regulations
- Public forums or focused hearings
- Newsletters
- Attorney general or counsel office opinions
- Internet websites
- Position papers

B. ***Establishing professional code of ethics:*** Boards may wish to consider helping to create a national or international code of ethics for the profession in one does not exist. In professions with existing ethical standards, those should be widely and vigorously disseminated.

C. ***Equivalent licensure criteria:*** Fairly and ethically address concerns relating both to protecting the public and assuring access to qualified practitioners, boards may wish to consider recommending that their jurisdiction's licensure criteria become comparable or equivalent across jurisdictional boundaries. This may serve to assure the public of acceptable levels of training and experience as well as potentially to permit greater interjurisdictional mobility.

Areas of interest include:

- Adoption of national examinations where available and appropriate
- Adoption of uniform pre-professional criteria, with time-frames reflecting changing requirements
- Adoption of a standard number of years in practice for endorsement/reciprocity
- Determination of acceptable prior malpractice history through appropriate profession-specific or interprofessional databanks (e.g., CIN-BAD, NPDB)

D. ***Criteria for removing members:*** boards may wish to consider developing and standardizing criteria for recommending the removal of non-contributing or ethically compromised board members. *It is noted that board membership frequently occurs as an extension of the political process, along with its implied limitations.*

III. Board Decisions

- A. ***Focused on mission:*** All board decisions must be made with the primary mission squarely in mind: Each board is charged, in some fashion or language, with protecting the public; all other considerations become secondary.
- B. ***Boards that are part of larger regulatory community:*** All board decisions must be made with the awareness of the responsibility each board has to the larger regulatory community. Board responsibility does not end at the jurisdictional or professional border.
- C. ***Reporting board actions:*** Whenever and wherever legally appropriate, information on board decisions and actions should be reported:
- To the general public (through rules and regulations, public forums or focused hearings, newsletters, Internet websites)
 - To all licensees
 - Appropriate profession-specific, interjurisdictional or interprofessional databanks
- D. ***Reporting criteria:*** Boards must be aware of reporting criteria to each appropriate professional databank, and be aware of possible overlap when some licensees may be practicing in more than one discipline.
- Be certain that all board decisions and actions are reported to the appropriate databank in a timely manner
 - Access the information in the interjurisdictional databanks on a regularly scheduled basis
 - Board staff must collate data and report any information obtained about a license at the next meeting for board consideration
- E. ***Proposed changes:*** Boards may from time to time decide to proposed changes in the laws and/or rules or regulations which govern the profession. When this occurs, the board should strive to:
- Reach a consensus, in both language and sentiment, among the board members about the need for changes proposed
 - Be certain that the proposed changes are within the applicable codes and laws of the “umbrella” agency or jurisdiction
 - Hold all required or appropriate public hearings, including proper notification of licensees
 - Share, whenever possible, information and background research which supports or validates the changes with other interested boards
 - Be prepared to explain and defend, with any and all appropriate research and documentation, the proposed changes to the legislative and executive branches

IV. Board Disciplinary Actions

- A. **Rights to due process:** Boards must establish procedures, within the enabling laws of the “umbrella” agency and/or jurisdiction, which ensure the rights to due process for ALL parties.
- B. **Confidentiality:** In the healing arts especially, but in all board actions, confidentiality must be scrupulously maintained when and where such confidentiality is appropriate.
- C. **No prejudgment:** Disciplinary actions must not be prejudged by preferential treatment of those involved because of personal values, friendship, or standing in the community.
- D. **Recusal:** Boards must establish and follow a clear recusal process when a real or strongly perceived conflict of interest arises.
- E. **Proper processes:** With the existing legal framework for each “umbrella” agency or jurisdiction which governs disciplinary action, each board should strive to:
- File adequate and timely notice of charges
 - Clearly communicate in writing with the respondent about discovery, evidence, board procedures, etc.
 - Share all information from respondents with the board
 - Utilize alternative dispute resolution for cases which meet pre-established criteria
 - During hearings, allow full and open testimony: ask witnesses if they have anything else to say
 - Seek legal advice: be certain that current laws are being properly applied
 - Determine first if laws/rules have been violated; weigh the impact of sanctions secondarily
 - Maintain confidentiality with all parties, especially the media, during the proceedings
 - When appropriate under law, report in a timely manner public disciplinary actions to the public, licensees, professional databanks interjurisdictional databanks

External Activities

Introduction

Actions of the individual board members will be evaluated both inside and outside the boardroom. Conduct must at all times be of the highest moral and ethical character. The action and interaction of the individual board members will reflect the integrity of the board.

Many areas of potential conflict will occur during a member's tenure and following retirement from active board service. Activities that are conducted outside of the board meeting and that are a part of external activities should be closely evaluated for ethical conformity.

Many of these conflicts will be painfully obvious while others will be only conflicts of perception. It is suggested that if a board member senses possible conflict of interest, he/she may wish to consult an impartial third party for advice and direction (i.e. assistant attorney general, ethics commission, leadership of the board, and/or professional staff).

At all times, board members must make decisions that are directed by all ethical considerations. The board member's moral compass must always be truly pointed in the correct ethical direction.

To assist elected and appointed board members in their efforts to develop maximum awareness of areas actual and perceived conflicts inherent in external activities, this section of the Code describes those areas most likely to jeopardize the public trust in the boards.

External Activities and Related Areas

I. Conflict of Interest

- A. **Defined:** Conflict of interest is defined as having any interest, financial or otherwise, direct or indirect, or engaging in any business or transaction or professional activity or incurring any obligation of any nature, which is in substantial conflict with the proper discharge of the board member's duties in the public interest.
- B. **Disclosure:** Board members must make public (and recuse themselves from) any conflict of interest that exists to ensure the integrity of the board and all of its decisions.

Disclosure and recusal are important tools to avoid actual or perceived conflict of interest. Board members must not overuse recusal as an excuse to avoid conflict in exercising their full responsibilities.

C. *Types of Potential Conflict in External Activities*

Personal conflicts are those actions that may ultimately have a personal consequence that is an indirect effect of a decision or action. No decisions should be made that will advance the personal benefit of the board members. Some examples of personal conflict include:

- **Personal gain:** Will this decision affect the board member's personal life in any direct way?
- **Sexual favors:** Will this behavior affect the board member's position unfairly?
- **Influence:** Will this behavior affect the board member's position unfairly? Will it result in unwarranted privileges or exemptions?
- **Effects on personal relationship:** Will there be an effect on the board member's current, past or future personal relationship(s)?

II. Confidentiality

- A. **Rules of confidentiality:** At all times the board member must conform to the rules of confidentiality in dealings outside the boardroom
- B. **During and after board membership:** Protected information obtained in the capacity of board member must remain confidential during and after board membership.
- **Actions prior to and subsequent to board membership:** Termination of board membership does not dissolve the board member from responsibility. Actions must continue to be governed by the same rules that apply during active board membership. Confidentiality must be maintained on all confidential subjects that the individual was privy to as a board member.

III. Sexual Relationships

- A. ***During board tenure:*** No board member should engage in a sexual relationship with any other board member or staff during board membership.

IV. Professional Activities

- A. ***Holding office:*** A board member shall not hold an office in a professional or trade association of the regulated profession

V. Representation of Responsibilities

- A. ***Spokesperson:*** A board member should not represent himself/herself as a spokesperson for the board to influence his/her status in areas outside of the business of the board.
- B. ***Disclosure of Information:*** A board member should not share information with any other person, or encourage another person to act in any way prohibited to the board member.
- C. ***Representation of responsibilities to others:*** Actions or statements made to others outside of the board should not be designed to influence the outcome of any board decision.

Accountability



Introduction

An ethical board is accountable to all its stakeholders. These include:

- The public, whose health and safety it is sworn to protect
- The practitioners, whose livelihood depends on fair and equitable adoption and application of statutes and regulations

In most instances, the board is also responsible to the appointing or electing authority and to the regulated profession in general.

Boards should have in place internal and external assessment tools to review and evaluate their processes as they relate to public protection.

This section of the Code is designed to assist boards in assessing whether their processes are accountable to their stakeholders.

General assessment

When and how does the board evaluate the overall organization, budget, procedures, legislative and policy activities, communications, involvement in national/international association of the profession's regulatory boards?

Some specific areas:

I. Does the board maintain appropriate record keeping?

Some areas may include:

- Number of licensees
- Number and general types of complaints made
- Number and type of disciplinary actions taken
- Documented amount of time it takes to handle a complaint, including number of investigative hours
- Comparison of your licensed profession to others in the same jurisdiction
- Comparison of the licensed profession in the jurisdiction to the same profession nationally and internationally
- Accurate budgets and financial reports, adequate funding, demonstrating cost-effectiveness, and revenue sources, value of volunteer time by board members
- Clear and concise interpretations of practice issues, including catalogued legal opinions

II. What are the criteria to review complaint process?

Some areas include:

- Has current system in place to track the complaint process
- Re-evaluates the complaint process regularly for maximum effectiveness
- Resolves complaints in a timely manner
- Ensures procedures conform to accepted standards
- Avoids bias
- Is not arbitrary or capricious
- Maintains adequate investigative resources
- Reports all public actions to profession's central database
- Offers expedited and alternative dispute resolution for cases meeting appropriate and predetermined standards

III. How does the board evaluate its public relations efforts to make board services available?

Some areas may include:

- Use of Internet websites, properly and accurately indexed
- Regular press releases to press, with appropriate designation of spokespersons
- Consumer friendly education materials, widely distributed
- Proactive reports to legislature
- Regular newsletters or other communications tools sent to licensees
- Board meeting locations varied to maximize access to the board
- Yellow pages listing
- User surveys and feedback

IV. How are the bases for evaluating a board member for suitability for reappointment?

Some areas may include:

- Attends regularly
- Maintains confidentiality of board processes
- Is well prepared for meeting- reads materials before arrival
- Participates in discussion
- Is honest about personal agendas and leaves them outside the boardroom

->Appendix: Reference documents

1. Glossary- *still under development*
2. Contents of a sample ethics code
3. Understanding the board/staff relationship
4. A Framework for Ethical Decision Making
Michael McDonald (reprinted with permission by the author)
5. Sample case questions and discussion- *still under development*
6. Bibliography- *still under development*

->APPENDIX 1

Glossary

Conflict of Interest

Having any interest, financial or otherwise, direct or indirect, or engaging in any business or transaction or professional activity or incurring any obligation of any nature, which is in substantial conflict with the proper discharge of the board member's duties in the public interest.

Ethical Philosophy

The attempt to clarify and refine the conceptual apparatus of practical judgment

ETHICS and METAETHICS, Raziel Abelson, New York University, St. Martin's Press, New York 1963

Ethics

Well based standards of right and wrong that prescribe what humans ought to do, usually in terms of rights, obligations, benefits to society, fairness, or specific virtues. It also refers to the study and development of one's ethical standards.

The study of conduct and moral judgment; moral philosophy
Webster's New World Dictionary, College Edition, The World Publishing Company, Cleveland and New York, 1968

(Greek: the manner and habits of man or of animals)

The rules or principles which govern right conduct
Dorland's Medical Dictionary, 27th edition, W.B. Saunders Company, Harcourt Brace Jovanovich, Inc., Philadelphia 1986

Ethics Code

An Ethics Code is not law. It is a document that provides practical detail to laws, rules, or regulations that address ethics and other areas pertinent to board service.

MORE DEFINITIONS TO BE DEVELOPED

Relative

Compensation

Equal Benefit to a class

Personal or private interest

Classes of Public Servant

Pecuniary benefit/ financial interest

Confidential information

Appearance of conflict

Fiduciary

Recusal

Disclosure

Open Meetings

Public body

Executive Session

->APPENDIX 2

Contents of Sample Ethics Code

A. Purpose

B. Definitions

C. Body- Code of Conduct

1. *Expectations*

Personal qualities- qualifications for service
Board decisions and actions
External activities and relationships

2. *Actions which may constitute violations*

Threats
Bribery
Granting of sexual favors
Conflict of interest
Gifts
Private compensation
Trading in special influence
Use of public position for personal gain
Contracts with other jurisdictions
Disclosure of confidential information

3. *Required actions in conflicts*

Disclosure
Recusal
Effect on quorum

4. *Post-service restrictions*

Respect for protected information

D. Range of sanctions-civil and criminal

1. *Fines*

2. *Imprisonment*

3. *Removal from office*

E. Process of waivers/securing advisory opinions

F. Enforcement body (commission)

1. Composition/terms
2. Compensation
3. Powers and duties
4. Reporting obligations
5. Disqualifications
6. Range of sanctions
7. Confidentiality provisions
8. Right of appeal to higher body

->APPENDIX 3

Understanding the Board/Staff Relationship

From the 23rd Annual FARB Forum- February 6, 1999

“Commandments Thou Shall Not Break as Board Member or Staff”

What board members bring to the board/staff relationship

- Expertise in a variety of technical areas for which the jurisdiction could not pay
- The sanction of various external publics
- Knowledge of various facts about the community or profession
- Continuity of policy and program
- The ability to be a spokesperson
- Influence to attract financial resources, human resources, and public resources
- Preservation of the democratic process
- An objective view of the operations; the capacity for critical review
- Ability to affect change in the jurisdiction
- Collective wisdom

What staff brings to the board/staff relationship

- Because of their unique position as the bridge between board and jurisdiction and between licensees, staff can coordinate board activities and can spot problems and pitfalls before board members generally do.
- Connection between cultures in a culturally diverse jurisdiction
- Objectivity in reaction to board member suggestions
- Expertise in legal regulation of the profession
- Basic knowledge of the jurisdiction
- Ability to interpret and apply board policy decisions

What board members can reasonably expect of staff

- Attention to details of meetings, conferences, etc.
- Adequate preparation for meetings in which board volunteers must play a leadership role
- Complete, concise, and accurate information
- Candor in individual and organizational relationships
- Judicious use of time
- Meeting of agreed-upon deadlines, with notification if deadlines cannot be met
- Prompt response to requests for information
- Prompt return of phone calls

NOTE: Staff should NOT be expected to perform personal or professional duties for board members outside of the staff job description.

APPENDIX 3 (continued)

Understanding the Board/Staff Relationship

What staff can reasonably expect of board members

- Fulfillment of commitments within agreed-upon deadlines
- Organizational knowledge and ability
- Candid performance appraisal and assistance in performance
- Leadership rather than “followship”; initiative rather than response
- Support in controversial situations
- Easy access by phone or visitation
- Sensitivity to staff’s organizational problems
- Loyalty, confidentiality

Major problems with a board of directors

- Constant turnover of members of board
- Selection of board members
- Ego of members
- Lack of attendance
- Resistance to change
- Duck big issues
- Dissident members
- Indecisive on issues
- Too democratic

Major disappointments experienced as board member

- Personal goals for improvement of the organization have not been realized
- Board operation is not as efficient and/or well-managed as it could be
- Lack of effort and dedication on the part of other board members
- Disagreement with some of the board's policies
- Inadequacies of staff

->APPENDIX 4

A framework for Ethical Decision Making

Michael McDonald (reprinted with permission of the author)

1. Identify the problem.

1.1. **Be alert; be sensitive to morally or politically charged situations.** Look behind the technical requirements of your job to see the moral dimensions. Use your ethical resources to determine relevant moral standards. Use your moral intuition.

1.2. **Gather information and do not jump to conclusions.** While accuracy is important, there can be a trade-off between gathering more information and letting morally significant option disappear. Sometimes you may have to make supplementary assumption because there is insufficient information and no time to gather more information.

1.3. **State the case briefly with as many of the relevant facts and circumstances as you can gather within the decision time available.**

1.3.1. **What decisions have to be made?** There may be more than one appropriate decision.

1.3.2. **By whom?** Remember that there may be more than one decision-maker and their interactions can be important.

2. Specify feasible alternatives.

2.1. **State the live options at each stage of decision-making for each decision maker.**

You then should ask what the likely consequences are of various decisions. Here, you should remember to take into account good or bad consequences not just for you or you board, but for all affected persons (i.e. the public).

3. Use your ethical resources to identify morally significant factors in each alternative.

3.1. **Principles.** These are principles that are widely accepted in one form or another in the common moralities of many communities and organizations.

3.1.1. **Respect autonomy.** Would I be exploiting others, treating them paternalistically, or otherwise affecting them without their free and informed consent? Have promises been made? Are legitimate expectations on the part of other because I am a professional person?

- 3.1.2. **Do not harm.** Would I be harming someone to who I have a general or specific obligation as a professional or as a human being?
 - 3.1.3. **Do good.** Should I be preventing harm, removing harm, or even providing positive benefits to others?
 - 3.1.4. **Be fair.**
 - 3.2. **Moral models. Sometimes you will get moral insight from modeling your behavior on a person of great moral integrity.**
 - 3.3. **Use ethically informed sources.** Policies and other source materials, professional norms such as board policy, legal precedents, and wisdom from your religious or cultural traditions.
 - 3.4. **Context.** Contextual features of the case that seems important such as the past history of relationships with various parties.
 - 3.5. **Personal judgments, you associates, and trusted friends or advisors can be invaluable.** Of course, in talking a tough decision over with others, you have to respect confidentiality issues within the context of the individual situation.
- 4. Propose and test possible resolutions.**
- 4.1. **Perform a sensitivity analysis.** Consider your choice critically by considering which factors would have to change to get you to alter your decision.
 - 4.2. **Impact on others' ethical performance?** Think about the effect of each choice upon the choices of other responsible parties. Are you making it easier or harder for them to do the right thing? Are you setting a good example?
 - 4.3. **Would a good person do this?** Ask yourself what would a virtuous professional (one with integrity and experience) do in these circumstances?
 - 4.4. **What if everyone in similar circumstances did this?** Formulate your choice as a general maxim for all similar cases?
 - 4.5. **Does it seem right?** Are you still satisfied with your choice? If you are still satisfied, then go with your choice. If not, consider the factors that make you uncomfortable with a view to coming up with a new general rule with which you are satisfied.
- 5. Make your choice.**
- 5.1. **Live with it.**
 - 5.2. **Learn from it.** This means accepting responsibility for your choice. It also means accepting the possibility that you might be wrong or that you will make a less than optimal decision. The object is to make a good choice with the information available not to make a perfect choice. Learn from your failures and successes.

Agency Management Report

KPMs For Reporting Year 2015

Finalize Date: 9/15/2015

Agency: DENTISTRY, BOARD of

	Green = Target to -5%	Yellow = Target -6% to -15%	Red = Target > -15%	Pending	Exception Can not calculate status (zero entered for either Actual or Target)
Summary Stats:	60.00%	20.00%	20.00%	0.00%	0.00%

Detailed Report:

KPMs	Actual	Target	Status	Most Recent Year	Management Comments
1 - Continuing Education Compliance - Percent of Licensees in compliance with continuing education requirements.	100	100	Green	2015	The OBD audits 15% of all license renewals each year to see that licensees are in compliance with the Continuing Education Rules, those audits have shown a high compliance rate.
2 - Time to Investigate Complaints - Average time from receipt of new complaints to completed investigation.	12.00	3.50	Red	2015	The OBD is optimistic that once the new dental investigator is trained, that the overall time to complete investigations will start trending down from the last few years results.
3 - Days to Complete License Paperwork - Average number of working days from receipt of completed paperwork to issuance of license.	7	7	Green	2015	The OBD strives to complete all renewal and application paperwork in 7 days or less.
4 - CUSTOMER SATISFACTION WITH AGENCY SERVICES - Percent of customers rating their satisfaction with the agency's customer service as "good" or "excellent": overall, timeliness, accuracy, helpfulness, expertise, availability of information.	85	85	Green	2015	The OBD continues to have around an 80% positive rating from the cusotmers who complete the Customer Service Survey.

Agency Management Report

KPMs For Reporting Year 2015

Finalize Date: 9/15/2015

KPMs	Actual	Target	Status	Most Recent Year	Management Comments
5 - Board Best Practices - Percent of total best practices met by the Board.	93	100	Yellow	2015	The OBD continues to complete the Board Best Practices Evaluation and strives for 100% compliance.

This report provides high-level performance information which may not be sufficient to fully explain the complexities associated with some of the reported measurement results. Please reference the agency's most recent Annual Performance Progress Report to better understand a measure's intent, performance history, factors impacting performance and data gather and calculation methodology.

DENTISTRY, BOARD of
Annual Performance Progress Report (APPR) for Fiscal Year (2014-2015)

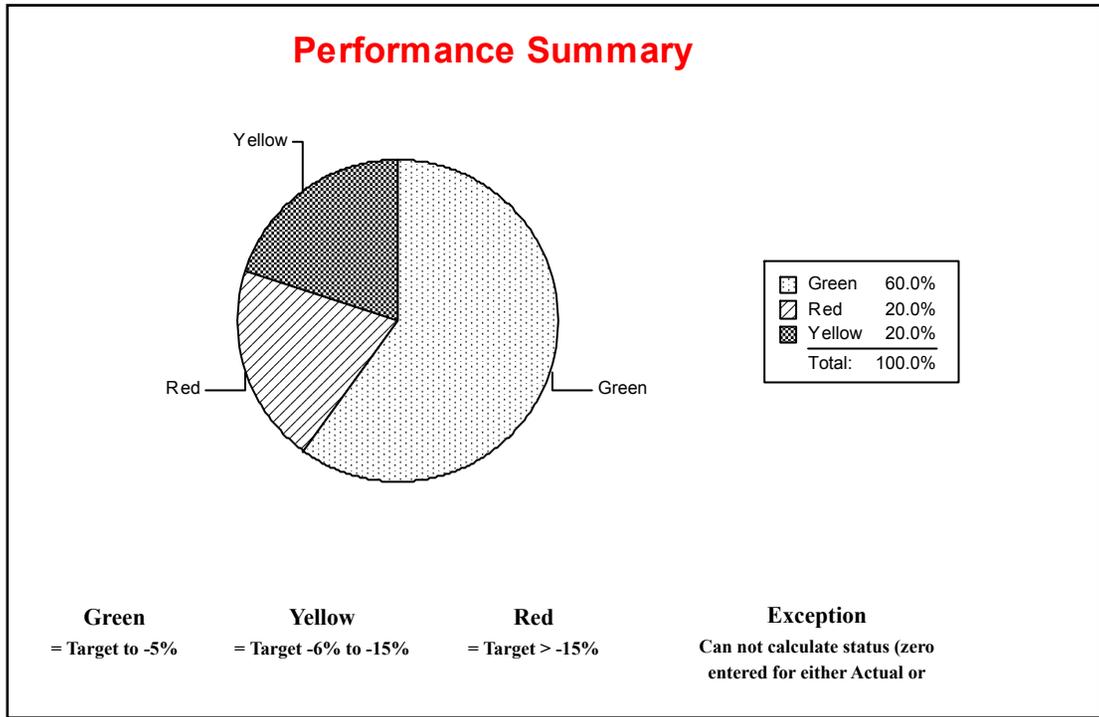
Original Submission Date: 2015

Finalize Date: 9/15/2015

2014-2015 KPM #	2014-2015 Approved Key Performance Measures (KPMs)
1	Continuing Education Compliance - Percent of Licensees in compliance with continuing education requirements.
2	Time to Investigate Complaints - Average time from receipt of new complaints to completed investigation.
3	Days to Complete License Paperwork - Average number of working days from receipt of completed paperwork to issuance of license.
4	CUSTOMER SATISFACTION WITH AGENCY SERVICES - Percent of customers rating their satisfaction with the agency's customer service as "good" or "excellent": overall, timeliness, accuracy, helpfulness, expertise, availability of information.
5	Board Best Practices - Percent of total best practices met by the Board.

New Delete	Proposed Key Performance Measures (KPM's) for Biennium 2015-2017
	Title: Rationale:

DENTISTRY, BOARD of	I. EXECUTIVE SUMMARY
Agency Mission: To assure that the citizens of Oregon receive the highest possible quality oral health care.	
Contact: Stephen Prisby, Executive Director	Contact Phone: 971-673-3200
Alternate:	Alternate Phone:



1. SCOPE OF REPORT

The Board of Dentistry is charged with the regulation of the practice of dentistry and dental hygiene by setting standards for entry to practice, examination of applicants, issuance and renewal of licenses, and enforcing the standards of practice. The Board also is required by law to establish standards for the administration of anesthesia in dental offices. The Board determines dental procedures that may be delegated to dental assistants and establishes standards for training and certification of dental assistants. As of September 1, 2015, there were 3811 dentists, and 4,391 dental hygienists holding Oregon licenses. The Board operates in an atmosphere of constant change, rapidly developing technology, changing treatment modalities, demographic and geographic disparities in access to dental care, growing public demand for a greater diversity of provider groups, and constantly shifting societal norms and values. Agency operations

are supported solely from license application, renewal, exam and permit fees, plus revenues generated from fines imposed for late renewals, civil penalties assessed, and miscellaneous receipts from the sale of mailing lists and copies of public records. The Board is composed of ten members appointed by the Governor and confirmed by the Senate for four-year terms. There are six dentists, one of whom must be a dental specialist, two dental hygienists and two public members. 7.0 FTE staff that carry out the day-to-day functions of the agency. In addition, the Board contracts with numerous dental professionals to provide expertise in specific dental specialty areas. Primary program activities are Licensing and Examination, Enforcement and Monitoring, and Administration.

2. THE OREGON CONTEXT

The Oregon Board of Dentistry has no Primary Links to the Oregon Benchmarks; however, Board activities support the following benchmarks as secondary links. #29 Skills Training: Percentage of Oregonians in the labor force who received at least 20 hours of skills training in the past year. #30 Volunteerism: Percentage of Oregonians who volunteer at least 50 hours of their time per year to civic, community or nonprofit activities. #44 Adult Non-smokers: Percentage of Oregonians, 18 and older who smoke cigarettes. #52 Substance Use During Pregnancy: Percentage of pregnant women who abstain from using: a. alcohol; b. tobacco. #50 Child Abuse or Neglect: Number of children, per 1,000 persons under 18, who are: a. neglected/abused; b. at a substantial risk of being neglected/abused.

3. PERFORMANCE SUMMARY

All but one current Performance Measures Targets are being met.

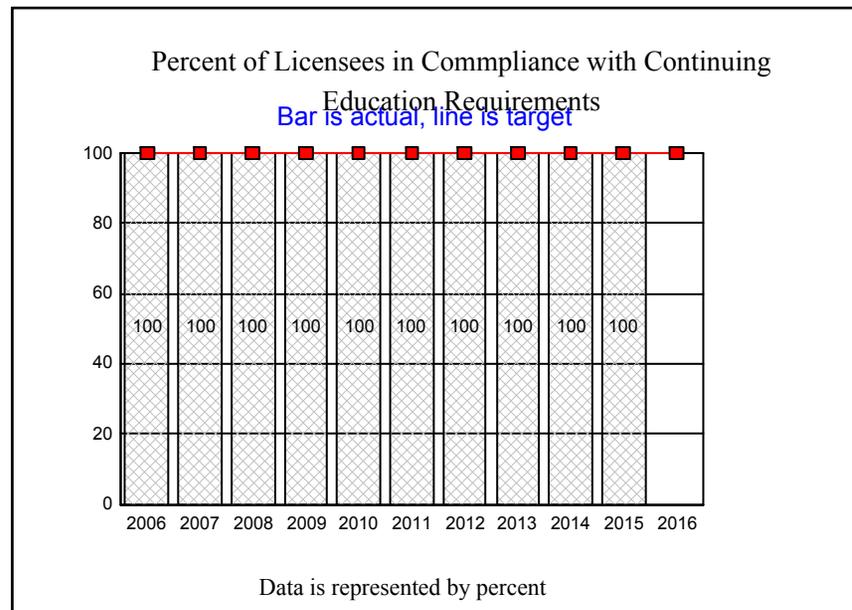
4. CHALLENGES

As with all state agencies, those that are funded by Other Funds continue to be challenged by adhering to all revenue and expenditure guidelines outlined by the Governor and the Legislature, although no direct taxpayer dollars fund the Oregon Board of Dentistry.

5. RESOURCES AND EFFICIENCY

The Oregon Board of Dentistry 2015- 2017 Legislatively Adopted Budget is \$2,985,971.00

KPM #1	Continuing Education Compliance - Percent of Licensees in compliance with continuing education requirements.	2001
Goal	Public Protection - Protect the public by assuring that all licensees are competent to practice safely and ethically.	
Oregon Context	The Oregon Board of Dentistry has no primary links to the Oregon Benchmarks.	
Data Source	Agency records from continuing education audit logs.	
Owner	Oregon Board of Dentistry, Stephen Prisby, Executive Director (971) 673-3200.	



1. OUR STRATEGY

The Board's strategy is that Licensees should keep current on practice issues. One way to do this is to take continuing education courses on a biennial basis. To determine if the licensees are in compliance is to audit approximately 15% of all licensees to establish a baseline.

2. ABOUT THE TARGETS

A target of 100% compliance seems to be an appropriate level for all licenses.

3. HOW WE ARE DOING

The profession is complying with the requirements to complete continuing education as a prerequisite to renewing their license.

4. HOW WE COMPARE

There are no outside comparisons of similar jurisdictions to use.

5. FACTORS AFFECTING RESULTS

There are no specific factors affecting the results.

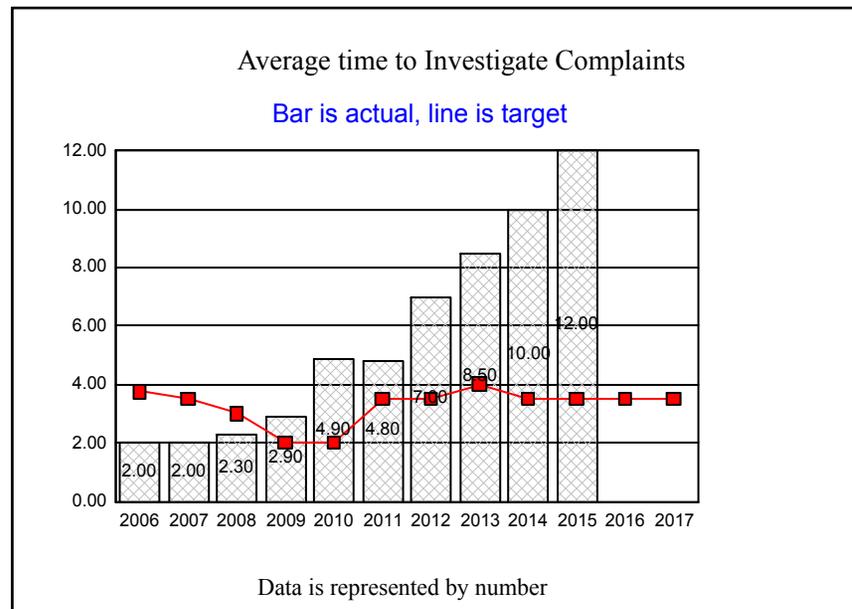
6. WHAT NEEDS TO BE DONE

Nothing needs to be done at this time.

7. ABOUT THE DATA

The reporting cycle is the Oregon fiscal year. The Board audits 15% of all licensees that are eligible for renewal, based on those that are audited and renew. We compare the Continuing Education Log that they are required to submit to see if they have met the requirements of the Law and Administrative Rules; if they are not in compliance, they are turned over for investigation of a possible violation of the Oregon Dental Practice Act.

KPM #2	Time to Investigate Complaints - Average time from receipt of new complaints to completed investigation.	2000
Goal	Public Protection - Protect the public by assuring that all licensees are competent to practice safely and ethically.	
Oregon Context	The Oregon Board of Dentistry has no primary links to the Oregon Benchmarks.	
Data Source	Database - investigative files.	
Owner	Oregon Board of Dentistry, Stephen Prisby, Executive Director, (971) 673-3200.	



1. OUR STRATEGY

The Board's strategy is that the investigation of complaints should take place in a timely fashion. By establishing the average time from the receipt of a new complaint until the investigation is completed is a way of measuring the timeliness of the Board's workload.

2. ABOUT THE TARGETS

The targets provide for a time frame to complete investigations based on the complexity of the issues and the staff available to conduct the investigation. The targets appear to be an excellent goal, but challenging now. Since 2010 the time to complete investigations has increased due to the volume and the complex nature of the cases, many involving multiple licensees. This Performance Measure was established in 2000.

3. HOW WE ARE DOING

The Board has seen an increase in the complexity of the complaints and these complaints are requiring a lot more time, as cases with multiple licensees involved do. We are also seeing a substantial number of cases involving payment and financial disputes, requiring an investigation and the end result is that they are monetary in nature and thus not truly within the jurisdiction of the Board.

4. HOW WE COMPARE

There are no outside comparisons of similar jurisdictions to use.

5. FACTORS AFFECTING RESULTS

The complexity of the cases that are being investigated continues, most cases used to involve one licensee now complaints have seen multiple licensees which require the review of multiple patient records from many different licensees.

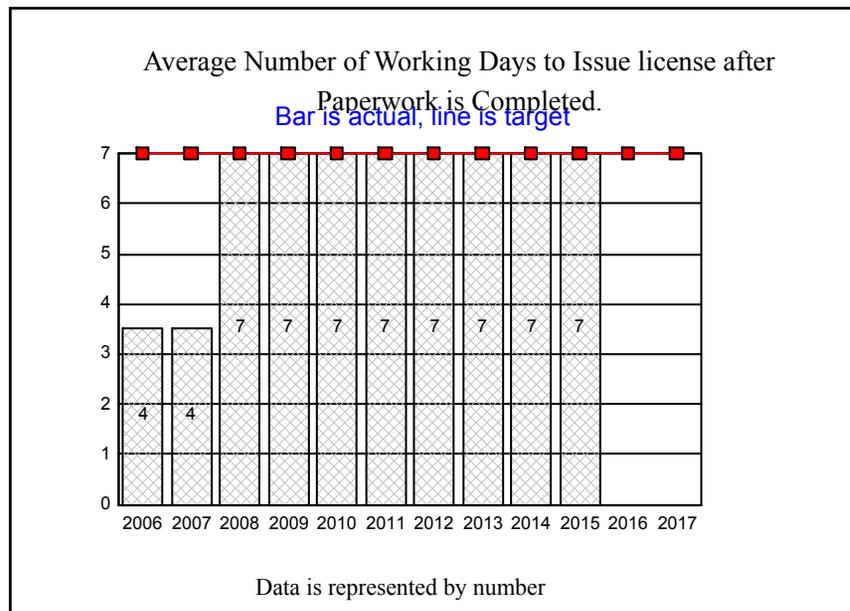
6. WHAT NEEDS TO BE DONE

The enforcement staff is working at an increased pace to try to eliminate the time it takes to investigate complaints. The OBD received legislative approval to increase the biennial license fee by \$75 on all licensees to fund an additional dental investigator position. Once the dental investigator is hired and properly trained, we expect to make progress on reducing the overall time it takes to investigate complaints.

7. ABOUT THE DATA

The reporting cycle is the Oregon fiscal year, and is generated from the computerized database that is used to track all complaints.

KPM #3	Days to Complete License Paperwork - Average number of working days from receipt of completed paperwork to issuance of license.	2003
Goal	Public Protection - Protect the public by assuring that all licensees are competent to practice safely and ethically.	
Oregon Context	The Oregon Board of Dentistry has no primary links of the Oregon Benchmarks.	
Data Source	Database- licensing information	
Owner	Oregon Board of Dentistry, Stephen Prisby, Executive Director, (971) 673-3200.	



1. OUR STRATEGY

The Board's strategy is that the processing of completed paperwork for the issuance of a license, either new or a renewal, should take place in a reasonable period of time to assure public protection and to assure that those desiring to work in Oregon can do so in a timely fashion.

2. ABOUT THE TARGETS

The targets provide for a realistic time frame to issue a license or to renew a license when all paperwork has been completed in accordance with all of the Board's rules and regulations.

3. HOW WE ARE DOING

The targets as established have been met or been exceeded.

4. HOW WE COMPARE

There are no outside comparisons of similar jurisdictions to use.

5. FACTORS AFFECTING RESULTS

There are no specific factors affecting the results.

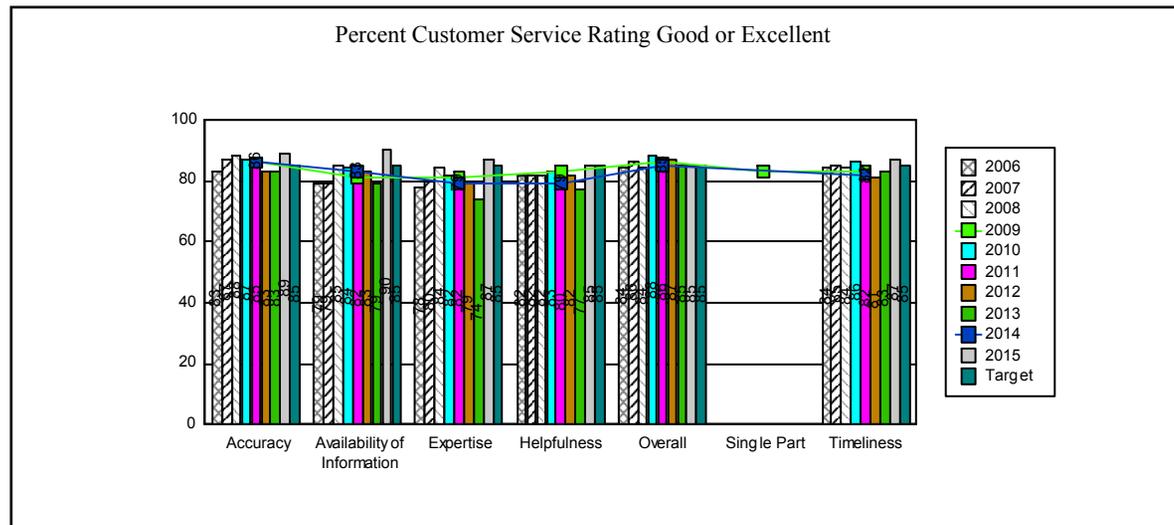
6. WHAT NEEDS TO BE DONE

Nothing needs to be done at this time.

7. ABOUT THE DATA

The reporting cycle is the Oregon fiscal year, and is generated from the computerized database that is used to track all application and renewal files.

KPM #4	CUSTOMER SATISFACTION WITH AGENCY SERVICES - Percent of customers rating their satisfaction with the agency's customer service as "good" or "excellent": overall, timeliness, accuracy, helpfulness, expertise, availability of information.	2006
Goal	Agency Overall Satisfaction Percent of customers rating their overall satisfaction with the agency above average or excellent and Customer Satisfaction Percent of customers rating satisfaction with agency services above average or excellent for: A: Timeliness; B: Accuracy; C; Helpfulness; D: Expertise; E: Information Availability	
Oregon Context	The Oregon Board of Dentistry has no primary links to the Oregon Benchmarks.	
Data Source	Customer Service Surveys completed and returned July 1, 2014 through June 30, 2015.	
Owner	Oregon Board of Dentistry, Stephen Prisby, Executive Director, (971) 673-3200.	



1. OUR STRATEGY

In compliance with the Oregon Legislatures directive, the Board conducted a Customer Service Survey as one tool to determine the customer satisfaction with the accuracy of carrying out the Mission of the Board

2. ABOUT THE TARGETS

The Targets provide a realistic and attainable goal for overall positive ratings for customer service.

3. HOW WE ARE DOING

Those completing the survey rated the Board as having an 85% overall satisfaction level and approximately 10% gave an unsatisfactory response.

4. HOW WE COMPARE

There are no outside comparisons of similar jurisdictions to use.

5. FACTORS AFFECTING RESULTS

There are no specific factors affecting the results.

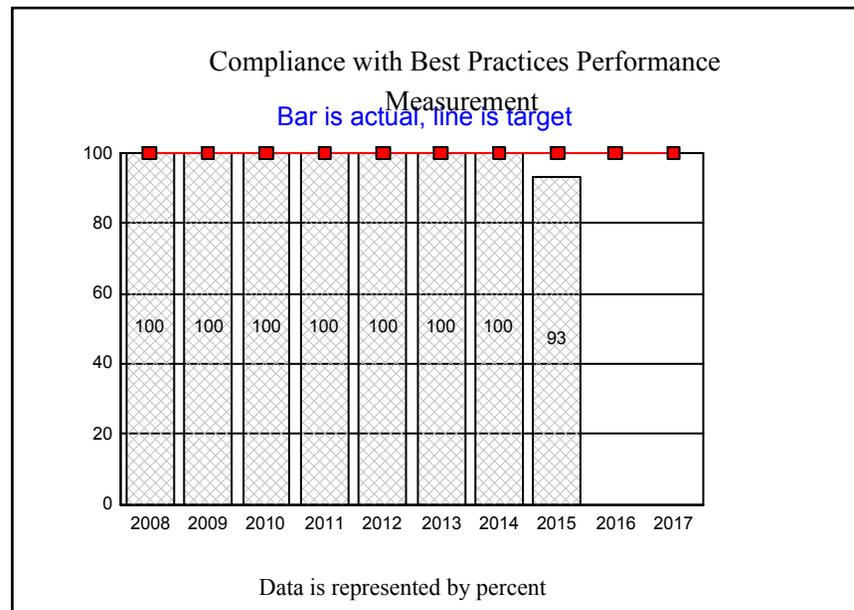
6. WHAT NEEDS TO BE DONE

Nothing needs to be done at this time.

7. ABOUT THE DATA

The reporting cycle is the Oregon fiscal year, and is generated from the computerized database that is used to track all application and renewal files.

KPM #5	Board Best Practices - Percent of total best practices met by the Board.	2007
Goal	To have 100% compliance with the Best Practice Performance Measures for Governing Boards and Commissions.	
Oregon Context	The Oregon Board of Dentistry has no primary links to Oregon Benchmarks.	
Data Source	Evaluation completed by the Oregon Board of Dentistry Members at the August 28, 2015 Board Meeting.	
Owner	Oregon Board of Dentistry, Stephen Prisby, Executive Director (971) 673-3200.	



1. OUR STRATEGY

The Board's strategy is to be in 100% compliance with Best Practices Performance Measurements for Governing Boards and Commissions.

2. ABOUT THE TARGETS

A target of 100% compliance seems to be an appropriate level for the Board.

3. HOW WE ARE DOING

The Board is in compliance with the Best Practices Performance Measurement for Governing Boards and Commissions and achieved 14 out of 15 best practices criteria. The Board agreed that a former board member did not act in accordance with their role as a public representative.

4. HOW WE COMPARE

The Agency believes it can achieve 100% compliance with the current Board members.

5. FACTORS AFFECTING RESULTS

The Board agreed that a former Board member did not act in accordance with their role as a public representative.

6. WHAT NEEDS TO BE DONE

Nothing needs to be done at this time.

7. ABOUT THE DATA

The Board Members completed the Self Assessment Best Practices list during the July 30, 2010 Board Meeting.

DENTISTRY, BOARD of	III. USING PERFORMANCE DATA
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Agency Mission: To assure that the citizens of Oregon receive the highest possible quality oral health care.

Contact: Stephen Prisby, Executive Director	Contact Phone: 971-673-3200
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Alternate:	Alternate Phone:
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The following questions indicate how performance measures and data are used for management and accountability purposes.

1. INCLUSIVITY	<ul style="list-style-type: none"> * Staff : Review of current performance measures on an annual basis. * Elected Officials: Approving an making changes to legislatively approved performance measures. * Stakeholders: Reviewing letters, telephone calls and e-mails regarding the Board's performance measures. * Citizens: Reviewing letters, telephone calls and e-mails regarding the Board's performance measures.
2 MANAGING FOR RESULTS	All data collected on performance measures is reviewed and presented to the Board and Staff. All appropriate changes are made regarding continued compliance with performance measures.
3 STAFF TRAINING	Staff has been informed of all comments provided to the Executive Director regarding performance measures .
4 COMMUNICATING RESULTS	<ul style="list-style-type: none"> * Staff : At staff meetings and through e-mails and memos on customer satisfaction. * Elected Officials: Use of Web-site, testimony before Legislatiure and responding to direct inquiries. * Stakeholders: Use of Web-site, presentations and responding to direct inquiries. * Citizens: Use of Web-site, presentations and responding to direct inquiries.

Best Practices Self-Assessment

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

Best Practices Assessment Score Card

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