

PUBLIC PACKET

**OREGON BOARD  
OF  
DENTISTRY**

**BOARD MEETING  
OCTOBER 18, 2013**



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# APPROVAL OF MINUTES

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**OREGON BOARD OF DENTISTRY  
MINUTES  
August 16, 2013**

MEMBERS PRESENT:       Jonna E. Hongo, D.M.D., President  
                                  Brandon Schwindt, D.M.D., Vice-President  
                                  Todd Beck, D.M.D.  
                                  Mary Davidson, M.P.H., R.D.H.  
                                  Alton Harvey, Sr.  
                                  Norman Magnuson, D.D.S.  
                                  Patricia Parker, D.M.D.  
                                  Julie Ann Smith, D.D.S., M.D.  
                                  John Tripp, R.D.H.

STAFF PRESENT:         Patrick D. Braatz, Executive Director  
                                  Paul Kleinstub, D.D.S., M.S., Dental Director/Chief Investigator  
                                  Michelle Lawrence, D.M.D., Consultant (portion of meeting)  
                                  Harvey Wayson, Investigator (portion of meeting)  
                                  Lisa Warwick, Office Specialist (portion of meeting)

ALSO PRESENT:         Lori Lindley, Sr. Assistant Attorney General

VISITORS PRESENT:     Beryl Fletcher, ODA; Steven M. Timm, DMD, ODA; Magda D'Angelis-Morris, DMD, PCC; William Saiget, DMD, Interdent; Sheri Billetter, ODAA; Vickie Woodward, RDH, ODHA

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

**NEW BUSINESS**

**MINUTES**

Dr. Magnuson moved and Dr. Parker seconded that the minutes of the June 21, 2013 Board meeting be approved as amended. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

**ASSOCIATION REPORTS**

**Oregon Dental Association**

There was no report.

**Oregon Dental Hygienists' Association**

Ms. Woodward had nothing to report.

**Oregon Dental Assistants Association**

Ms. Billetter stated that the ODAA will hold its annual fall education and business meeting on September 28<sup>th</sup>. She stated that it would be in the form of a round table presentation and that all assistants are welcome.

## **COMMITTEE AND LIAISON REPORTS**

### **WREB Liaison Report**

Dr. Magnuson stated that he attended the Dental Exam Review Board (DERB) meeting. He explained that a few years ago WREB split into two boards, one in charge of exams the other in charge of ethics, finance and other business functions. He stated that they are expecting some big changes in 2015 which will include a new exam that will not only include a treatment exam, but also involve a number of open ended questions regarding the treatment plan and patient care. He stated that this will also change how the exams are graded. The change was approved by DERB and the Board of Directors. He added that the Board of Directors approved a computer upgrade for WREB too.

Ms. Davidson stated that she attended the Hygiene Exam Review Board (HERB) meeting. HERB made changes to exam scoring. She stated it would also now be a patient rejection if cocaine or Methamphetamines have been used by the patient 24 hours prior to testing. She stated that it was over all a very productive meeting and that some great new things are on the horizon. Ms. Davidson also announced that she is the new chair of the HERB.

### **AADB Liaison Report**

Dr. Parker stated that the annual meeting would take place Oct 30-31.

Ms. Davidson had nothing to report.

### **ADEX Liaison Report**

Dr. Parker had nothing to report.

### **NERB Liaison Report**

Dr. Hongo and Dr. Smith had nothing to report.

### **Committee Meeting Dates**

Mr. Braatz stated that a Rules Oversight Committee Meeting had been scheduled for August 22, 2013.

## **EXECUTIVE DIRECTOR'S REPORT**

### **Budget Status Report**

Mr. Braatz attached the latest budget report for the 2011-2013 Biennium for the Board to review. The report, which is from July 1, 2011 through June 30, 2013, shows revenue of \$2,573,469.69 and expenditures of \$2,311,401.54. Mr. Braatz added that these are not the actual final numbers for 2011 – 2013 but that they should be fairly close. He continued by saying that this reflects that the OBD exceeded the revenue projection of \$2,457,200.00 by \$116,269.69 and did not spend the expenditure limit of \$2,502,044.00 but under spent the budget by \$182,927.47. The Board's newly Legislatively Approved Budget for the 2013 – 2015 Biennium is \$2,614,968.00. Mr. Braatz invited the Board members to ask any questions on the budget report.

### **Customer Service Survey Report**

Mr. Braatz attached the latest OBD Customer Service Survey results showing responses from July 1, 2012 through June 30, 2013. He stated that the majority of responses continue to be positive from those who return the survey. He added that any comments included are available for the Board to review.

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

Sunday, July 21, 2013 – Mr. Braatz made a presentation on “Record Keeping” and “Updates from the OBD” to the Oregon Periodontists Society at the Columbia Gorge Hotel in Hood River.

Friday, July 26, 2013 – Mr. Braatz made a presentation on “Record Keeping” and “Updates from the OBD” to Advantage Dental at Eagle Crest in Redmond. Mr. Braatz stated that he had some negative feedback during this meeting regarding the anesthesia rule changes.

### **Office Lease**

Mr. Braatz announced that the OBD has signed a one year lease with PSU for the existing space with the hope that we will be able to sublet the space when we move to our new location around the beginning of December, 2013. Mr. Braatz stated that the new lease will be for 7 years and 8 months and that the OBD will not begin rent payments until August 1, 2014.

### **Board Best Practices Self-Assessment**

Mr. Braatz stated that it was once again time to complete the attached ‘Best Practices Self-Assessment’ which will be included in as part of the 2013 Performance Measures Report. Mr. Braatz and the Board reviewed the self-assessment and Mr. Braatz stated the results would be part of the Meeting minutes approved at the October meeting.

### **Agency Head Financial Transactions**

Mr. Braatz stated that Board Policy requires that at least once a year the entire Board review the agency head financial transactions and that acceptance of the report would be recorded in the minutes. The Board reviews this report at the close of the fiscal year typically.

Dr. Magnuson moved and Mr. Harvey seconded that the Board approve the Agency Head Financial Report. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

### **HPSP Annual Report**

Mr. Braatz stated that the third annual HPSP report was attached for the Board’s review and that he or Mr. Wayson would be happy to answer any questions that the Board may have.

### **State of Oregon 2013-2015 Affirmative Action Report**

Mr. Braatz stated that attached was the 2013-2015 Affirmative Action Summary Report for the Board’s review. He added that all state agencies within the Executive Branch have successfully submitted their agency’s Affirmative Action Plan and that the Summary Report highlights agency best practices, recommendations and data that capture a biennial overview of EEO data across the State of Oregon Enterprise.

### **Newsletter**

Mr. Braatz reminded the Board that we were beginning to work on the fall newsletter and that if the Board had anything they’d like to submit they should do that shortly. Mr. Braatz stated that he’d like to have a September 15<sup>th</sup> deadline for article submission. Dr. Beck wanted to readdress the publishing of names for disciplinary cases in the newsletter as he’s had a lot of feedback from the community against it.

## **UNFINISHED BUSINESS**

## **CORRESPONDENCE**

### **The Board received a letter from Ryan J. Hughes, DDS, MS**

Dr. Hughes sent a letter to the Board regarding the recent rule change that requires those administering benzodiazepines or narcotics in children under six to hold a Moderate, Deep or General Anesthesia Permit. Dr. Hughes asked the Board to reinstate his sedation permit in order to allow him to continue to provide care.

Dr. Beck moved and Dr. Parker seconded to issue Dr. Hughes an Enteral Moderate Sedation Permit, based on him previously holding a deep sedation permit. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

The letter generated discussion of the rule. Dr. Schwindt moved and Dr. Smith seconded that the Board review the recently revised rule at the next anesthesia committee meeting. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

### **The Board received a letter from Judy Mohr Peterson, Oregon Health Authority**

Ms. Peterson sent a letter to the Board clarifying the position of the Oregon Health Authority on the use of silver compounds in dentistry. She included the summary of the opinion of the Health Evidence Review Commission (HERC) that met in January which stated:

"There is evidence in resource-poor countries that silver diamine fluoride is effective at preventing and arresting caries. However, there is no evidence of the effectiveness of silver nitrate + fluoride varnish which is what would be used in the US (because the FDA has not approved silver diamine fluoride) and there are no US studies of either type of treatment. There are concerns about costs of repeated visits when restoration is still required and there is no data supporting that delayed restoration compared to immediate restoration is beneficial. Cosmetic concerns about permanent black staining in the teeth exist. Although the international studies are promising, no US major dental organizations currently recommend the use of silver compounds. This appears to be an experimental treatment at this time, and more research demonstrating efficacy and safety is required prior to allowing OHP patients to have this procedure done."

Mr. Braatz stated that there was another letter submitted in opposition to Ms. Mohr Peterson's letter but it came in too late to get in the packet and would be handed out to the Board.

## **OTHER BUSINESS**

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

## **PERSONAL APPEARANCES AND COMPLIANCE ISSUES**

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

## **LICENSING ISSUES**

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

## **CONSENT AGENDA**

### **2013-0201 and 2013-0204**

Dr. Schwindt moved and Dr. Parker seconded that the above referenced cases be closed with No Further Action per the staff recommendations. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

## **COMPLETED CASES**

**2013-0027, 2012-0118, 2013-0044, 2013-0135, 2012-0033, 2012-0140, 2013-0149, 2013-0213, 2013-0162, 2012-0098, and 2012-0044** Dr. Schwindt and Mr. Harvey seconded that the above referenced cases be closed with a finding of No Violation of the Dental Practice Act or No Further Action per the Board recommendations. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

### **ADAMS, BRANNICK D., D.D.S. 2012-0152**

Dr. Parker moved and Mr. Harvey seconded that the Board issue a Notice of Proposed Disciplinary Action and offer the Licensee a Consent Order in which the Licensee would agree to be reprimanded, to pay a \$3,000.00 civil penalty within 30 days of the effective date of the Order, complete 20 hours of Board approved community service to be completed within six months of the effective date of the Order, 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. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

### **2013-0098**

Mr. Harvey moved and Dr. Magnuson seconded that the Board, for Respondent #1, close the case with a Letter of Concern addressing the issue of ensuring that the monitoring of heat sterilization devices is done on a weekly basis; for Respondent #2, close the case with a finding of No Violation; and for Respondent #3, close the case with a finding of No Violation. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

### **2013-0186 & 2013-0187**

Dr. Smith moved and Mr. Harvey seconded that the Board close the matter with a Letter of Concern addressing the issue of ensuring that uncertified assistants are not allowed to administer medications. The motion passed with Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye. Dr. Schwindt recused himself.

### **BUGNI, JOHN S., D.M.D. 2012-0085**

Dr. Beck moved and Dr. Parker seconded that the Board to issue a Notice of Proposed Disciplinary Action and offer the Licensee a Consent Order in which the Licensee would agree to be reprimanded, pay a \$6,000.00 civil penalty, complete 40 hours of community service within 12 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. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

### **CHVATAL, BRAD A., D.M.D. 2013-0039**

Mr. Tripp moved and Mr. Harvey seconded that the Board issue a Notice of Proposed Disciplinary Action and offer the Licensee a Consent Order in which the Licensee would agree to be reprimanded, pay a \$6,000.00 civil penalty within 90 days, complete 40 hours of community service within 12 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. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

**2012-0207**

Ms. Davidson moved and Dr. Parker seconded that the Board issue a STRONGLY worded Letter of Concern addressing the issue of ensuring that the standard of care is followed in reference to permanently seating crowns on teeth with incomplete endodontic therapy. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

**DANG, MY T., D.D.S. 2012-0111**

Dr. Magnuson moved and Ms. Davidson seconded that the Board issue a Notice of Proposed Disciplinary Action and offer the Licensee a Consent Order in which the Licensee would agree to be reprimanded, pay a \$6,000.00 civil penalty, complete 40 hours of community service within 12 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. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

**DAVENPORT, RICHARD W., D.M.D. 2012-0153**

Dr. Parker moved and Dr. Smith seconded that the Board issue a Notice of Proposed Disciplinary Action and offer the Licensee a Consent Order in which the Licensee would agree to be reprimanded. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

**DUFFIN, RALPH K., D.D.S. 2013-0015**

Mr. Harvey moved and Dr. Smith seconded that the Board issue a Notice of Proposed License Revocation and offer Licensee a Consent Order whereby Licensee retires his Oregon dental license and agrees not to reapply for reinstatement at any time. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

**HARRELL, MARY K., D.M.D. 2013-0185 & 2013-0121**

Dr. Smith moved and Dr. Magnuson seconded that the Board Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand; Board approved continuing education with three hours – record keeping within six months, four hours – treatment of the medically compromised patient within six months, 16 hours – simple extractions, surgical extractions, extraction complications, and root removal within six months; restricted license barring all extractions until completion of a Board approved mentor program focused on extractions. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

**2013-0038**

Dr. Beck moved and Dr. Smith seconded that the Board for Respondent #1, close the case with a finding of No Violation; and for Respondent #2, close the case with a Letter of Concern reminding the licensee to ensure that a dental diagnosis is documented to justify treatment that is subsequently provided; that the epinephrine concentration in the anesthetic used is documented; and that continuing education documents are retained and accessible for two licensure cycles. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

**2013-0083**

Mr. Tripp moved and Dr. Parker seconded that the Board close the matter with a Letter of Concern reminding the Licensee that it is the Licensee's responsibility to participate in the appropriate number of continuing education hours required for each licensure cycle, and that proof of attendance at all continuing education courses be kept for at least four years. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

**MIYAMOTO-SHEMALI, MIKA, D.M.D. 2011-0034**

Dr. Magnuson moved and Dr. Parker seconded that the Board issue a Notice of Proposed Disciplinary Action and offer the Licensee a Consent Order in which the Licensee would agree to be reprimanded; to pay a \$25,000.00 civil penalty; to complete 80 hours of community service within 18 months; to not employ her husband, Eli Shemali, at the physical location of her practice or allow him any access to patients or patient records; to 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 two times per year; 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. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

**2013-0216**

Ms. Davidson moved and Dr. Beck seconded that the Board close the matter with a finding of No Violation of the Dental Practice Act. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

**PHILSTROM, DANIEL J., D.D.S. 2013-0006**

Dr. Parker moved and Mr. Harvey seconded that the Board issue a Notice of Proposed Disciplinary Action and offer the Licensee a Consent Order in which the Licensee would agree to be reprimanded and to open a case to review allegation of unacceptable patient care on the part of another respondent. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

**2013-0159**

Mr. Harvey moved and Dr. Smith seconded that the Board close the matter with a Letter of Concern reminding the Licensee that it is the Licensee's responsibility to participate in the appropriate number of continuing education hours required for each licensure cycle. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

**2013-0092**

Dr. Smith moved and Ms. Davidson seconded that the Board grant Applicant a dental hygiene license. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

**ROBINSON, TRACY R., D.M.D. 2013-0058**

Dr. Beck moved and Mr. Tripp seconded that the Board issue a Notice of Proposed Disciplinary Action and offer the Licensee a Consent Order in which the Licensee would agree to be reprimanded, pay a \$10,000.00 civil penalty to be paid within 120 days, to complete 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. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

**2013-0158**

Mr. Tripp moved and Dr. Magnuson seconded that the Board close the matter with a STRONGLY worded Letter of Concern addressing the issue of ensuring that the Licensee is in compliance with the Board's rules for the dispensing and administration of medications by dental assistants, that written informed consent is documented when providing moderate sedation, and that when informed consent is obtained prior to providing treatment, PARQ or its equivalent is documented in the patient records. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson,

Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

**2013-0193**

Dr. Magnuson moved and Mr. Harvey seconded that the Board close the matter with a STRONGLY Worded Letter of Concern addressing the issue of ensuring that Licensee strictly adheres to sterilization rules, and that gloves remain intact while treating patients. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

**2013-0129**

Ms. Davidson moved and Dr. Parker seconded that the Board close the matter with a Letter of Concern addressing the issue of ensuring that when radiographs are taken prior to the extraction of teeth, the radiographs show the periapical regions of the teeth to be extracted. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

**YOON, JASON I., D.M.D. 2014-0007**

Dr. Parker moved and Mr. Tripp seconded that the Board issue a Notice of Proposed Disciplinary Action and offer the Licensee a Consent Order in which the Licensee would agree to be reprimanded, to pay a \$5,000.00 civil penalty, to complete a nitrous oxide sedation course and apply for a nitrous oxide permit, and to complete at least three hours of continuing education in record keeping. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

**PREVIOUS CASES REQUIRING BOARD ACTION**

**BAUMGARDNER, CYNTHIA K., R.D.H. 2012-0192**

Mr. Harvey moved and Dr. Beck seconded that the Board accept Licensee's proposal and offer Licensee a Consent Order incorporating a reprimand and completion of 20 hours of Board approved community service within six months of the effective date of the Order. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

**BLODGETT, KELLY J., D.M.D. 2013-0130**

Dr. Magnuson moved and Mr. Harvey seconded that the Board offer Licensee a re-worded Consent Order, incorporating a reprimand, a \$6,000.00 civil penalty, 40 hours of community service to be completed within 12 months 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. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

**BOYDSTON, ANGELA D., D.M.D. 2013-0113**

Dr. Magnuson moved and Ms. Davidson seconded that the Board issue an Order of Dismissal, dismissing the Notice of Proposed Disciplinary Action issued 4/24/13, and close the case with a Letter of Concern reminding Licensee to ensure that uncertified persons do not administer medications. The motion passed with Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye. Dr. Schwindt recused himself.

**LICENSEE 2004-0173**

Dr. Smith moved and Mr. Harvey seconded that the Board close with a determination of No Further Action. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson,

Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

**LICENSEE 2008-0254**

Dr. Beck moved and Dr. Parker seconded that the Board grant Licensee's request and release License from the requirements of her Amended Voluntary Diversion Agreement and her contract with HPSP. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

**LICENSEE 2012-0025**

Mr. Tripp moved and Dr. Magnuson seconded that the Board issue a dental license to Licensee providing he agree to the terms of an Agreement, whereby he enters into the State's Health Professionals' Services Program; for a period of five years practices dentistry only in a group setting; and other provisions to support his recovery and protect the public. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

**MATTHEWS, CHRISTOPHER, D.M.D. 2011-0023**

Dr. Magnuson moved and Ms. Davidson seconded that the Board move to issue an Order of Dismissal, dismissing the Notice of Proposed Disciplinary Action, dated 6/29/11, and close the case with a Letter of Concern reminding Licensee to ensure that, when obtaining informed consent before treatment is provided, PARQ or its equivalent is documented in the patient record. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

**MURRAY-KENNETH A., D.D.S. 2012-0005**

Dr. Magnuson moved and Ms. Davidson seconded that the Board offer Licensee a re-worded Consent Order, incorporating a reprimand, a \$6,000.00 civil penalty, 40 hours of community service to be completed within 12 months 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. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

**NOUREDINE, HADI A., D.M.D. 2012-0188**

Dr. Magnuson moved and Ms. Davidson seconded that the Board offer Licensee a re-worded Consent Order, incorporating a reprimand, a \$6,000.00 civil penalty, 40 hours of community service to be completed within 12 months 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. The motion passed with Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye. Dr. Schwindt recused himself.

**OVER, LARRY M., D.M.D. 2013-0005**

Ms. Davidson moved and Mr. Harvey seconded that the Board decline Licensee's proposal and offer Licensee a re-worded Consent Order incorporating a reprimand, a \$6,000.00 civil penalty, 40 hours of community service to be completed within 12 months and, for a period of one year from 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. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

**SMITH, GRANT M., D.D.S. 2013-0119**

Dr. Parker moved and Dr. Smith seconded that the Board issue a Default Order of License Suspension. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr.

Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

#### **SUNDBERG, VISEH, D.D.S. 2012-0095**

Dr. Magnuson moved and Dr. Beck seconded that the Board offer Licensee a re-worded Consent Order, incorporating a reprimand, a \$6,000.00 civil penalty, 40 hours of community service to be completed within 12 months 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. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

#### **USO III, MADRID, D.D.S. 2013-0107**

Mr. Harvey moved and Mr. Tripp seconded that the Board deny Licensee's request and offer Licensee a Consent Order incorporating a reprimand and a \$1,000.00 civil penalty to be paid within three months of the effective date of the Order, and requirement that Licensee submit, with his license renewal applications, documentation verifying completion of continuing education for the licensure period 4/1/13 to 3/31/15. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

#### **WALLE, NEIL M., D.D.S. 2010-0197**

Dr. Smith moved and Dr. Magnuson seconded that the Board recognize Licensee's treatment of patient BH and release him from the requirement that he complete the treatment of this patient. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

### **LICENSURE AND EXAMINATION**

#### **Ratification of Licenses Issued**

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

#### **Dental Hygiene**

H6483	KIMBERLY E UPTON, R.D.H.	6/19/2013
H6484	ALLIE M MC EOWEN, R.D.H.	6/19/2013
H6485	MARLEY M WINKELMAN, R.D.H.	6/26/2013
H6486	BRANDY L SENESTRARO, R.D.H.	6/26/2013
H6487	ASHA M LITTLE, R.D.H.	6/26/2013
H6488	ANNEKATHRIN WARTMANN, R.D.H.	6/26/2013
H6489	ANDREA HEDGES, R.D.H.	6/26/2013
H6490	KIMBERLY R HALL, R.D.H.	7/8/2013
H6491	RENEE J LAWSON, R.D.H.	7/8/2013
H6492	PEGGY P JUHASZ, R.D.H.	7/8/2013
H6493	ALYSSA PACKARD, R.D.H.	7/8/2013
H6494	SHANNON T PETRJANOS, R.D.H.	7/8/2013
H6495	MICHELLE N CHAGNON, R.D.H.	7/8/2013
H6496	SHAUNA D SONODA, R.D.H.	7/8/2013
H6497	NEGAR N GARDNER, R.D.H.	7/8/2013
H6498	BAILEY M LAPP, R.D.H.	7/8/2013

H6499	HALEY N O'REAR, R.D.H.	7/9/2013
H6500	CHANDRA L WADE-ROGERS, R.D.H.	7/9/2013
H6501	TIFFANY A MATSUMOTO, R.D.H.	7/9/2013
H6502	SARAH M HAYS, R.D.H.	7/9/2013
H6503	MELINDA R NALDER, R.D.H.	7/9/2013
H6504	LINDSAY P KELLER, R.D.H.	7/9/2013
H6505	AUDREY L LUTES, R.D.H.	7/9/2013
H6506	CASEY L SCROGGINS, R.D.H.	7/16/2013
H6507	SARA A NATHMAN, R.D.H.	7/16/2013
H6508	AMANDA M CAMPBELL, R.D.H.	7/16/2013
H6509	KARLEE R EYTZEN, R.D.H.	7/16/2013
H6510	LILY BURRIS, R.D.H.	7/16/2013
H6511	KATHINA J JUSTICE, R.D.H.	7/16/2013
H6512	LOLEINA D LAPINA, R.D.H.	7/16/2013
H6513	CALLI J CROSLIN, R.D.H.	7/16/2013
H6514	ALYSHA A HELLBUSCH, R.D.H.	7/16/2013
H6515	JACKIE L BERNHARDT, R.D.H.	7/16/2013
H6516	CINDY KIEU, R.D.H.	7/17/2013
H6517	LINDSEY D SALTS, R.D.H.	7/22/2013
H6518	ALYSSA D DURANT, R.D.H.	7/29/2013
H6519	KIM D SALINAS, R.D.H.	7/29/2013
H6520	STEPHANIE L MASON, R.D.H.	7/29/2013
H6521	ERICA L FILIPETTI, R.D.H.	7/29/2013
H6522	JESSICAH M KIRKPATRICK, R.D.H.	7/29/2013
H6523	MICHELLE C CLOBES, R.D.H.	7/29/2013
H6524	ALAYNA N GOEBEL, R.D.H.	7/29/2013
H6525	KRISTIN A WEST, R.D.H.	7/29/2013
H6526	LINSAY K MC CULLOUGH, R.D.H.	7/29/2013
H6527	LENA Y GATES, R.D.H.	7/29/2013
H6528	MEGAN M BRIDGEMAN, R.D.H.	7/29/2013
H6529	COURTNEY L MC EOWEN, R.D.H.	7/29/2013
H6530	SARA PRUSZKOWSKI, R.D.H.	7/29/2013
H6531	MICHELLE M EDWARDS, R.D.H.	7/30/2013
H6532	ALYSSA HEMMINGSON, R.D.H.	7/30/2013
H6533	TAMAR DAVIS, R.D.H.	7/30/2013
H6534	JESSICA A TIMBERLAKE, R.D.H.	7/30/2013
H6535	SIERRA N CORDELL, R.D.H.	7/30/2013
H6536	STEPHANIE M RODRIGUEZ-PUHLMAN, R.D.H.	7/30/2013
H6537	ANNA MARIA POSTEUCA, R.D.H.	7/30/2013
H6538	GEN N SAECHAO, R.D.H.	7/30/2013
H6539	KIM J ZUTAVERN COMBS, R.D.H.	7/31/2013
H6540	DEIDRE E ELLIOTT, R.D.H.	7/31/2013
H6541	SARAH A HUDDLESTON, R.D.H.	7/31/2013
H6542	SNEZHANA V GROZ, R.D.H.	7/31/2013
H6543	DENISE L HOLT, R.D.H.	7/31/2013
H6544	HEATHER H FOSTER, R.D.H.	7/31/2013
H6545	KYRA N SPEER, R.D.H.	7/31/2013
H6546	NAYEON KIM, R.D.H.	7/31/2013
H6547	KATELYNN W YOUNG, R.D.H.	7/31/2013
H6548	JAYME E HAUCK, R.D.H.	7/31/2013
H6549	HALIE R GEORGE, R.D.H.	7/31/2013

H6550	ALICIA R FRIEDEMANN, R.D.H.	7/31/2013
H6551	KINDEE R RAMIREZ, R.D.H.	7/31/2013
H6552	KELLY R ANSLEY, R.D.H.	7/31/2013
H6553	MELISSA R ABBOTT, R.D.H.	7/31/2013
H6554	CARYN M DASTRUP, R.D.H.	7/31/2013
H6555	JOLEE H MC CARTY, R.D.H.	7/31/2013
H6556	SARA ELIZABETH COATES, R.D.H.	7/31/2013
H6557	ELIZABETH A STEWART, R.D.H.	7/31/2013
H6558	BRITTNEY E AMIEL, R.D.H.	7/31/2013
H6559	SPLAUSHA M HORNE, R.D.H.	7/31/2013
H6560	DENISE OOSTHUIZEN, R.D.H.	7/31/2013

### DENTISTS

D9877	JEFFREY A SULITZER, D.M.D.	6/19/2013
D9878	MEGAN L NEVILLS, D.M.D.	6/19/2013
D9879	JAY M SLATER, D.M.D.	6/19/2013
D9880	ROBERT M FROME, D.M.D.	6/19/2013
D9881	YENBA T BUI, D.M.D.	6/19/2013
D9882	PATRICK J CORNING, D.M.D.	6/19/2013
D9883	YOSHIYUKI CHARLIE MURAKI, D.M.D.	6/19/2013
D9884	WAYNE K VAN DE GRAAFF, D.D.S.	6/19/2013
D9885	MATTHEW C SCHAPPER, D.M.D.	6/19/2013
D9886	STANLEY E RAMLEY, D.D.S.	6/19/2013
D9887	SARAH E TOWARD, D.D.S.	6/26/2013
D9888	ERIC N ALSTON, D.M.D.	6/26/2013
D9889	MARCY J WATSON, D.D.S.	6/26/2013
D9890	LUCAS B MESDAG, D.M.D.	6/26/2013
D9891	CHELSEA N BARAFF, D.M.D.	7/8/2013
D9892	SUSANNY THENUS, D.M.D.	7/8/2013
D9893	HETALBAHEN TRIVEDI, D.M.D.	7/8/2013
D9894	SHANE L PHILLIPS, D.D.S.	7/8/2013
D9895	RACHAEL M HEYDT, D.D.S.	7/16/2013
D9896	MATTHEW S RYSKALCZYK, D.M.D.	7/16/2013
D9897	DAVID M WILSON, D.M.D.	7/16/2013
D9898	CHRISTOPHER H HILL, D.M.D.	7/16/2013
D9899	TOCHUKWU ONWUACHUSI-OKEKE, D.D.S.	7/16/2013
D9900	ERICA J COE, D.M.D.	7/16/2013
D9901	KELLY E GILMORE, D.M.D.	7/16/2013
D9902	QUINN R HUMMEL, D.M.D.	7/16/2013
D9903	JEREMIAH D SHAKESPEAR, D.D.S.	7/16/2013
D9904	JONATHAN E NELSON, D.M.D.	7/16/2013
D9905	ANDREW G PETERSON, D.M.D.	7/16/2013
D9906	JENNIFER L SNARSKIS, D.M.D.	7/16/2013
D9907	GENA VINSKY, D.M.D.	7/16/2013
D9908	MATTHEW J YOUNG, D.M.D.	7/16/2013
D9909	STEPHANIE N NESS, D.M.D.	7/16/2013
D9910	TAYLOR C FOWLES, D.M.D.	7/16/2013
D9911	MATTHEW K CHUNG, D.D.S.	7/16/2013
D9912	VLADIMIR R JOVIC, D.M.D.	7/16/2013
D9913	AMY J TREVOR, D.M.D.	7/29/2013

D9914	CHAD W HARTZELL, D.M.D.	7/31/2013
D9915	AARON HUANG, D.D.S.	7/31/2013
D9916	PETER C DENNIS, D.M.D.	7/31/2013
D9917	JEREMY M STARR, D.D.S.	7/31/2013
D9918	DUSTIN J MC BRIDE, D.M.D.	7/31/2013
D9919	PETER N NGUYEN, D.M.D.	7/31/2013
D9920	CHARLES L KINCAID, D.D.S.	7/31/2013
D9921	CHERYL L SIXKILLER, D.D.S.	7/31/2013
D9922	ALEXANDER W NESS, D.M.D.	7/31/2013
D9923	MILI PATEL, D.D.S.	7/31/2013
D9924	TAMER EL NAGGAR, D.D.S.	7/31/2013
D9925	GEOFFREY W BLATTER, D.M.D.	7/31/2013
D9926	JORDAN D ANDERSON, D.D.S.	7/31/2013
D9927	PRASHANT POPLAI, D.D.S.	7/31/2013
D9928	BRIAN J KITCHELL, D.M.D.	7/31/2013
D9929	NATALYA R RAMSAY, D.M.D.	7/31/2013
D9930	RAYMOND B TUCKER, D.D.S.	7/31/2013
D9931	J. TRAVIS DUFFY, D.M.D.	7/31/2013
D9932	AMANDA N KREMER, D.M.D.	7/31/2013
D9933	ALYSE M DRAKULICH, D.M.D.	7/31/2013
D9934	AMY K ANTHONY, D.M.D.	7/31/2013
D9935	ROXANA SHAHNAVAZ, D.D.S.	7/31/2013
D9936	ROBERT J KOWAL, D.D.S.	7/31/2013
D9937	BRANDON L BIEHLER, D.M.D.	7/31/2013
D9938	DANIEL D EASTMAN, D.D.S.	7/31/2013
D9939	NICOLE M MC KAY, D.M.D.	7/31/2013
D9940	JAMES P DURNIN, D.M.D.	8/5/2013
D9941	NICHOLAS R BACKOWSKI, D.M.D.	8/5/2013

Dr. Parker moved and Ms. Davidson seconded that licenses issued be ratified as published. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

**Reinstatement of Licensee Gary W. Cooper, DDS**

Dr. Beck moved and Mr. Harvey seconded that the Board reinstate the dental license of Gary W. Cooper, DDS. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

**Request for Approval of General Anesthesia Permit, Kenneth L Reed, DMD**

Mr. Tripp moved and Mr. Harvey seconded that the Board approve the general anesthesia permit of Dr. Kenneth L. Reed, DMD. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

**Request for Approval of Moderate Sedation Permit, Douglas L. Park, DDS**

Dr. Magnuson moved and Dr. Beck seconded that the Board approve the moderate sedation permit of Dr. Douglas L. Park, DDS. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

**Announcement**

No announcements

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

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

## **ADMINISTRATIVE REVIEW**

### **REVIEW**

Dr. Magnuson moved and Dr. Parker seconded that the Board accept Mr. Braatz's performance rating as presented by the Administrative Workgroup. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

### **ADMINISTRATIVE GOALS**

Dr. Beck moved and Mr. Harvey seconded that the Board approve the goals presented for the executive director for the 2013-2014 year. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

### **EXCEPTIONAL PERFORMANCE LEAVE WITH PAY**

Dr. Magnuson moved and Ms. Davidson seconded that the Board grant Mr. Braatz 40 hours of exceptional performance leave with pay. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

## **ADJOURNMENT**

The meeting was adjourned at 1:30 p.m. Dr. Hongo stated that the next Board meeting would take place October 18, 2013.

Approved by the Board October 18, 2013.

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Jonna A. Hongo, D.M.D.  
President

**OREGON BOARD OF DENTISTRY**  
**Special Teleconference Minutes**  
**September 5, 2013**

MEMBERS PRESENT: Jonna E. Hongo, D.M.D., President  
VIA PHONE: Brandon Schwindt, D.M.D., Vice-President  
Todd Beck, D.M.D.  
Mary Davidson, M.P.H., R.D.H.  
Alton Harvey, Sr.  
Norman Magnuson, D.D.S.  
James Morris  
Patricia Parker, D.M.D.  
Matt Tripp, R.D.H.

STAFF PRESENT: Patrick D. Braatz, Executive Director  
Paul Kleinstub, D.D.S., M.S., Dental Director/Chief Investigator  
Michelle Lawrence, D.M.D., Consultant  
Stephen Prisby, Office Manager  
Harvey Wayson, Investigator

ALSO PRESENT VIA PHONE: Lori Lindley, Sr. Assistant Attorney General

VISITORS PRESENT: None

**Call to Order:** The meeting was called to order by the President at 12:00 p.m. at the Board office; 1600 SW 4<sup>th</sup> Ave., Suite 770, Portland, Oregon.

## **NEW BUSINESS**

### **COMMITTEE AND LIAISON REPORTS**

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

Dr. Schwindt stated that the Rules Oversight Committee met August 22, 2013 and recommended that the Board send the Rules as presented below to a public rulemaking hearing as presented.

#### **OAR 818-012-0005 – Scope of Practice**

Mr. Harvey moved and Mr. Morris seconded that the Board send OAR 818-012-0005 forward to a public rulemaking hearing as presented. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker and Mr. Tripp voting aye.

#### **OAR 818-012-0040 (4) Infection Control Guidelines**

Dr. Magnuson moved and Dr. Beck seconded that the Board send OAR 818-012-0040 (4) forward to a public rulemaking hearing as presented. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker and Mr. Tripp voting aye.

**OAR 818-013-0001 (16)-(23) Definitions**

Dr. Parker moved and Dr. Magnuson seconded that the Board send OAR 818-013-0001 (16)-(23) forward to a public rulemaking hearing as presented. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker and Mr. Tripp voting aye.

**OAR 818-013-0005 – Participation in Health Professionals’ Service Program**

Dr. Magnuson moved and Ms. Davidson seconded that the Board send OAR 818-013-0005 forward to a public rulemaking hearing as presented. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker and Mr. Tripp voting aye.

**OAR 818-026-0060 (1)(c)(A) – Moderate Sedation Permit**

Dr. Beck moved and Mr. Harvey seconded that the Board send OAR 818-026-0060 (1)(c)(A) forward to a public rulemaking hearing as presented. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker and Mr. Tripp voting aye.

**OAR 818-042-0060 (2)(c) – Certification - Radiologic Proficiency**

Mr. Tripp moved and Dr. Parker seconded that the Board send OAR 818-042-0060 (2)(c) forward to a public rulemaking hearing as presented. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker and Mr. Tripp voting aye.

**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.**

**COMPLETED CASES**

Dr. Schwindt recused himself from the following cases and left the conference call at 12:10 p.m.

**ANGLE, DARYLL L., D.D.S. 2012-0147 & 2013-0035**

Dr. Magnuson moved and Mr. Harvey seconded that the Board combine cases 2012-0147 and 2013-0035, with cases 2011-0184, 2012-0031, and 2012-0172, to issue a Second Amended Notice of Proposed Disciplinary Action, and to offer the Licensee a Consent Order in which the Licensee would agree to be reprimanded; make a restitution payment to patient CK’s parent MK in the amount of \$3919.98; make a restitution payment to patient MS’s parent TS in the amount of \$3500.00; upon case completion, and prior to de-banding any current patient, submit the next 20 active cases for review by a Board approved orthodontist within a period of two years from the effective date of the Order, at a cost to be borne by the Licensee; monthly submission of spore testing results for a period of one year from the effective date of the Order; complete three hours of Board approved continuing education in the area of record keeping within six months of the effective date of the Order; and pay a civil penalty in the amount of \$25,000.00 per Board protocols. The motion passed with Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker and Mr. Tripp voting aye.

**PREVIOUS CASES REQUIRING BOARD ACTION**

**RODRIGUEZ, ROBERT L. JR., D.M.D. 2009-0275**

Dr. Beck moved and Mr. Harvey seconded that the Board issue a Final Order incorporating a reprimand, three hours of Board approved continuing education in record keeping to be completed

September 5, 2013

Special Teleconference Board Meeting

Page 2 of 3

in six months, three hours of Board approved continuing education in dental risk management to be completed in six months, and reimburse the Board \$7,197.23 for the costs of the disciplinary proceedings within 90 days of the effective date of the Order. The motion passed with Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker and Mr. Tripp voting aye.

### **ADJOURNMENT**

The meeting was adjourned at 12:40 p.m.

Approved by the Board October 18, 2013.

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Jonna A. Hongo, D.M.D.  
President

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# ASSOCIATION REPORTS

**Nothing to report under this tab**

# COMMITTEE REPORTS

**Nothing to report under this tab**

**EXECUTIVE  
DIRECTORS  
REPORT**

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## **EXECUTIVE DIRECTOR'S REPORT**

**October 18, 2013**

### **OBD Budget Status Report**

Attached is the latest budget report for the 2013 - 2015 Biennium. This report, which is from July 1, 2013 through August 31, 2013, shows revenue of \$297,483.21 and expenditures of \$170,513.44. If Board members have questions on this budget report format, please feel free to ask me. **Attachment #1**

### **Customer Service Survey**

Attached is a chart which shows the OBD State Legislatively Mandated Customer Service Survey Results from July 1, 2013 through September 30, 2013.

The results of the survey show that the OBD continues to receive positive comments from the majority of those that return the surveys. The booklet containing the written comments that are on the survey forms, which staff has reviewed, are available on the table for Board members to review. **Attachment #2**

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

I made a presentation on "Updates from the OBD" to the Oregon Dental Association House of Delegates on September 6, 2013 in Sun River, Oregon.

I made a presentation on "Updates from the OBD" to the Marion Dental Research Group on Wednesday, September 18, 2013 in Salem, Oregon.

I made a presentation on "Updates from the OBD" to the Orthodontics Study Club on Monday, October 7, 2013 in Portland, Oregon.

### **Office Lease**

It is hoped that by the time of this Board Meeting the lease for our new space will have been signed and sealed.

We are working on a move date of December 6, 2013 with the Board being operational in the new space on December 9, 2013.

I will be able to go into more details at the Board Meeting and be able to answer questions regarding the move and the new lease.

### **Annual Performance Progress Report 2012 - 2013**

Attached please find the 2012 – 2013 Annual Performance Report for the OBD. **Attachment #3**

### **Newsletter**

We are working on trying to get the newsletter to the publisher around November 1<sup>st</sup>.

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

**REVENUES**

<u>Budget</u> <u>Obj</u>	<u>Budget Obj Title</u>	<u>Monthly Activity</u>	<u>Biennium to Date</u> <u>Activity</u>	<u>Financial Plan</u>	<u>Unobligated Plan</u>	<u>Monthly Avg to</u> <u>Date</u>	<u>Monthly Avg to</u> <u>Spend</u>
0205	OTHER BUSINESS LICENSES	183,950.00	274,704.00	0.00	-274,704.00	137,352.00	-12,486.55
0505	FINES AND FORFEITS	17,500.00	19,500.00	0.00	-19,500.00	9,750.00	-886.36
0605	INTEREST AND INVESTMENTS	350.49	672.64	0.00	-672.64	336.32	-30.57
0975	OTHER REVENUE	1,626.50	2,606.57	0.00	-2,606.57	1,303.29	-118.48
		<b>203,426.99</b>	<b>297,483.21</b>	<b>0.00</b>	<b>-297,483.21</b>	<b>148,741.61</b>	<b>-13,521.96</b>

**PERSONAL SERVICES**

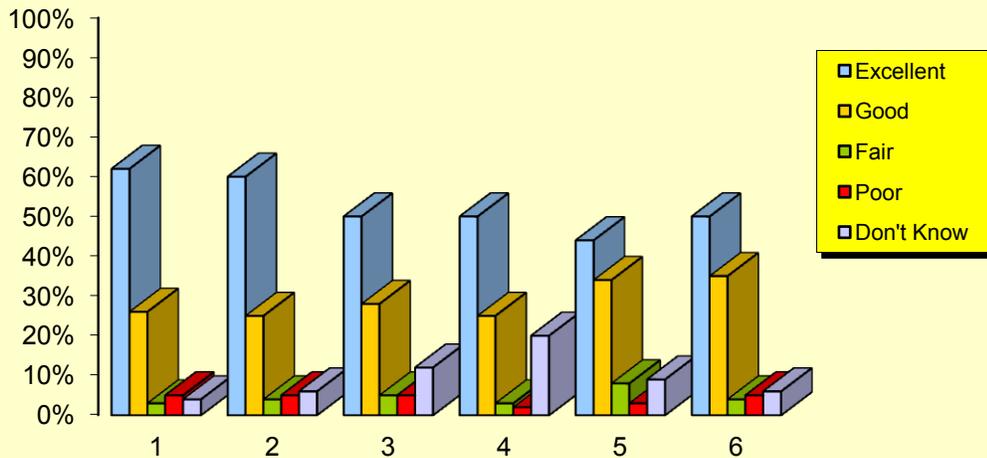
<u>Budget</u> <u>Obj</u>	<u>Budget Obj Title</u>	<u>Monthly Activity</u>	<u>Biennium to Date</u> <u>Activity</u>	<u>Financial Plan</u>	<u>Unobligated Plan</u>	<u>Monthly Avg to</u> <u>Date</u>	<u>Monthly Avg to</u> <u>Spend</u>
3110	CLASS/UNCLASS SALARY & PER DIEM	38,749.00	73,273.74	0.00	-73,273.74	36,636.87	-3,330.62
3170	OVERTIME PAYMENTS	150.21	150.21	0.00	-150.21	75.11	-6.83
3180	SHIFT DIFFERENTIAL	1.50	1.50	0.00	-1.50	0.75	-0.07
3210	ERB ASSESSMENT	8.25	16.50	0.00	-16.50	8.25	-0.75
3220	PUBLIC EMPLOYEES' RETIREMENT SYSTEM	5,400.22	10,770.40	0.00	-10,770.40	5,385.20	-489.56
3221	PENSION BOND CONTRIBUTION	2,197.69	4,383.11	0.00	-4,383.11	2,191.56	-199.23
3230	SOCIAL SECURITY TAX	2,925.26	5,515.79	0.00	-5,515.79	2,757.90	-250.72
3250	WORKERS' COMPENSATION ASSESSMENT	22.20	40.82	0.00	-40.82	20.41	-1.86
3260	MASS TRANSIT	208.30	415.44	0.00	-415.44	207.72	-18.88
3270	FLEXIBLE BENEFITS	8,288.14	16,576.28	0.00	-16,576.28	8,288.14	-753.47
		<b>57,950.77</b>	<b>111,143.79</b>	<b>0.00</b>	<b>-111,143.79</b>	<b>55,571.90</b>	<b>-5,051.99</b>

**SERVICES and SUPPLIES**

<u>Budget</u> <u>Obj</u>	<u>Budget Obj Title</u>	<u>Monthly Activity</u>	<u>Biennium to Date</u> <u>Activity</u>	<u>Financial Plan</u>	<u>Unobligated Plan</u>	<u>Monthly Avg to</u> <u>Date</u>	<u>Monthly Avg to</u> <u>Spend</u>
4100	INSTATE TRAVEL	5,223.90	6,100.54	0.00	-6,100.54	3,050.27	-277.30
4125	OUT-OF-STATE TRAVEL	2,036.94	3,752.64	0.00	-3,752.64	1,876.32	-170.57
4150	EMPLOYEE TRAINING	0.00	2,090.00	0.00	-2,090.00	1,045.00	-95.00
4175	OFFICE EXPENSES	948.79	4,618.24	0.00	-4,618.24	2,309.12	-209.92
4200	TELECOMM/TECH SVC AND SUPPLIES	30.42	60.84	0.00	-60.84	30.42	-2.77
4225	STATE GOVERNMENT SERVICE CHARGES	6,445.75	6,493.50	0.00	-6,493.50	3,246.75	-295.16
4250	DATA PROCESSING	479.00	812.75	0.00	-812.75	406.38	-36.94
4275	PUBLICITY & PUBLICATIONS	463.03	951.98	0.00	-951.98	475.99	-43.27
4300	PROFESSIONAL SERVICES	4,237.50	10,069.68	0.00	-10,069.68	5,034.84	-457.71



## Oregon Board of Dentistry Customer Service Survey July 1, 2013 - September 30, 2013



- 1 How do you rate the timeliness of the services provided by the OBD?  
E= 62% G= 26% F= 3% P= 5% DK= 4%
- 2 How do you rate the ability of the OBD to provide services correctly the first time?  
E= 60% G= 25% F= 4% P= 5% DK= 6%
- 3 How do you rate the helpfulness of the OBD?  
E= 50% G= 28% F= 5% P= 5% DK= 12%
- 4 How do you rate the knowledge and expertise of the OBD?  
E= 50% G= 25% F= 3% P= 2% DK= 20%
- 5 How do you rate the availability of information at the OBD?  
E= 44% G= 34% F= 8% P= 3% DK= 9%
- 6 How do you rate the overall quality of services provided by the OBD?  
E= 50% G= 35% F= 4% P= 5% DK= 6%

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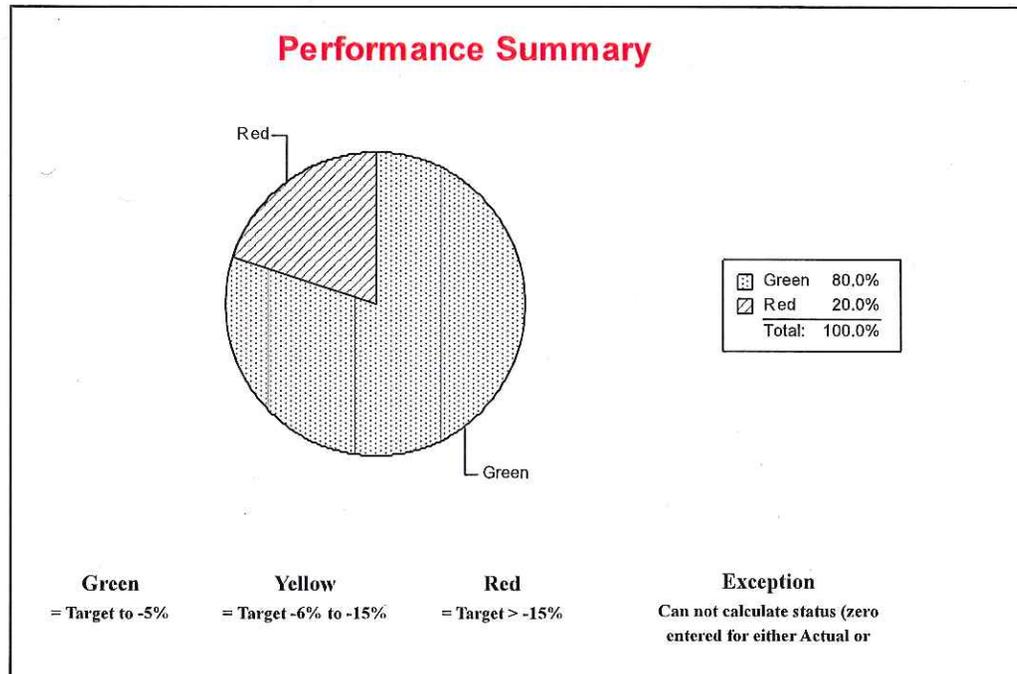
**DENTISTRY, BOARD of**  
**Annual Performance Progress Report (APPR) for Fiscal Year (2012-2013)**

Original Submission Date: 2013

Finalize Date: 9/2/2013

2012-2013 KPM #	2012-2013 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.

<b>DENTISTRY, BOARD of</b>		<b>I. EXECUTIVE SUMMARY</b>	
<b>Agency Mission:</b> To assure that the citizens of Oregon receive the highest possible quality of oral health care.			
<b>Contact:</b> Patrick D Braatz, Executive Director		<b>Contact Phone:</b> 971-673-3200	
<b>Alternate:</b>		<b>Alternate Phone:</b>	



**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 August 1, 2013, there were 3,689 dentists, and 4,136 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.

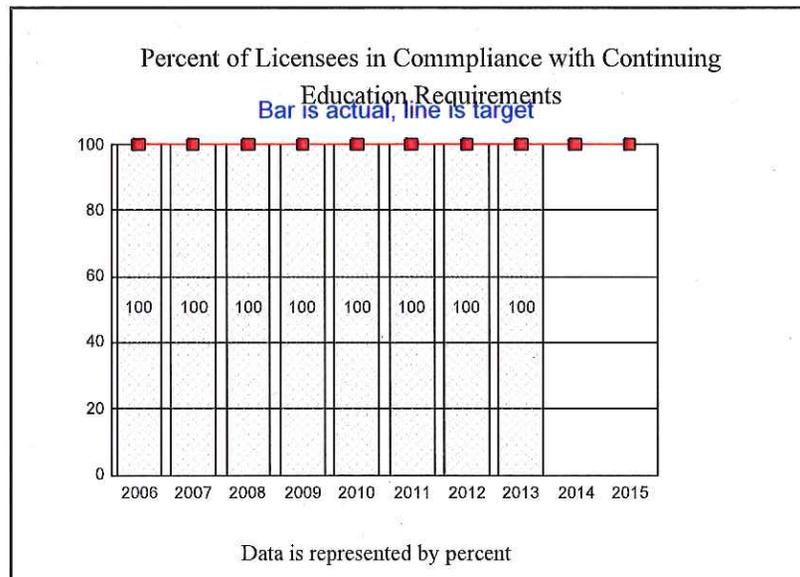
## **4. CHALLENGES**

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 2013- 2015 Legislatively Adopted Budget is \$2,614,968.

<b>DENTISTRY, BOARD of</b>		<b>II. KEY MEASURE ANALYSIS</b>
<b>KPM #1</b>	Continuing Education Compliance - Percent of Licensees in compliance with continuing education requirements.	2001
<b>Goal</b>	Public Protection - Protect the public by assuring that all licensees are competent to practice safely and ethically.	
<b>Oregon Context</b>	The Oregon Board of Dentistry has no primary links to the Oregon Benchmarks.	
<b>Data Source</b>	Agency records from continuing education audit logs.	
<b>Owner</b>	Oregon Board of Dentistry, Patrick D. Braatz, 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**

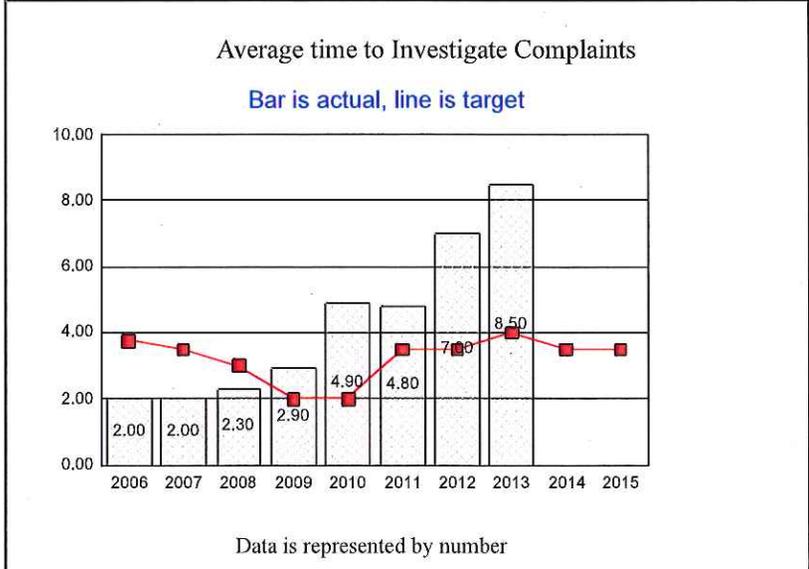
Nothing needs to be done at this time.

**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.

<b>DENTISTRY, BOARD of</b>	<b>II. KEY MEASURE ANALYSIS</b>
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<b>KPM #2</b>	Time to Investigate Complaints - Average time from receipt of new complaints to completed investigation.	2000
<b>Goal</b>	Public Protection - Protect the public by assuring that all licensees are competent to practice safely and ethically.	
<b>Oregon Context</b>	The Oregon Board of Dentistry has no primary links to the Oregon Benchmarks.	
<b>Data Source</b>	Database - investigative files.	
<b>Owner</b>	Oregon Board of Dentistry, Patrick D. Braatz, Executive Director, (971) 673-3200	



**1. OUR STRATEGY**

The Boards 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 Boards workload.

**2. ABOUT THE TARGETS**

The targets provide for a realistic 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 reasonable and in the past have shown a gradual decline in the number of average months to complete an investigation since this Performance Measure was established, until 2010.

**3. HOW WE ARE DOING**

The Board has seen a significant increase in the kind of complaints and the complexity of the complaints during the current economic downturn, these complaints are requiring a full 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 current economic downturn and the loss of a consultant investigator for over 6 months have caused the time to complete investigations to rise.

**6. WHAT NEEDS TO BE DONE**

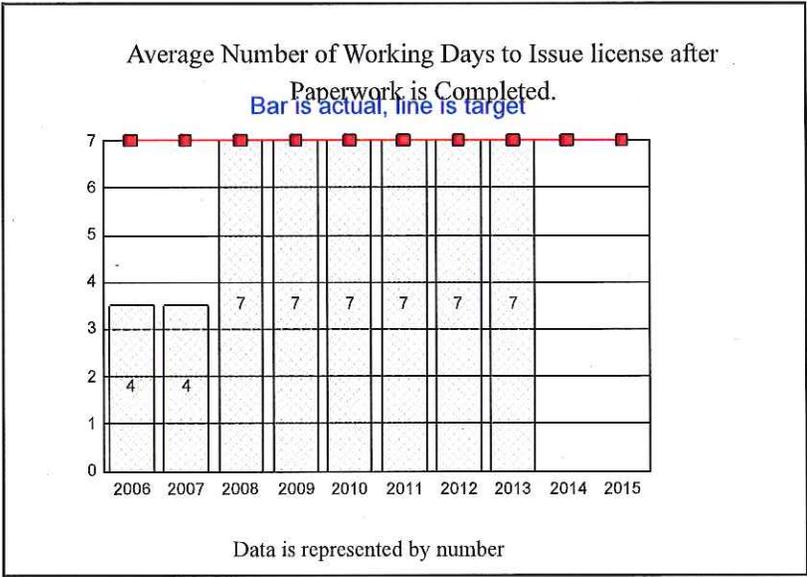
The enforcement staff is working at an increased pace to try to eliminate the time it takes to investigate complaints.

**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.

<b>DENTISTRY, BOARD of</b>	<b>II. KEY MEASURE ANALYSIS</b>
----------------------------	---------------------------------

<b>KPM #3</b>	Days to Complete License Paperwork - Average number of working days from receipt of completed paperwork to issuance of license.	2003
<b>Goal</b>	Public Protection - Protect the public by assuring that all licensees are competent to practice safely and ethically.	
<b>Oregon Context</b>	The Oregon Board of Dentistry has no primary links of the Oregon Benchmarks	
<b>Data Source</b>	Database- licensing information	
<b>Owner</b>	Oregon Board of Dentistry, Patrick D. Braatz, Executive Director, (971) 673-3200	



**1. OUR STRATEGY**

The Boards 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 Boards 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.

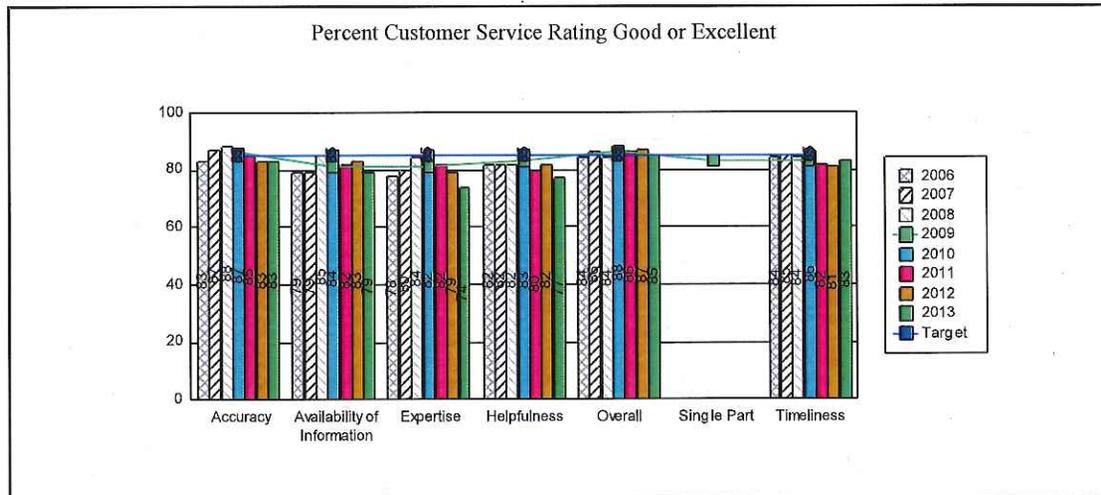
**6. WHAT NEEDS TO BE DONE**

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.

<b>KPM #4</b>	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
<b>Goal</b>	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	
<b>Oregon Context</b>	The Oregon Board of Dentistry has no primary links to the Oregon Benchmarks.	
<b>Data Source</b>	Customer Service Surveys completed and returned July 1, 2012 through June 30, 2013.	
<b>Owner</b>	Oregon Board of Dentistry, Patrick D. Braatz, 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 87% 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.

<b>DENTISTRY, BOARD of</b>	<b>II. KEY MEASURE ANALYSIS</b>
----------------------------	---------------------------------

<b>KPM #5</b>	Board Best Practices - Percent of total best practices met by the Board.	2007
<b>Goal</b>	To have 100% compliance with the Best Practice Performance Measures for Governing Boards and Commissions	
<b>Oregon Context</b>	The Oregon Board of Dentistry has no primary links to Oregon Benchmarks.	
<b>Data Source</b>	Evaluation completed by the Oregon Board of Dentistry Members at July 30, 2010 Board Meeting.	
<b>Owner</b>	Oregon Board of Dentistry, Patrick D. Braatz, 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.

**4. HOW WE COMPARE**

The Agency continues to perform at a 100% rating.

**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 Board Members completed the Self Assessment Best Practices list during the July 30, 2010 Board Meeting.

<b>DENTISTRY, BOARD of</b>	<b>III. USING PERFORMANCE DATA</b>
<b>Agency Mission:</b> To assure that the citizens of Oregon receive the highest possible quality of oral health care.	
<b>Contact:</b> Patrick D Braatz, Executive Director	<b>Contact Phone:</b> 971-673-3200
<b>Alternate:</b>	<b>Alternate Phone:</b>

<b>The following questions indicate how performance measures and data are used for management and accountability purposes.</b>	
<b>1. INCLUSIVITY</b>	<ul style="list-style-type: none"> <li>* <b>Staff :</b> Review of current performance measures on an annual basis.</li> <li>* <b>Elected Officials:</b> Approving an making changes to legislatively approved performance measures.</li> <li>* <b>Stakeholders:</b> Reviewing letters, telephone calls and e-mails regarding the Board's performance measures.</li> <li>* <b>Citizens:</b> Reviewing letters, telephone calls and e-mails regarding the Board's performance measures.</li> </ul>
<b>2 MANAGING FOR RESULTS</b>	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.
<b>3 STAFF TRAINING</b>	Staff has been informed of all comments provided to the Executive Director regarding performance measures.
<b>4 COMMUNICATING RESULTS</b>	<ul style="list-style-type: none"> <li>* <b>Staff :</b> At staff meetings and through e-mails and memos on customer satisfaction.</li> <li>* <b>Elected Officials:</b> Use of Web-site, testimony before Legislature and responding to direct inquiries.</li> <li>* <b>Stakeholders:</b> Use of Web-stie, presentations and responding to direct inquiries.</li> <li>* <b>Citizens:</b> Use of Web-site, presentations and responding to direct inquiries.</li> </ul>

# Agency Management Report

## KPMs For Reporting Year 2013

Finalize Date: 9/2/2013

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)
<b>Summary Stats:</b>	80.00%	0.00%	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	2013	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.	8.50	4.00	Red	2013	The OBD over the last three years has consistently been below the target set for the average number of days to complete an investigation and prepare a report for the Board, unfortunately this year the trend has changed.
3 - Days to Complete License Paperwork - Average number of working days from receipt of completed paperwork to issuance of license.	7	7	Green	2013	The OBD has strived 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	2013	The OBD continues to have a over 80% positive rating from the cusotmers who complete the Customer Service Survey.

# Agency Management Report

## KPMs For Reporting Year 2013

Finalize Date: 9/2/2013

KPMs	Actual	Target	Status	Most Recent Year	Management Comments
5 - Board Best Practices - Percent of total best practices met by the Board.	100	100	Green	2013	The OBD continues to complete the Board Best Practices Evaluation and had a 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.

## Legislatively Approved 2013-2015 Key Performance Measures

**Agency:** DENTISTRY, BOARD of

**Mission:** To assure that the citizens of Oregon receive the highest possible quality of oral health care.

Legislatively Proposed KPMs	Customer Service Category	Agency Request	Most Current Result	Target 2014	Target 2015
1 - Continuing Education Compliance - Percent of Licensees in compliance with continuing education requirements.		Approved KPM	100.00	100.00	100.00
2 - Time to Investigate Complaints - Average time from receipt of new complaints to completed investigation.		Approved KPM	8.50	3.50	3.50
3 - Days to Complete License Paperwork - Average number of working days from receipt of completed paperwork to issuance of license.		Approved KPM	7.00	7.00	7.00
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.		Approved KPM	83.00	85.00	85.00
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.	Accuracy	Approved KPM	83.00	85.00	85.00
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.	Availability of Information	Approved KPM	79.00	85.00	85.00
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.	Expertise	Approved KPM	74.00	85.00	85.00
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.	Helpfulness	Approved KPM	77.00	85.00	85.00

**Agency: DENTISTRY, BOARD of**

Mission: To assure that the citizens of Oregon receive the highest possible quality of oral health care.

<b>Legislatively Proposed KPMs</b>	<b>Customer Service Category</b>	<b>Agency Request</b>	<b>Most Current Result</b>	<b>Target 2014</b>	<b>Target 2015</b>
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.	Overall	Approved KPM	85.00	85.00	85.00
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.	Timeliness	Approved KPM	83.00	85.00	85.00
5 - Board Best Practices - Percent of total best practices met by the Board.		Approved KPM	100.00	100.00	100.00

**LFO Recommendation:**

**Sub-Committee Action:**

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UNFINISHED  
BUSINESS  
&  
RULES

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

<u>Oregon Board of Dentistry</u>	818
Agency and Division	Administrative Rules Chapter Number
<u>Stephen Prisby</u>	(971) 673-3200
Rules Coordinator	Telephone
<u>Oregon Board of Dentistry, 1600 SW 4th Ave., Suite 770, Portland, OR 97201</u>	
Address	

**RULE CAPTION**

Amends Practice, HPSP, Sedation Permit, infection control, use of silver nitrate and radiologic proficiency rules.

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

Hearing Date	Time	Location	Hearings Officer
10-17-13	7:00 p.m.	OHSU Center for Health/Healing, 749 SW Whitaker Street, 3rd fl, Rm 1A	Board President

**RULEMAKING ACTION**

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

**ADOPT:**

**AMEND:**

818-012-0005, 818-012-0040, 818-013-0001, 818-013-0005, 818-026-0060, 818-035-0030, 818-042-0040, 818-042-0060

**REPEAL:**

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

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

**Statutory Authority:**

ORS 181, 183, 679, 680

**Other Authority:**

**Statutes Implemented:**

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

**RULE SUMMARY**

- The Board is amending 818-012-0005 to clarify the use of Botulinum Toxin Type A.
- The Board is amending 818-012-0040 to clarify the record keeping requirements for sterilization equipment.
- The Board is amending 818-013-0001 to delete language from the rule.
- The Board is amending 818-013-0005 to delete language from the rule.
- The Board is amending 818-026-0060 to clarify the rule.
- The Board is amending 818-035-0030 to allow the use of silver nitrate solutions.
- The Board is amending 818-042-0040 to exclude the administration of silver nitrate solution from list of prohibited actions.
- The Board is amending 818-042-0060 to add digital radiographs as an option for proficiency.

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

**FILED**  
9-12-13 9:46 AM  
ARCHIVES DIVISION  
SECRETARY OF STATE

<u>10-17-2013 4:00 p.m.</u>	<u>Stephen Prisby</u>	<u>stephen.prisby@state.or.us</u>
Last Day (m/d/yyyy) and Time for public comment	Rules Coordinator Name	Email Address

\*The Oregon Bulletin is published on the 1st of each month and updates the rule text found in the Oregon Administrative Rules Compilation. Notice forms must be submitted to the Administrative Rules Unit, Oregon State Archives, 800 Summer Street NE, Salem, Oregon 97310 by 5:00 pm on the 15th day of the preceding month unless this deadline falls on a Saturday, Sunday or legal holiday when Notice forms are accepted until 5:00pm on the preceding workday. ARC 923-2003

\*The Oregon Bulletin is published on the 1st of each month and updates the rule text found in the Oregon Administrative Rules Compilation. Notice forms must be submitted to the Administrative Rules Unit, Oregon State Archives, 800 Summer Street NE, Salem, Oregon 97310 by 5:00 pm on the 15th day of the preceding month unless this deadline falls on a Saturday, Sunday or legal holiday when Notice forms are accepted until 5:00pm on the preceding workday.  
ARC 923-2003

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

Oregon Board of Dentistry  
Agency and Division

818  
Administrative Rules Chapter Number

Amends Practice, HPSP, Sedation Permit, infection control, use of silver nitrate and radiologic proficiency rules.

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

In the Matter of:

The amendment of OARs:

818-012-0005  
818-012-0040  
818-013-0001  
818-013-0005  
818-026-0060  
818-035-0030  
818-042-0040  
818-042-0060

**Statutory Authority:**

ORS 181, 183, 679, 680

**Other Authority:**

**Statutes Implemented:**

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

**Need for the Rule(s):**

The amendment to 818-012-0005 clarifies the training a dentist needs to use Botulinum Toxin Type A.

The amendment to 818-012-0040 clarifies the record keeping requirements for sterilization equipment.

The amendment to 818-013-0001 eliminates a self-referral to the HPSP.

The amendment to 818-013-0005 eliminates a self-referral to the HPSP.

The amendment to 818-026-0060 clarifies which Part of the ADA Guidelines referenced in rule.

The amendment to 818-035-0030 to allow the use of silver nitrate solutions for registered dental hygienists.

The amendment to 818-042-0040 to exclude the administration of silver nitrate solution from list of prohibited actions for dental assistants.

The amendment to 818-042-0060 adds digital radiographs as an option to become radiologic proficient for dental assistants.

**Documents Relied Upon, and where they are available:**

The Oregon Board of Dentistry has a website at [www.Oregon.gov/dentistry](http://www.Oregon.gov/dentistry) where all documents are available and posted.

**Fiscal and Economic Impact:**

none

**Statement of Cost of Compliance:**

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

The only impact on the Oregon Board of Dentistry will be updating forms and the Dental Practice Act.

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

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

It is not possible to estimate the exact number of small businesses, as the majority of dental practices are considered small businesses.

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

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

none

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

none

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

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

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

10-17-2013 4:00 p.m.	Stephen Prisby	stephen.prisby@state.or.us
Last Day (m/d/yyyy) and Time for public comment	Printed Name	Email Address

<p><b>FILED</b></p> <p>9-12-13 9:46 AM</p> <p>ARCHIVES DIVISION SECRETARY OF STATE</p>
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**ABOUT THE OHSU CENTER FOR HEALTH & HEALING**

The OHSU Center for Health & Healing is located in Portland's South Waterfront neighborhood and at the foot of the Portland Aerial Tram. The main lobby includes the Casey Optical Studio, a pharmacy, the March Wellness spa and fitness center, parking elevators, elevators to access floors 1-16, the Daily Café and coffee stand. An information desk is available directly across from the parking elevators.

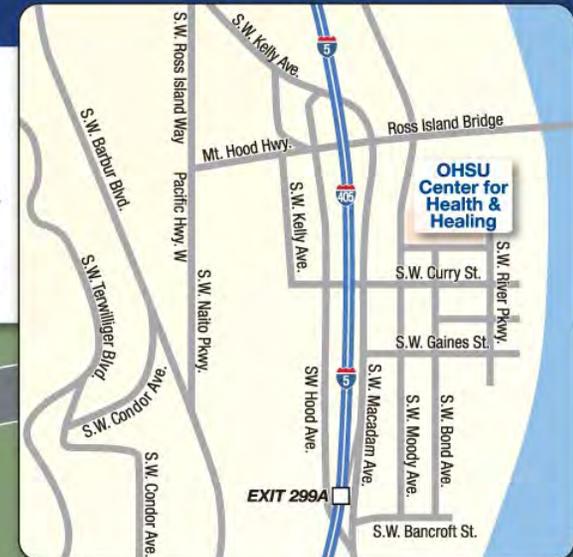
Portland's streetcar conveniently stops at the corner of S.W. Moody and S.W. Gibbs, which is across the street and just north of the OHSU Center

for Health & Healing. The streetcar accommodates bikes and wheelchairs. Schedules and fare information are available online at [www.portlandstreetcar.org](http://www.portlandstreetcar.org).

**PARKING**

Parking is available underneath the OHSU Center for Health & Healing. The entrance to the garage is on S.W. Whitaker, directly across the street from the center. Parking is free for patients. Once you park your car, take the parking elevators up to the main lobby and transfer to the building elevators to reach floors 1 through 16.

For more information and directions to the campus, please visit [www.ohsuhealth.com/maps](http://www.ohsuhealth.com/maps) or call 503.494.8311.



As the only academic medical center in the state, Oregon Health & Science University has an extraordinary range of doctors, scientists, nurses, technicians and others who work together for the benefit of every patient, every day. OHSU is dedicated to providing personalized patient care, combined with the latest treatments and therapies, to deliver a quality of healthcare not available anywhere else in Oregon. The knowledge of all for the care of one.

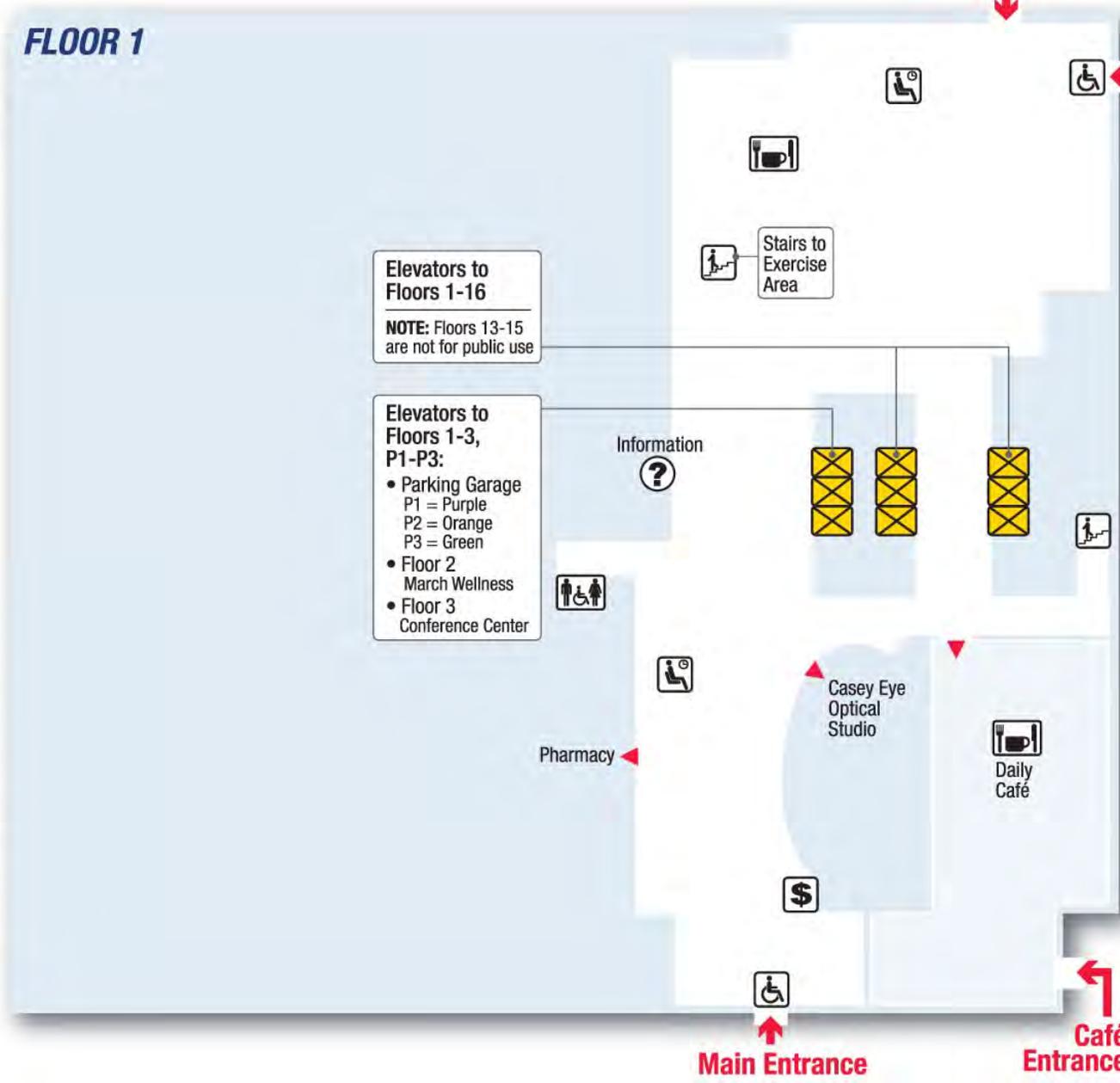
We welcome you to visit our 100-acre Marquam Hill campus located in southwest Portland, overlooking downtown Portland.

TriMet Lift Service Stop



**FLOOR 1**

To Portland Aerial Tram  
  
 Entrance  
  
 Portland Streetcar Stop



**Elevators to Floors 1-16**  
 NOTE: Floors 13-15 are not for public use

**Elevators to Floors 1-3, P1-P3:**

- Parking Garage  
 P1 = Purple  
 P2 = Orange  
 P3 = Green
- Floor 2  
 March Wellness
- Floor 3  
 Conference Center

Legend	
Information .....	
Entrance .....	
Elevators .....	
Stairs .....	
Accessible Entrance .....	
Coffee/Dining .....	
Accessible Restroom .....	
Waiting Area .....	
Telephone .....	
ATM .....	
Parking .....	
TriMet .....	

To Parking Garage

S.W. Whitaker Street

1 **DIVISION 12**

2 **STANDARDS OF PRACTICE**

3 **818-012-0005**

4 **Scope of Practice**

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

6 (a) Rhinoplasty;

7 (b) Blepharoplasty;

8 (c) Rhytidectomy;

9 (e) Submental liposuction;

10 (f) Laser resurfacing;

11 (g) Browlift, either open or endoscopic technique;

12 (h) Platysmal muscle plication;

13 (i) Dermabrasion;

14 (j) Otoplasty;

15 (k) Lip augmentation;

16 (l) Hair transplantation, not as an isolated procedure for male pattern baldness; and

17 (m) Harvesting bone extra orally for dental procedures, including oral and maxillofacial  
18 procedures,

19  
20 (2) unless the dentist:

21  
22 (a) Has successfully completed a residency in Oral and Maxillofacial Surgery accredited by the  
23 American Dental Association, Commission on Dental Accreditation (CODA); and

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

27 (c) Holds privileges either:

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

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

34

35 *3) A dentist may utilize Botulinum Toxin Type A to treat a condition that is within the*  
36 *scope of the practice of dentistry after completing a minimum of 16 hours in a hands on*  
37 *clinical course(s) approved by the Academy of General Dentistry Program Approval for*  
38 *Conitnuing Education (AGD PACE) or course(s) whose instructors have been approved*  
39 *by the American Dental Association Continuing Education Recognition Program (ADA*  
40 *CERP).*

41 Stat. Auth.: ORS 679 & 680

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

43 Hist.: OBD 6-2001, f. & cert. ef. 1-8-01; OBD 1-2013, f. 5-15-13, cert. ef. 7-1-13

1 **818-012-0040**

2 **Infection Control Guidelines**

3 In determining what constitutes unacceptable patient care with respect to infection control, the  
4 Board may consider current infection control guidelines such as those of the Centers for  
5 Disease Control and Prevention and the American Dental Association. Additionally, licensees  
6 must comply with the following requirements:

7 (1) Disposable gloves shall be worn whenever placing fingers into the mouth of a patient or  
8 when handling blood or saliva contaminated instruments or equipment. Appropriate hand  
9 hygiene shall be performed prior to gloving.

10 (2) Masks and protective eyewear or chin-length shields shall be worn by licensees and other  
11 dental care workers when spattering of blood or other body fluids is likely.

12 (3) Between each patient use, instruments or other equipment that come in contact with body  
13 fluids shall be sterilized.

14 (4) Heat sterilizing devices shall be tested for proper function on a weekly basis by means of a  
15 biological monitoring system that indicates micro-organisms kill. Testing results shall be  
16 retained by the licensee for the current calendar year and the two preceding calendar  
17 years.

18 Stat. Auth.: ORS 679.120, 679.250(7), 680.075 & 680.150 Stats. Implemented: ORS 679.140,  
19 679.140(4) & 680.100

20 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  
21 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-  
22 08, cert. ef. 12-1-08

1 **DIVISION 13**

2 **HEALTH PROFESSIONALS' SERVICES PROGRAM**

3 **818-013-0001**

4 **Definitions**

5 For the purpose of this section, the following definitions apply:

6 (1) "Confidential" means that, to the highest degree possible, the identities of the licensees  
7 investigated for alleged addiction to, dependence upon, or abuse of alcohol, drugs, and mind  
8 altering substances, or mental health disorders, and who have a diagnosed substance abuse  
9 disorder or mental health disorder, will be kept confidential by the Board and not be a matter of  
10 public record.

11 (2) "Diagnosis" means the principal mental health or substance use diagnosis listed in the DSM.  
12 The diagnosis is determined through the evaluation and any examinations, tests, or  
13 consultations suggested by the evaluation, and is the medically appropriate reason for services.

14 (3) "Direct Observe" means that a collection taker is in the restroom with donor and observes  
15 the providing of the sample throughout the entire process.

16 (4) "Diversion Coordinator" means the individual(s) authorized by the Board and the Executive  
17 Director to know the identities of the licensees who are candidates for or who are enrolled in  
18 HPSP.

19 (5) "Division" means the Oregon Health Authority, Addictions and Mental Health Division.

20 (6) "DSM" means the *Diagnostic and Statistical Manual of Mental Disorders*, published by the  
21 American Psychiatric Association.

22 (7) "Evaluation" means the process a Board approved, independent evaluator uses to diagnose  
23 the licensee's symptoms and to recommend treatment options for the licensee.

24 (8) "Health Professionals' Services Program" (HPSP) means the consolidated, statewide health  
25 professionals program for licensees diagnosed with a substance use disorder, a mental health  
26 disorder, or both types of disorders, as established by ORS 676.190.

27 (9) "Independent evaluator" means a Board approved individual or entity qualified to evaluate,  
28 diagnose, and recommend treatment regimens for substance abuse disorders, mental health  
29 disorders, or co-occurring disorders.

30 (10) "Mental health disorder" means a clinically significant behavioral or psychological syndrome  
31 or pattern that occurs in an individual and that is associated with present distress or disability or  
32 with a significantly increased risk of suffering death, pain, disability, or an important loss of  
33 freedom that is identified in the DSM. "Mental health disorder" includes gambling disorders.

34 (11) "Monitoring agreement" means an individualized agreement between a licensee and the  
35 HPSP vendor that meets the requirements for a diversion agreement set by ORS 676.190.

36 (12) "Monitoring Entity" means an independent third-party that monitors licensees' program  
37 enrollment statuses and monitoring agreement compliance.

38 (13) "Non-disciplinary" means the Board will not take disciplinary action or enter disciplinary  
39 orders against a licensee who agrees to enter into the HPSP and remains compliant with that  
40 program.

41 (14) "Non-identifying" means a system where the licensee is referred to by number rather than  
42 name and the licensee's identity remains confidential to the Board.

43 (15) "Program" means the process whereby allegations of addiction to, dependence upon, or  
44 abuse of alcohol, drugs, or mind altering substances or mental health disorders are  
45 investigated, evaluated, and reported to the Board for action.

46 ~~[(16) "Self-referred licensee" means a licensee who seeks to participate in the HPSP~~  
47 ~~program without referral from the Board.]~~

48 ~~[(17)]~~ (16) "Substance Use Disorders" means disorders related to the taking of a drug of abuse  
49 including alcohol, to the side effects of a medication, and to a toxin exposure. The disorders  
50 include substance use disorders such as substance dependence and substance abuse, and  
51 substance-induced disorders, including substance intoxication, withdrawal, delirium, and

52 dementia, as well as substance induced psychotic disorder, mood disorder, etc., as defined in  
53 DSM criteria.

54 ~~(18)~~ (17) "Substantial non-compliance" means that a licensee is in violation of the terms of his  
55 or her monitoring agreement in a way that gives rise to concerns about the licensee's ability or  
56 willingness to participate in the program. Substantial non-compliance and non-compliance  
57 include, but are not limited to, the factors listed in ORS 676.190(1)(f). Conduct that occurred  
58 before a licensee entered into a monitoring agreement does not violate the terms of that  
59 monitoring agreement.

60 ~~(19)~~ (18) "Successful completion" means the licensee has complied with the licensee's  
61 monitoring agreement to the satisfaction of the Board.

62 ~~(20)~~ (19) "Toxicology testing" means urine testing or alternative chemical monitoring including,  
63 but not limited to blood, saliva, or breath as conducted by a laboratory certified, accredited or  
64 licensed and approved for toxicology testing.

65 ~~(21)~~ (20) "Treatment" means the planned, specific, individualized health and behavioral-health  
66 procedures, activities, services and supports that a treatment provider uses to remediate  
67 symptoms of a substance use disorder, mental health disorder or both types of disorders.

68 ~~(22)~~ (21) "Vendor" means the entity that has contracted with the Division to conduct the  
69 program.

70 ~~(23)~~ (22) "Voluntary" means that the Board cannot compel a licensee to enter the HPSP.  
71 Stat. Auth.: ORS 676, 679 & 680

72 Stats. Implemented: ORS 676.185, 676.190, 676.195, 676.200 & 676.140(e)

73 Hist.: OBD 2-2010(Temp), f. & cert. ef. 8-6-10 thru 2-1-11; OBD 1-2011, f. 1-11-11, cert. ef. 2-1-  
74 11; OBD 4-2011, f. & cert. ef. 11-15-11

1 **818-013-0005**

2 **Participation in Health Professionals' Services Program**

3 (1) Effective July 1, 2010, the Board participates in the Health Professionals' Services Program  
4 (HPSP).

5 (a) The Board establishes procedures to process cases of licensees preparatory to transfer to  
6 HPSP.

7 (b) The procedures will be confidential, non-disciplinary, and voluntary.

8 (c) The Executive Director will have overall management responsibilities for the procedures. The  
9 Executive Director will designate Board staff to serve as Diversion Coordinator(s) who will  
10 manage and conduct investigations and report to the Board.

11 (d) The Diversion Coordinator(s) will investigate information related to addiction to, dependence  
12 upon, or abuse of alcohol, drugs, or mind altering substances or mental health disorders, by  
13 licensees and provide licensees with resources for evaluations, if appropriate.

14 (2) Only licensees of the Board who meet the referral criteria may be referred by the Board to  
15 the HPSP.

16 (a) The Board may refer a licensee to the HPSP in lieu of public discipline.

17 (b) In the event a licensee declines to submit to an evaluation or declines referral to HPSP, the  
18 Diversion Coordinator(s) will present the matter to the Board for decision and the Board's action  
19 may jeopardize the confidential nature of licensee's status as a candidate for, or enrollment in,  
20 HPSP.

21 ~~**[(3) Licensees may self-refer to HPSP without Board approval as permitted by ORS**~~

22 ~~**676.190(5).1**~~

23 Stat. Auth.: ORS 676, 679 & 680

24 Stats. Implemented: ORS 676.185, 676.190, 676.195, 676.200 & 676.140(e)

25 Hist.: OBD 2-2010(Temp), f. & cert. ef. 8-6-10 thru 2-1-11; OBD 1-2011, f. 1-11-11, cert. ef. 2-1-

26 11

1 **DIVISION 26**

2 **ANESTHESIA**

3 **818-026-0060**

4 **Moderate Sedation Permit**

5 Moderate sedation, minimal sedation, and nitrous oxide sedation.

6 (1) The Board shall issue or renew a Moderate Sedation Permit to an applicant who:

7 (a) Is a licensed dentist in Oregon;

8 (b) Either holds a current Advanced Cardiac Life Support (ACLS) or Pediatric Advanced Life  
9 Support (PALS) certificate, whichever is appropriate for the patient being sedated, or

10 successfully completes the American Dental Association's course "*Recognition and*  
11 *Management of Complications during Minimal and Moderate Sedation*" at least every two years;

12 and

13 (c) Satisfies one of the following criteria:

14 (A) Completion of a comprehensive training program in enteral and/or parenteral sedation that  
15 satisfies the requirements described in Part ~~III~~ V of the *ADA Guidelines for Teaching Pain*  
16 *Control and Sedation to Dentists and Dental Students* (2007) at the time training was  
17 commenced.

18 (i) Enteral Moderate Sedation requires a minimum of 24 hours of instruction plus management  
19 of at least 10 dental patient experiences by the enteral and/or enteral-nitrous oxide/oxygen  
20 route.

21 (ii) Parenteral Moderate Sedation requires a minimum of 60 hours of instruction plus  
22 management of at least 20 dental patients by the intravenous route.

23 (B) Completion of an ADA accredited postdoctoral training program (e.g., general practice  
24 residency) which affords comprehensive and appropriate training necessary to administer and  
25 manage parenteral sedation, commensurate with these Guidelines.

26 (C) In lieu of these requirements, the Board may accept equivalent training or experience in  
27 moderate sedation anesthesia.

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

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

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

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

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

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

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

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

48 (h) Sphygmomanometer, precordial/pretracheal stethoscope, capnograph, pulse oximeter, oral  
49 and nasopharyngeal airways, laryngeal mask airways, intravenous fluid administration  
50 equipment, automated external defibrillator (AED); and

51 (i) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the  
52 drugs used, vasopressors, corticosteroids, bronchodilators, antihistamines, antihypertensives  
53 and anticonvulsants.

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

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

60 (5) Before inducing moderate sedation, a dentist who induces moderate sedation shall:

61 (a) Evaluate the patient and document, using the American Society of Anesthesiologists *Patient*  
62 *Physical Status Classifications*, that the patient is an appropriate candidate for moderate  
63 sedation;

64 (b) Give written preoperative and postoperative instructions to the patient or, when appropriate  
65 due to age or psychological status of the patient, the patient's guardian; and

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

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

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

71 (a) Patients must have continuous monitoring using pulse oximetry and End-tidal CO<sub>2</sub> monitors.

72 The patient's blood pressure, heart rate, and respiration shall be recorded at regular intervals  
73 but at least every 15 minutes, and these recordings shall be documented in the patient record.

74 The record must also include documentation of preoperative and postoperative vital signs, all  
75 medications administered with dosages, time intervals and route of administration. If this

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

77 patient under moderate sedation shall be continuously monitored;

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

79 patients recovering from moderate sedation.

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

81 care of a responsible third party.

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

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

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

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

86 preoperative psychological status;

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

88 (d) The patient can sit up unaided;

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

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

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

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

93 discharged.

94 (11) After adequate training, an assistant, when directed by a dentist, may introduce additional

95 anesthetic agents to an infusion line under the direct visual supervision of a dentist.

96 (12) Permit renewal. In order to renew a Moderate Sedation Permit, the permit holder must

97 provide documentation of having current ACLS or PALS certification or current certification of

98 successful completion of the American Dental Association's course "*Recognition and*

99 *Management of Complications during Minimal and Moderate Sedation*" and must complete 14

100 hours of continuing education in one or more of the following areas every two years: sedation,

101 physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or

102 pharmacology of drugs and agents used in sedation. Training taken to maintain current ACLS or  
103 PALS certification or successful completion of the American Dental Association's course  
104 *"Recognition and Management of Complications during Minimal and Moderate Sedation"* may  
105 be counted toward this requirement. Continuing education hours may be counted toward  
106 fulfilling the continuing education requirement set forth in OAR 818-021-0060.

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

108 Stat. Auth.: ORS 679

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

110 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-  
111 1999, f. 6-25-99, cert. ef. 7-1-99; Administrative correction 8-12-99; OBD 2-2000(Temp), f. 5-22-  
112 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,  
113 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-  
114 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  
115 11-27-11; OBD 4-2011, f & cert. ef. 11-15-11

1 **DIVISION 35**

2 **DENTAL HYGIENE**

3 **818-035-0030**

4 **Additional Functions of Dental Hygienists**

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

7 (a) Make preliminary intra-oral and extra-oral examinations and record findings;

8 (b) Place periodontal dressings;

9 (c) Remove periodontal dressings or direct a dental assistant to remove periodontal dressings;

10 (d) Perform all functions delegable to dental assistants and expanded function dental assistants  
11 providing that the dental hygienist is appropriately trained;

12 (e) Administer and dispense silver nitrate solution, antimicrobial solutions or other  
13 antimicrobial agents in the performance of dental hygiene functions.

14 (f) Prescribe fluoride, fluoride varnish, antimicrobial solutions for mouth rinsing or other non-  
15 systemic antimicrobial agents.

16 (g) Use high-speed handpieces to polish restorations.

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

18 (i) Perform all aspects of teeth whitening procedures.

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

21 (a) Determine the need for and appropriateness of sealants or fluoride; and

22 (b) Apply sealants or fluoride.

23 Stat. Auth.: ORS 679 & 680

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

25 Hist.: DE 5-1984, f. & ef. 5-17-84; DE 3-1986, f. & ef. 3-31-86; DE 2-1992, f. & cert. ef. 6-24-92;

26 OBD 7-1999, f. 6-25-99, cert. ef. 7-1-99; OBD 1-2001, f. & cert. ef. 1-8-01; OBD 15-2001, f. 12-

- 27 7-01, cert. ef. 1-1-02; OBD 1-2004, f. 5-27-04, cert. ef. 6-1-04; OBD 2-2005, f. 1-31-05, cert. ef.  
28 2-1-05; OBD 3-2007, f. & cert. ef. 11-30-07; OBD 1-2008, f. 11-10-08, cert. ef. 12-1-08; OBD 2-  
29 2009, f. 10-21-09, cert. ef. 11-1-09

DRAFT

1 **DIVISION 42**

2 **DENTAL ASSISTING**

3 **818-042-0040**

4 **Prohibited Acts**

5 No licensee may authorize any dental assistant to perform the following acts:

6 (1) Diagnose or plan treatment.

7 (2) Cut hard or soft tissue.

8 (3) Any Expanded Function duty (818-042-0070 and 818-042-0090) or Expanded Orthodontic  
9 Function duty (818-042-0100) without holding the appropriate certification.

10 (4) Correct or attempt to correct the malposition or malocclusion of teeth except as provided by  
11 OAR 818-042-0100.

12 (5) Adjust or attempt to adjust any orthodontic wire, fixed or removable appliance or other  
13 structure while it is in the patient's mouth.

14 (6) Administer or dispense any drug except [silver nitrate solution](#), fluoride, topical anesthetic,  
15 desensitizing agents or drugs administered pursuant to OAR 818-026-0060(11), 818-026-  
16 0065(11), 818-026-0070(11) and as provided in 818-042-0070 and 818-042-0115.

17 (7) Prescribe any drug.

18 (8) Place periodontal packs.

19 (9) Start nitrous oxide.

20 (10) Remove stains or deposits except as provided in OAR 818-042-0070.

21 (11) Use ultrasonic equipment intra-orally except as provided in OAR 818-042-0100.

22 (12) Use a high-speed handpiece or any device that is operated by a high-speed handpiece  
23 intra-orally.

24 (13) Use lasers, except laser-curing lights.

25 (14) Use air abrasion or air polishing.

26 (15) Remove teeth or parts of tooth structure.

27 (16) Cement or bond any fixed prosthetic or orthodontic appliance including bands, brackets,  
28 retainers, tooth moving devices, or orthopedic appliances except as provided in 818-042-0100.

29 (17) Condense and carve permanent restorative material except as provided in OAR 818-042-  
30 0095.

31 (18) Place any type of cord subgingivally.

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

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

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

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

42 (23) Perform periodontal probing.

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

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

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

46 Stat. Auth.: ORS 679 & 680

47 Stats. Implemented: ORS 679.020, 679.025 & 679.250

48 Hist.: OBD 9-1999, f. 8-10-99, cert. ef. 1-1-00; OBD 2-2000(Temp), f. 5-22-00, cert. ef. 5-22-00  
49 thru 11-18-00; OBD 1-2001, f. & cert. ef. 1-8-01; OBD 15-2001, f. 12-7-01, cert. ef. 1-1-02; OBD  
50 3-2OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10005, f. 10-26-05, cert. ef. 11-1-05; OBD 3-2007, f. &  
51 cert. ef. 11-30-07; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10; OBD 4-2011, f. & cert. ef. 11-15-11;  
52 OBD 2-2012, f. 6-14-12, cert. ef. 7-1-12

1 **818-042-0060**

2 **Certification — Radiologic Proficiency**

3 (1) The Board may certify a dental assistant in radiologic proficiency by credential in accordance  
4 with OAR 818-042-0120, or if the assistant:

5 (2) Submits an application on a form approved by the Board, pays the application fee and:

6 (a) Completes a course of instruction in a program approved by the Oregon Health Authority,  
7 Oregon Public Health Division, Office of Environmental Public Health, Radiation Protection  
8 Services, or the Oregon Board of Dentistry, in accordance with OAR 333-106-0055 or submits  
9 evidence that RPS recognizes that the equivalent training has been successfully completed;

10 (b) Passes the written Dental Radiation Health and Safety Examination administered by the  
11 Dental Assisting National Board, Inc. (DANB), or comparable exam administered by any other  
12 testing entity authorized by the Board, or other comparable requirements approved by the  
13 Oregon Board of Dentistry; and

14 (c) Passes a clinical examination approved by the Board and graded by the Dental Assisting  
15 National Board, Inc. (DANB), or any other testing entity authorized by the Board, consisting of  
16 exposing, developing and mounting a full mouth series of radiographs or by submitting a  
17 digital full mouth series of radiographs (14 to 18 periapical and 4 bitewing radiographs)  
18 within one hour and under the supervision of a person permitted to take radiographs in Oregon.

19 No portion of the clinical examination may be completed in advance; a maximum of three  
20 retakes is permitted; only the applicant may determine the necessity of retakes. The  
21 radiographs should be taken on an adult patient with at least 24 fully erupted teeth. The  
22 radiographs must be submitted for grading within six months after they are taken.

23 Stat. Auth.: ORS 679

24 Stats. Implemented: ORS 679.020, 679.025 & 679.250

25 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-

26 2004, f. 11-23-04 cert. ef. 12-1-04; OBD 3-2005, f. 10-26-05, cert. ef. 11-1-05; OBD 3-2007, f. &  
27 cert. ef. 11-30-07; OBD 4-2011, f. & cert. ef. 11-15-11

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September 24, 2013

Dear Oregon Board of Dentistry;

I am enclosing the Joint Staff Report on the Corporate Practice of Dentistry released by the United States Senate in June 2013 (without the 1,480 pages of exhibits).<sup>37</sup> The report discloses the results of the investigations into two corporate dental chains, unveiling the schemes through which the companies defied state laws and made significant profits for their corporate owners on the taxpayer's dime. These profits most often came at the expense of patient care.

The corporate practice of dentistry has spread like cancer due to its highly profitable business model and the lack of effective oversight. As a result, taxpayers have been bilked of hundreds of millions of dollars through unnecessary dental treatment for children. Children have received unnecessary and improperly done procedures, often performed abusively, resulting in trauma and a lifelong fear of the dentist. Young dentists, baited by a lucrative salary, have been led astray and scarred from experiences at these dental mills that reward production over patient welfare.

Most states have effective rules forbidding corporate ownership and control of dental offices, but few states actually enforce such rules. The Federal government has done nothing to stop this misconduct. This report explains how these chains operate and how they can be stopped. The recommendations propose: 1) the exclusion of known, corporate controlled dental clinics from the Medicaid program, 2) State enforcement of existing laws against the corporate practice of dentistry, and 3) the inclusion of licensure to mid-level dental providers and the allowance of Medicaid reimbursement to those providers. The Senate's position on the corporate practice of dentistry has been made clear, and I hope this report assists you in your responsibilities with the state dental board.

Sincerely,

  
James Moriarty



<sup>37</sup> For the complete report see:

<http://www.finance.senate.gov/library/prints/download/?id=1c7233e0-9d08-4b83-a530-b761c57a900b>

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113TH CONGRESS }  
*1st Session*

COMMITTEE PRINT

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113-16

**JOINT STAFF REPORT ON  
THE CORPORATE PRACTICE OF DENTISTRY  
IN THE MEDICAID PROGRAM**

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PREPARED BY THE STAFF OF THE  
COMMITTEE ON FINANCE  
UNITED STATES SENATE

MAX BAUCUS, *Chairman*

AND

COMMITTEE ON THE JUDICIARY  
UNITED STATES SENATE

CHUCK GRASSLEY, *Ranking Member*



JUNE 2013

Printed for the use of the Committee on Finance

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## **I. Preface**

The United States Senate Committee on Finance has jurisdiction over the Medicare and Medicaid programs. As the Chairman and a senior member and former Chairman of the Committee, we have a responsibility to the more than 100 million Americans who receive health care coverage under these programs to oversee their proper administration and ensure the taxpayer dollars are appropriately spent. This report describes the investigative work, findings, and recommendations of the Minority Staff of the Senate Committee on the Judiciary and the Majority Staff of the Senate Committee on Finance regarding the corporate practice of dentistry in the Medicaid program. The issues are analyzed primarily in the context of one company, Small Smiles. We received whistleblower complaints about the company, it has been the subject of a False Claims Act lawsuit, and it has been under a corporate integrity agreement with independent monitoring by the Department of Health and Human Services Office of Inspector General since January 2010. In addition, we briefly examined complaints received regarding ReachOut Healthcare America (ReachOut).

At the outset of this investigation, Church Street Health Management (CSHM), the parent company of Small Smiles, cooperated with Committee staff until it emerged from bankruptcy. After emerging from bankruptcy and hiring new counsel, CSHM ceased cooperating. Under the old ownership, Committee staff was able to obtain reports by the Independent Monitor, a private, independent oversight entity whose services were mandated as part of CSHM's settlement agreement with the U.S. Department of Justice (DOJ). However, the new owners and counsel refused to give Committee staff access to on-going reports from the Independent Monitor. ReachOut cooperated with the Committees' investigation. More than 10,000 pages of documents were obtained from CSHM, ReachOut, whistleblowers, and Federal entities. The Committee staff conducted six meetings with Small Smiles, six meetings with the U.S. Department of Health and Human Services Office of Inspector General, one site visit, and various stakeholder meetings throughout the course of the investigation. Likewise, the Committee staff met with ReachOut three times in addition to meeting with various stakeholders.

## **II. Executive Summary**

Across the country, there are companies that identify themselves as dental management companies. These organizations are typically organized as a corporation or limited liability company. They work with dentists in multiple states and purport to provide general administrative management services. In late 2011, whistleblowers and other concerned citizens came forward with information that some of these companies were doing more than providing

management services. In some cases, dental management companies own the dental clinics and have complete control over operations, including the provision of clinical care by clinic dentists.

While there is no Federal requirement that licensed dentists, rather than corporations, own and operate dental practices, many states have laws that ban the corporate practice of dentistry. In those states where owners of dental practices must be dentists licensed in that state, the ownership structure used by some dental management companies is fundamentally deceptive. It hides from state authorities the fact that all rights and benefits of ownership actually flow to a corporation through contracts between the company and the “owner dentist.” These contracts render the “owner dentist” an owner in name only.

Notably, these clinics tend to focus on low-income children eligible for Medicaid. However, these clinics have been cited for conducting unnecessary treatments and in some cases causing serious trauma to young patients; profits are being placed ahead of patient care.

In one case, the corporate structure of a dental management company appears to have negatively influenced treatment decisions by over-emphasizing bottom-line financial considerations at the expense of providing appropriate high-quality, low-cost care. As a consequence, children on Medicaid are ill-served and taxpayer funds are wasted.

Our investigation into these allegations began by examining five corporate dental chains which were alleged to be engaged in these practices:

- Church Street Health Management (CSHM), which at the time owned 70 Small Smiles dental clinics in 22 states and the District of Columbia;
- NCDR, LLC, which owns 130 Kool Smiles clinics in 15 states and the District of Columbia;
- ReachOut Healthcare America (ReachOut) which operates mobile clinics that treat children at schools in several states;
- Heartland Dental Care, Inc. (Heartland), which operates more than 300 clinics in 18 states; and
- Aspen Dental Management, Inc., (Aspen) which operates more than 300 Aspen Dental clinics in 22 states.

While we initially looked broadly at all five companies, the focus shifted primarily to CSHM and ReachOut, due to similarities between the patient populations of these two companies. Both treat Medicaid-eligible children almost exclusively and therefore are reimbursed using taxpayer dollars.

#### **A. CSHM**

CSHM has management services agreements with dental clinics which extend far beyond providing typical management services. Through its agreements, CSHM assumes significant control over the practice of dentistry in Small Smiles clinics and is empowered to take substantially all of a clinic’s profits.

CSHM has management services agreements with “owner dentists” who typically work at one of the Small Smiles clinics and also “own” several clinics nearby. These “owner dentists” are paid a sal-

ary by CSHM as well as a flat fee when they sign state paperwork declaring that they own other clinics. In a glaring departure from industry practice, some “owner dentists” have never visited clinics that they purport to own, are not allowed to make hiring decisions, and do not even control the scheduling of patients. Moreover, Small Smiles dentists are required by their parent company, CSHM, to treat a high volume of patients daily, which subsequently has a significant impact on the quality of care delivered.

Defenders of this corporate structure are quick to claim that without their organizations, the under-served Medicaid population would not have access to dental care. Countless news reports cite low Medicaid reimbursement rates as the principal cause for the lack of access to dental care for low-income families. However, if states and Medicaid are having difficulty recruiting good dentists to serve such a vulnerable population due to lack of reimbursement, how are private investors so successful at producing huge profits from those allegedly inadequate Medicaid reimbursements? Do short-term profits come at the cost of quality care and a sustainable business model in the long run? Local dentistry practices should be able to provide quality care to the Medicaid population and still be profitable. Fortunes should not be made on Wall Street by sacrificing proper care for the underprivileged.

## **B. ReachOut Healthcare America**

The troubling case of Isaac Gagnon illustrates the concerns relating to the quality of ReachOut’s care and a pattern of treatment without parental consent. A then 4-year-old “medically fragile” boy, Isaac received invasive dental work in October 2011 from a mobile services unit that held a contract with ReachOut Healthcare America.<sup>1</sup> Notably, Isaac’s mother said that while she permitted ReachOut to review dental hygiene education with Isaac, she also expressed her wishes that no procedures be performed.<sup>2</sup>

On the day treatment was provided, the mobile dental unit visited Isaac’s special needs preschool. During treatment that lasted approximately 40 minutes, three adults held down a screaming, kicking, and gagging Isaac.<sup>3</sup> This disturbing conduct violated ReachOut’s own internal policy that a patient is never to be physically restrained in any manner, except by holding a patient’s hands when the patient “presents [an] imminent danger of harm to themselves.”<sup>4</sup> In the aftermath, Isaac was severely traumatized, and according to his mother, a “complete mess, emotionally.”<sup>5</sup> Moreover, since the treatment, Isaac has exhibited increasingly aggressive behavior—namely, kicking, screaming, and punching.<sup>6</sup>

Ultimately, after Isaac’s mother informed the school superintendent, the school board voted to sever contractual ties with ReachOut, and issued a cease and desist order.<sup>7</sup> Isaac’s mother was referred to a pediatric dentist who concluded after examining Isaac

<sup>1</sup> Interview with Stacey Gagnon, by Moriarty Leyedecker, PC at 2 (Nov. 11, 2011) (Exhibit 36).

<sup>2</sup> *See id.*

<sup>3</sup> *See id.* at 3.

<sup>4</sup> Letter from Reginald Brown, Attorney at WilmerHale, to Senators Baucus and Grassley at 5 (Feb. 23, 2012) (Exhibit 31).

<sup>5</sup> Interview with Stacey Gagnon, by Moriarty Leyedecker, PC at 4 (Nov. 11, 2011) (Exhibit 36).

<sup>6</sup> *See id.* at 5.

<sup>7</sup> *See id.* at 4.

that the two pulpotomies (root canals) and two silver crowns administered were both unnecessary, and in the case of the former, performed incorrectly.<sup>8</sup>

Another troubling case occurred in December 2011. Nevada's Clark County School District, with a student population of almost 400,000, severed contractual ties with ReachOut after receiving complaints from parents who alleged ReachOut did not give proper notification before proceeding with serious procedures such as fillings and crowns.<sup>9</sup> According to Amanda Fulkerson, spokesperson for the Clark County School District, "They [ReachOut] were going well beyond what we consider preventive care."<sup>10</sup>

The allegations against ReachOut that its dental practices were abusing children and billing Medicaid for unnecessary procedures were serious and disturbing, but we found that those practices were not necessarily widespread. Unlike CSHM, ReachOut's management services agreements truly provide only administrative and scheduling support, and do not constitute *de facto* ownership and control of its mobile dental clinics.<sup>11</sup>

In its Administrative Agreements with dentists, ReachOut uses language similar to the following example, which ensures that the sole authority to practice dentistry remains with the licensed dentist:

*Sole Authority to Practice.* Notwithstanding any other provision of this Agreement, Provider shall have exclusive authority and control over the healthcare aspects of Provider and its practice to the extent they constitute the practice of a licensed profession, including all diagnosis, treatment and ethical determinations with respect to patients which are required by law to be decided by a licensed professional.<sup>12</sup>

ReachOut maintains administrative services agreements with local dentists, or principal shareholders (PCs), who largely provide mobile services to schools, but also the military and in some states, nursing homes.<sup>13</sup> At the time of this report, ReachOut has contracts with 23 dental practices in 22 states. The contracts between ReachOut and dental practices relate only to nonclinical aspects.<sup>14</sup> ReachOut is paid set fees by the dentists for facilitating the mobile dentistry services. These services include providing equipment and supplies, maintaining inventory, and providing information systems, financial planning, scheduling, reporting, analysis, and customer service.<sup>15</sup>

<sup>8</sup> See *id.*

<sup>9</sup> See Ken Alltucker, *Mobile dental clinics drawing scrutiny*, AZCentral.com (Aug. 18, 2012) <http://www.azcentral.com/business/articles/20120810mobile-dental-clinics-scrutiny.html>.

<sup>10</sup> *Id.*

<sup>11</sup> See, e.g., Administrative Agreement between ReachOut and [REDACTED] DDS, PC (July 2, 2006) (bates RHA 0000007-0000021) (Exhibit 32).

<sup>12</sup> Administrative Agreement between ReachOut and [REDACTED], DDS at 9 (Apr. 23, 2009) (bates RHA 0000030) (Exhibit 33). Small Smiles has what is arguably similar language to that found in ReachOut's administrative agreement. However, ReachOut's language appears to be focused more on limiting its liability. Moreover, our investigation found that Small Smiles' contractual language is at odds with actual practice. See report Section IV(a); see Management Services Agreement, Small Smiles Dentistry for Children, Albuquerque, PC and FORBA, LLC at 2 (Oct. 1, 2010) (Exhibit 6).

<sup>13</sup> See Administrative Agreement between ReachOut and Big Smiles Colorado at 2-3 (July 1, 2009) (bates RHA 0000051-0000065) (Exhibit 34).

<sup>14</sup> See Letter from Reginald Brown, Attorney at WilmerHale, to Senators Baucus and Grassley at 2 (Feb. 23, 2012) (Exhibit 31).

<sup>15</sup> See *id.*

The basic plan behind the Administrative Agreement between ReachOut and the mobile dentists is “to provide *administrative and financial services* as set forth herein, so that the PC can focus on *furnishing high-quality dental care* directly and through third-party dentists to needy, primarily low-income, children in schools and out-of-home placement agencies needing mobile dentistry through the services of the PC’s dentist(s).”<sup>16</sup> The compensation for ReachOut is divided into two categories: direct expenses and administrative services. Administrative services are billed at a fee of \$500 per visit for all services provided.<sup>17</sup> Direct expenses are billed at the actual cost plus 15% of the entire professional corporation (PC)’s employee salaries and expenses paid from the PC’s account.<sup>18</sup>

Before children can receive treatment during school hours, they must obtain parental approval. ReachOut America maintains that all offered services must be pre-approved by the child’s parents or legal guardians. Verification of the legal guardianship of the child is the responsibility of the school. However, per contractual agreement, ReachOut facilitates the delivery of the Provider consent forms and coordinates the completion of the consent forms:

- Arrange for the delivery of the Provider consent forms to the proper school employee in each school for each student to take home.
- Coordinate that each school obtains completed consent forms by the students and that they are provided to the Administrator [ReachOut].<sup>19</sup>

In ReachOut’s case, the reported problems of unnecessary procedures, lack of parental consent, and patient abuse appear to be the result of ReachOut having management agreements with several unscrupulous dentists. Given the administrative nature of their arrangement, ReachOut lacks ability to police such bad actors. As of last year, the company had no standards for dentists with whom they contract to obtain parental consent for treatment—leaving each mobile clinic to devise its own forms and procedures. While these factors appear to have contributed to many of the problems reported to us involving the company, it is also evidence that ReachOut does not significantly control the operations of clinic dentists, and simply contracts with dentists to provide support services.

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<sup>16</sup> Administrative Agreement between ReachOut and [REDACTED] DDS, PC at 1 (July 2, 2006) (bates RHA 0000007–0000021) (emphasis added) (Exhibit 32).

<sup>17</sup> See *id.* at 9.

<sup>18</sup> See *id.*

<sup>19</sup> Administrative Agreement between ReachOut and [REDACTED] D.D.S., Big Smiles Maryland PC, at 5 (Apr. 1, 2009) (bates RHA 0000246) (Exhibit 35).

### III. Key Findings

1. Through management services agreements with dentists, CSHM is the *de facto* owner of all Small Smiles clinics. It retains all the rights of ownership, employs all staff, recruits all staff, makes all personnel decisions, and receives all income from each Small Smiles clinic.

2. CSHM entered into a Corporate Integrity Agreement (CIA) with the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) as part of the company's settlement with the U.S. Department of Justice (DOJ). As part of the agreement, an Independent Monitor (IM) conducts extensive audits of CSHM's clinics. During the last 3 years, the IM has found massive amounts of taxpayer dollars being recklessly spent on unnecessary procedures on children in the Medicaid program by Small Smiles clinics.

3. After 2 years of intense scrutiny by HHS OIG through the CIA, and attempting to follow newly prescribed rules, CSHM went bankrupt.

4. After 3 years of monitoring by the HHS OIG and emerging from bankruptcy with new ownership and leadership changes, CSHM has repeatedly failed to meet quality and compliance standards set forth in the CIA with HHS OIG. Breaches in quality and compliance include: (1) unnecessary treatment on children; (2) improper administration of anesthesia; (3) providing care without proper consent; and (4) overcharging the Medicaid program.

5. Despite CSHM's repeated violations of the CIA, resulting in both monetary fines and an HHS OIG-issued Notice of Intent to Exclude the company from Medicaid, HHS OIG has allowed Small Smiles to continue to participate in the program.

6. Despite state laws against the corporate practice of dentistry, numerous states have allowed companies such as CSHM to operate dental clinics under the guise of management services agreements. These practices appear contrary to the purpose of state law requiring clinics to be owned and operated by licensed dentists. The result is poor quality of care, billing Medicaid for unnecessary treatment, and disturbing consumer complaints.

7. Access to dental care is a problem in certain parts of the country, particularly rural areas for the dual reasons of fewer employment opportunities and lower reimbursement rates than urban counterparts. It is also a problem for some patients served by the Medicaid program due to the number of dentists who are unwilling to accept patients on Medicaid. Access is complicated by the burden of extremely high student loans of dentists graduating from dental school that makes serving rural or Medicaid populations problematic.

#### IV. Church Street Health Management and Small Smiles Dental Centers

Church Street Health Management was the successor company of an organization called FORBA (For Better Access). FORBA was founded in Pueblo, Colorado on February 9, 2001 by Dan DeRose.<sup>20</sup> At the time of incorporation, FORBA operated only a handful of Small Smiles clinics in Colorado and New Mexico.<sup>21</sup> Eventually, the company grew and expanded to a nationwide chain with more than 60 clinics, and benefitted from an influx of private equity dollars, including investments by The Carlyle Group and Arcapita.<sup>22</sup> Today, Small Smiles' mission is "to provide the highest quality dental care to low-income children in the Medicaid and [S]CHIP populations."<sup>23</sup>

An investigative report in 2008 by the ABC-7 I-Team in Washington, DC revealed serious abuses at Small Smiles clinics. Featured clinics prohibited parents from accompanying their children during treatments and excessively used a device called a papoose board, which is used to strap down young patients and immobilize them during treatment. The clinics performed a high number of crowns and pulpotomies on children who did not require such aggressive treatment and engaged in improper X-ray billing. The quality of care was significantly below any recognized medical standard according to independent pediatric dentists interviewed by ABC-7.<sup>24</sup>

This explosive report was triggered by several *qui tam* actions<sup>25</sup> initiating the investigations by the Department of Justice and the Department of Health and Human Services Office of Inspector General.<sup>26</sup> Acting Associate Attorney General Tony West went so far as to describe the conduct of Small Smiles as "really horrific stuff," and further stated, "[T]he behavior in that [clinic] was so egregious that we had to—I think we were compelled to be very aggressive about going after [the] fraud in that case."<sup>27</sup> The company eventually settled with the government and entered into a CIA, which provided for extensive audits by an Independent Monitor.<sup>28</sup> On February 20, 2012, after struggling to comply with the CIA, Church Street Health Management filed for Chapter 11 Bankruptcy protec-

<sup>20</sup> Articles of Incorporation of FORBA, Inc., Secretary of the State of Colorado, signed by Dan DeRose (Feb. 9, 2001) (Exhibit 1).

<sup>21</sup> See Small Smiles History, <http://www.smallsmiles.com/small-smiles-history.php> (last visited Mar. 22, 2013).

<sup>22</sup> Press Release, Arcapita, Arcapita Completes Largest US Corporate Transaction (Jan. 15, 2007) ([http://www.arcapita.com/media/press\\_releases/2007/01-15-07.html](http://www.arcapita.com/media/press_releases/2007/01-15-07.html)); Sydney P. Freedberg, *Dental Abuse of U.S. Poor Dodges Ejection from Medicaid*, BLOOMBERGBUSINESSWEEK, June 26, 2012, <http://www.businessweek.com/printer/articles/268590?type=bloomberg>; Dr. Steven Adair Joins FORBA Dental Management as Chief Dental Officer, BUSINESS WIRE, Sept. 19, 2008 (on file with author).

<sup>23</sup> See Small Smiles FAQs, <http://www.smallsmiles.com/faqs.php> (last visited Mar. 22, 2013).

<sup>24</sup> I-Team: Small Smiles Investigation, <http://www.youtube.com/watch?v=pIoMaw4zC9Q> (last visited Mar. 22, 2013).

<sup>25</sup> See BALLENTINE'S LAW DICTIONARY (2010) ("An action to recover a penalty brought by an informer in the situation where one portion of the recovery goes to the informer and the other portion to the state").

<sup>26</sup> Civil Settlement Agreement, FORBA and Dep't of Justice (Jan. 15, 2010) (Exhibit 2).

<sup>27</sup> Interview with Tony West, Acting Associate Attorney General, Department of Justice, in Washington, D.C. (Mar. 18, 2013) (on file with authors).

<sup>28</sup> Corporate Integrity Agreement, Department of Health and Human Services and FORBA Holdings, LLC (Jan. 15, 2010) (Exhibit 3).

tion.<sup>29</sup> The company emerged from bankruptcy under the moniker CSHM, which is how we will generally refer to the company in this report.

### A. Corporate Structure

CSHM argues that it does not own any dental clinics, but rather that it has management services agreements with dentists who own the clinics.<sup>30</sup> However, courts have voided management services agreements with similar characteristics to the agreements between CSHM and their dental clinics.<sup>31</sup> Based on our review of several management services agreements, employment contracts, and the payment structure, it appears that these arrangements are designed to give the appearance of complying with state laws requiring that dental clinics be owned by licensed dentists.<sup>32</sup> However, in practice, dental clinics are not owned by dentists in any meaningful sense.

Typically, an agreement between the owner of a business and a third-party management company would simply involve the business owner paying a fee to the management company in return for services. The arrangements between CSHM and its dental centers, however, are much more complex. Like traditional third-party management agreements, dental clinics are obligated to pay CSHM a management fee under the terms of their management agreements. However, in that the benefits of the dental operations are heavily weighted toward CSHM, this fee is unlike traditional agreements on account of the sheer asymmetry benefitting CSHM. Specifically, each calendar month, a dental clinic must pay CSHM *the greater of: (i) \$175,000; or (ii) 40% of the “Gross Revenues”;*<sup>33</sup> *or (iii) 100% of the “Residual.”*<sup>34</sup> “Residual” is defined as “the Gross Revenues and income *of any kind derived, directly or indirectly, from the Business . . .* based on the net amount actually collected after taking into account all refunds, allowances, and discounts.” Notably, “residual” excludes “owner dentist” or staff compensation and benefits (and other expenses).<sup>35</sup> Therefore, at a minimum for any given month, CSHM is collecting a \$175,000 management fee from dental clinics, even if the clinic loses money. However, for banner months CSHM is poised to reap 100% of a clinic’s gross revenues and income, minus “owner dentist” and staff salaries and benefits.

<sup>29</sup> Bankruptcy Filing, Case 3:12-bk-01573 (Feb. 2, 2012) (Exhibit 4).

<sup>30</sup> Letter from Theodore Hester, Attorney at King & Spalding, to Senators Baucus and Grassley (Nov. 29, 2011) (Exhibit 5).

<sup>31</sup> See, e.g., Consent Order Granting Permanent Inj. at 4, N.C. State Bd. of Dental Exam’rs v. Heartland Dental Care, Inc., 11 CVS 2343 (N.C. Gen. Court of Justice Super. Ct. Div. 2011) (rescinding the Management Services Agreements between Heartland and Drs. Cameron & Son) (Exhibit 61).

<sup>32</sup> See Appendix A. See generally Jim Moriarty, *Survey of State Laws Governing the Corporate Practice of Dentistry*, Moriarty Leyendecker 2012, at 10–11, [http://moriarty.com/content/documents/ML\\_PDFs/cpmd\\_4.10.12.pdf](http://moriarty.com/content/documents/ML_PDFs/cpmd_4.10.12.pdf).

<sup>33</sup> See Management Services Agreement, Small Smiles Dentistry for Children, Albuquerque, PC and FORBA, LLC at 8 (Oct. 1, 2010) (Exhibit 6). (“Gross Revenues shall mean all fees and charges recorded or booked on an accrual basis each month by or on behalf of Practice as a result of dental services furnished to patients by or on behalf of [dental] Practice as a result of dental services furnished to patients by or on behalf of [dental] Practice or the Clinic, less a reasonable allowance for uncollectable accounts, professional courtesies and discounts.”).

<sup>34</sup> See *id.* (emphasis added).

<sup>35</sup> *Id.* at 9.

According to a December 2011 letter from CSHM, “owners typically pay themselves a fixed administrative fee from the practices they own.”<sup>36</sup> However, when Senate staff interviewed a Small Smiles “owner dentist,” a different story emerged. After claiming that she owned five clinics in Maryland and Virginia, the interviewee stated that she was paid a flat fee by the company, as opposed to paying herself a fixed administrative fee.<sup>37</sup> Claiming that she had no input in choosing the amount of said fee, the “owner dentist” further indicated she did not know if she was entitled to additional payments based on the number of clinics she supposedly owned, but was currently receiving one flat fee as if she owned only one clinic.<sup>38</sup> When asked why she chose to tell state authorities that she owned additional clinics for no additional compensation, the “owner dentist” stated that CSHM told her the clinics would close if someone else could not be found to list as the owner.<sup>39</sup> This arrangement is in direct contradiction to the representations made by CSHM in its December 16, 2011, letter to Senators Grassley and Baucus.<sup>40</sup>

At Small Smiles, “owner dentists” enjoy none of the traditional benefits normally associated with ownership. The “owner dentist” has no equity in the practice in any meaningful sense of the word. According to the Buy-Sell Agreement, CSHM can replace the “owner dentists” at will, and the “owner dentist” has no right to sell the practice without consent from CSHM.<sup>41</sup> Furthermore, the Buy-Sell Agreement states that should an Event of Transfer occur, a Small Smiles representative is then entitled to buy *all* of the “owner dentist’s” ownership interests.<sup>42</sup> Event of Transfer includes (but is not limited to) the following: owner’s death, owner’s loss of license to practice dentistry, owner’s ineligibility to participate in Medicare or Medicaid, loss of owner’s professional liability insurance, or owner’s termination or end of employment with CSHM or Small Smiles.<sup>43</sup> In the event of an Event of Transfer or Involuntary Transfer,<sup>44</sup> the “owner dentist” is only entitled to the purchase price of \$100.<sup>45</sup> Notably, pursuant to stock pledge agreements with CSHM, “owner dentists” are prohibited from issuing additional shares of capital stock in the dental clinic without first obtaining

<sup>36</sup> Letter from Graciela M. Rodriguez, Attorney at King & Spalding, to Senators Baucus and Grassley (Dec. 16, 2011) (Exhibit 7).

<sup>37</sup> See Interview with Gillian Robinson-Warner, DDS, Lead Dentist of Small Smiles Clinic Oxon Hill, Md. (Mar. 7, 2012).

<sup>38</sup> See *id.*

<sup>39</sup> See *id.*

<sup>40</sup> See Letter from Graciela M. Rodriguez, Attorney at King & Spalding, to Senators Baucus and Grassley (Dec. 16, 2011) (Exhibit 7).

<sup>41</sup> *Id.*; see, e.g., CSHM/Small Smiles Dentistry for Children, Albuquerque, PC, Buy-Sell Agreement with [REDACTED] at 1 (Oct. 1, 2010) (CSHM-00000950) (Exhibit 8).

<sup>42</sup> CSHM/Small Smiles Dentistry for Children, Albuquerque, PC, Buy-Sell Agreement with [REDACTED] at 1 (Oct. 1, 2010) (CSHM-00000950) (Exhibit 8).

<sup>43</sup> CSHM/Small Smiles Dentistry for Children, Albuquerque, PC, Buy-Sell Agreement with [REDACTED] at 2–3 (Oct. 1, 2010) (CSHM-00000950) (Exhibit 8).

<sup>44</sup> See *id.* at 3 (“involuntary transfer” is an event “in which Owner shall be deprived or divested of any right, title or interest in or to any Ownership Interest, including, without limitation, upon the death of Owner, transfer in connection with marital divorce or separation proceedings, levy of execution, transfer in connection with bankruptcy, reorganization, insolvency or similar proceedings. . . .”).

<sup>45</sup> See Interview with Gillian Robinson-Warner, DDS, Lead Dentist of Small Smiles Clinic Oxon Hill, Md. (Mar. 7, 2012); see, e.g., CSHM/Small Smiles Dentistry for Children, Albuquerque, PC, Buy-Sell Agreement with [REDACTED] at 2–3 (Oct. 1, 2010) (CSHM-00000950) (Exhibit 8).

CSHM's discretionary express written consent.<sup>46</sup> Additionally, "owner dentists" may also not amend, alter, terminate or supplement the clinic's Articles of Incorporation, corporate Bylaws, and/or other vital documents without first obtaining CSHM's express written consent.<sup>47</sup>

All lease agreements for the clinic buildings, property, and equipment are with CSHM, not the "owner dentist."<sup>48</sup> The "owner dentist" cannot determine the schedule or number of patients that they or their dentists see each day.<sup>49</sup> Furthermore, the "owner dentist" cannot hire or fire employees or purchase new equipment without receiving approval from CSHM.<sup>50</sup>

The purpose of these arrangements is made abundantly clear in a 2006 memorandum assessing CSHM's (formerly FORBA) value:

Due to the state regulations prohibiting the corporate practice of dentistry, FORBA *does not technically* provide dental care to the patient, own any interest in its affiliated practices, or employ the dentists in the clinic. However, FORBA selects the new sites, negotiates the lease, oversees construction of the clinics, purchases the equipment, installs the IT and billing infrastructure, employs the staff, recruits the dentists and receives all of the income. Thus, it *effectively owns and manages* the clinics.<sup>51</sup>

Thus, by this description, it is clear that the dental management company actually maintains ownership and control over Small Smiles clinics. Moreover, the facts and circumstances surrounding the creation and implementation of the CIA illustrate that this particular ownership structure undermined the independent, professional, and clinical judgment of Small Smiles dentists. That is precisely the harm that state laws requiring that dentists own dental practices are designed to prevent.

In addition to the many other ways that CSHM limits the exercise of professional judgment by its dentists, the CIA *requires* CSHM to ensure compliance with quality of care standards,<sup>52</sup> perform regular audits,<sup>53</sup> and establish, implement, and distribute a Code of Conduct articulating consequences for non-complying dentists.<sup>54</sup> For example, the agreement requires CSHM's board to "ensure that each individual cared for by [CSHM] and in [CSHM] facilities receives the professionally recognized standards of care."<sup>55</sup> While the CIA provisions to ensure CSHM follows recognized standards of care are well-intentioned, it creates an affirmative duty for CSHM to exercise control over the professional judgment

<sup>46</sup> CSHM/Small Smiles Dentistry for Children, Albuquerque, PC, Stock Pledge Agreement with [REDACTED] at 3 (Oct. 1, 2010) (CSHM-00000959) (Exhibit 65).

<sup>47</sup> *See id.*

<sup>48</sup> *See* Interview with Gillian Robinson-Warner, DDS, Lead Dentist of Small Smiles Clinic Oxon Hill, Md. (Mar. 7, 2012).

<sup>49</sup> *See, e.g.*, e-mail from Dr. [REDACTED] to Dr. [REDACTED] (May 19, 2011, 4:57 pm) (Exhibit 9).

<sup>50</sup> *Id.*; *see also* Interview with Gillian Robinson-Warner, DDS, Lead Dentist of Small Smiles Clinic Oxon Hill, Md. (Mar. 7, 2012).

<sup>51</sup> MIC Memorandum, FORBA, LLC, Arcapita at 6 (June 2006) (FORBA 0046011) (Exhibit 10) (emphasis added). Arcapita was the private equity firm that owned FORBA, LLC.

<sup>52</sup> Corporate Integrity Agreement Between the Office of Inspector Gen. of the Dep't of Health & Human Serv. and Forba Holdings, LLC, at 13-14 (Jan. 14, 2010) (Exhibit 3).

<sup>53</sup> *Id.* at 10-11.

<sup>54</sup> *Id.* at 11-12.

<sup>55</sup> *Id.* at 8.

of dentists in states that do not allow a corporation to own dental clinics or interfere with dentists' professional judgment. Therefore, the CIA has the effect of enhancing control over dental clinic operations by CSHM which is a corporation that is not licensed to practice dentistry.

### **B. The Influence of Private Equity**

Venture capital and private equity deals are central to economic growth and innovation. However, the interest of private equity targeting dental practices within the Medicaid system is alarming—especially considering the regular complaints of private dentists and doctors about low Medicaid reimbursement rates. If a dentist in a small family practice cannot afford to take Medicaid patients because of low reimbursement rates, why would private equity invest capital in this business model? What can firms backed by private equity investment do to make money from Medicaid patients that locally owned and operated practices cannot or will not do? The answer is “volume.”

Through various meetings—both with CSHM executives and employees at the Small Smiles Oxon Hill facility—Committee staff were told that CSHM's business model was to increase patient volume as much as possible. In order to do this, CSHM executives and staff claimed that due to the population the clinics are serving, they must over-book appointments. This means, at times, two to three patients will be scheduled for a single time slot. CSHM claims that Medicaid patients tend to be unreliable, often not showing up for scheduled appointments. This is confirmed by a 2006 memorandum assessing FORBA's (CSHM's precursor) value:

Importantly, FORBA's unique business model mitigates the 33% broken appointment challenge in that patients are not scheduled to have appointments with specific dentists. Instead, any one of four dentists at a clinic can see a patient. Therefore, since FORBA employs a minimum of three to four dentists per clinic, *FORBA can leverage its critical mass of dentists and over-schedule appointments by 25%.*<sup>56</sup>

CSHM has also employed the use of bonuses as a way to incentivize their employees, both dentists and non-dentists, to maximize volume and profit. Under FORBA's leadership, employees received both a salary and productivity-based bonuses based on contests amongst dental clinics. Bonuses were based on: (1) daily average productivity, (2) broken appointment rates, (3) number of patients seen per day, and (4) number of patients converted from providing simple hygiene to operative dental work (at a higher reimbursement rate).<sup>57</sup> Based on a clinic's productivity level, employees could receive up to \$1,000.<sup>58</sup> FORBA would hold these contests multiple times throughout the year.

<sup>56</sup>MIC Memorandum, FORBA, LLC, Arcapita at 26–27 (June 2006) (FORBA\_0046011) (Exhibit 10) (emphasis added). Arcapita was the private equity firm that owned FORBA, LLC.

<sup>57</sup>See FORBA, March Madness at 1 (FORBA\_0236082/CSHM-00002086) (Exhibit 11).

<sup>58</sup>See FORBA, The Road to the Super Bowl (FORBA\_0230059/CSHM-00002004) (Exhibit 45).

Under management by CSHM, compensation is based on the revenue of that dental clinic as well as the collections of each dentist.<sup>59</sup> This productivity-based compensation arrangement prioritizes volume, operative procedures over preventive care, and encourages unnecessary care.<sup>60</sup> In fact, when asked what aspects of her job were the most dissatisfying in an exit interview with CSHM, one Lead Dentist disclosed, “Only after doctors were converted to production[-]based compensation. This conversion caused distractions and realignment of priorities. Inability to concentrate only on dentistry and patient needs.”<sup>61</sup> [sic]

If dentists in a CSHM clinic feel the schedule is unmanageable, they are not permitted to hire additional employees to handle the increased workload without approval from CSHM executives. Nor do they have the authority to reduce their own patient load. For example, in a May 2011 e-mail from a Lead Dentist to CSHM management, the Lead Dentist complained to CSHM management that staffing was not at the appropriate level to handle the patient load they were carrying.<sup>62</sup> CSHM replied that, “As we discussed yesterday, the patient load *will not be reduced* without collaboration from CSHM.”<sup>63</sup> The Lead Dentist replied, “I will not be [held] responsible for errors in my center when we have asked for help numerous times.”<sup>64</sup>

### C. Federal Government Intervention

In 2010, after a lengthy investigation into the company by the United States Department of Justice, CSHM entered into a CIA with the United States Department of Health and Human Services,<sup>65</sup> as well as settlement agreements with the United States Department of Justice and 22 states.<sup>66</sup> The Department of Justice settlement cites conduct by FORBA (now CSHM) from the time period of September 2006 through June 2010.<sup>67</sup> Specifically, the conduct noted in the agreement includes submitting Medicaid reimbursement claims for medically unnecessary pulpotomies, crowns, extractions, fillings, sealants, x-rays, anesthesia, and behavior management; failing to meet professionally recognized standards of care; and provision of care by unlicensed persons.<sup>68</sup> CSHM’s CIA with the Department of Health and Human Services required CSHM to institute rigorous compliance procedures and programs, as well as submit to regular audits and reviews by an Independent Monitor.<sup>69</sup>

To date, the Independent Monitor has audited and reviewed 60 Small Smiles clinics through an onsite review or desk audit since 2010. Consistently, the Independent Monitor reports reveal that

<sup>59</sup> See CSHM/Small Smiles Dental Center of Holyoke, LLC, Lead Dentist Employment Agreement with Dr. [REDACTED] at 4–6 (Aug. 30, 2010) (Exhibit 12).

<sup>60</sup> *Id.*

<sup>61</sup> CSHM Exit Interview, Medrina Gilliam at 1 (July 1, 2011) (CSHM–00006826) (Exhibit 13).

<sup>62</sup> See E-mail chain from Dr. [REDACTED] to Dr. [REDACTED] (May 19–20, 2011) (Exhibit 9).

<sup>63</sup> *Id.*

<sup>64</sup> *Id.*

<sup>65</sup> Letter from Dep’t Health and Human Services, OIG, to Senators Baucus and Grassley, re: Corporate Integrity Agreement with CSHM, w/attach. at 2 (Oct. 4, 2012) (Exhibit 14).

<sup>66</sup> CSHM/FORBA Holdings, LLC, State Settlement Agreement with the State of N.Y. (Jan. 20, 2010) (Exhibit 15).

<sup>67</sup> See Civil Settlement Agreement, FORBA and Dep’t of Justice (Jan. 15, 2010) (Exhibit 2).

<sup>68</sup> See *id.*

<sup>69</sup> See Letter from Dep’t Health and Human Services, OIG, to Senators Baucus and Grassley, re: Corporate Integrity Agreement with CSHM, w/attach. at 2 (Oct. 4, 2012) (Exhibit 14).

clinic employees had little awareness of the new compliance procedures, and that CSHM was giving its dentists passing grades on chart audits which the Independent Monitor says they clearly failed.<sup>70</sup> In fact, of the 14 reports that graded the clinic doctors on a 100-point scale, CSHM gave their doctors grades that were on average 44% higher than the grade that the Independent Monitor awarded.<sup>71</sup>

#### **D. Committee Staff Site Visit to Small Smiles of Oxon Hill, Maryland**

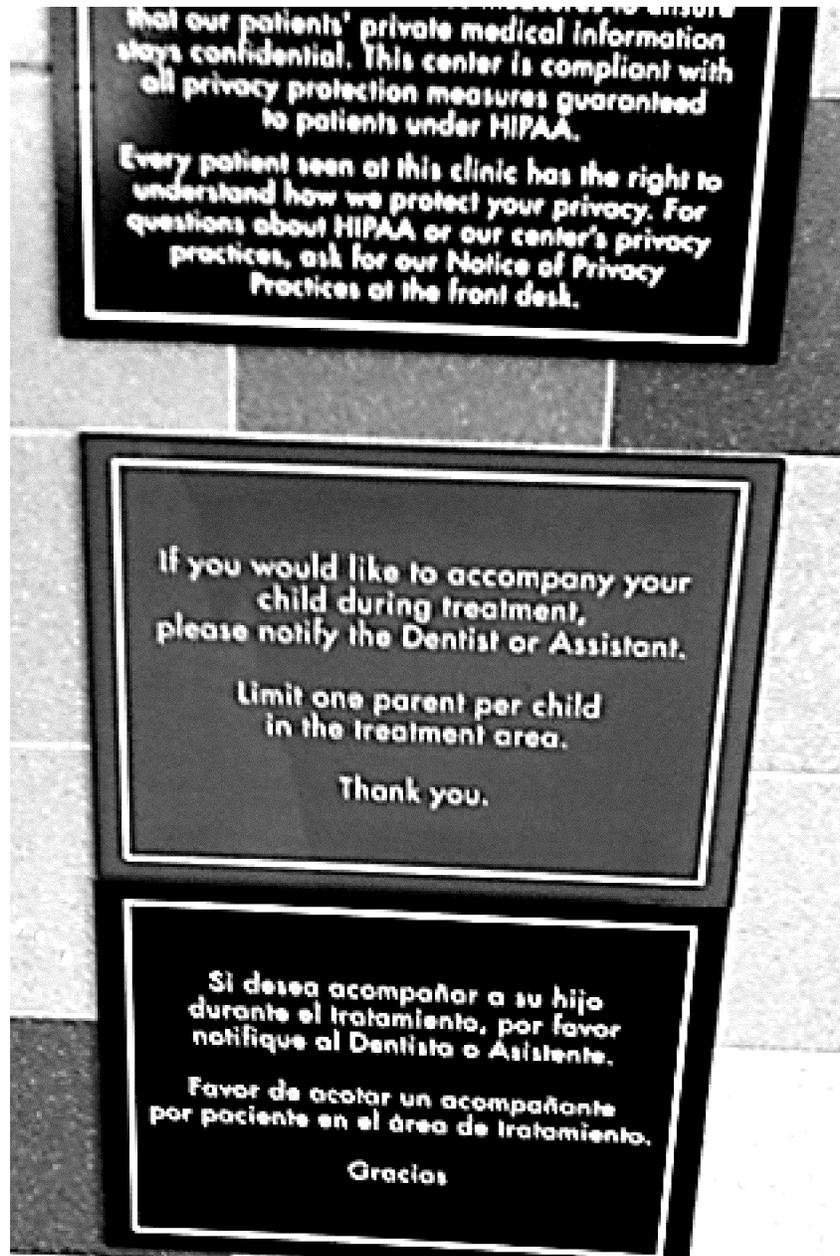
On March 7, 2012, Committee staff arranged a site visit at a Small Smiles Dental Center in Oxon Hill, Maryland, during an audit by the Independent Monitor.<sup>72</sup> The center was large, reasonably well kept, and clinic employees were friendly and welcoming. Signs informing parents of their right to join their children in the treatment area were prominently displayed in both English and Spanish.<sup>73</sup>

<sup>70</sup> See Independent Monitor Report, Oxon Hill, Md. at 11 (Apr. 20, 2012) (Exhibit 16).

<sup>71</sup> See Independent Monitor Report, Worcester, Mass. at 5 (Jan. 4, 2011) (Exhibit 46); Independent Monitor Report, Thornton, Colo. at 6 (Feb. 4, 2011) (Exhibit 47); Independent Monitor Report, Santa Fe, N.M. at 6 (Mar. 7, 2011) (Exhibit 48); Independent Monitor Report, Albuquerque, N.M. at 5 (Apr. 8, 2011) (Exhibit 49); Independent Monitor Report, Myrtle Beach, S.C. at 6 (May 9, 2011) (Exhibit 50); Independent Monitor Report, Augusta, Ga. at 6 (July 1, 2011) (Exhibit 51); Independent Monitor Report, Austin, Tex. at 6 (July 29, 2011) (Exhibit 52); Independent Monitor Report, Mattapan, Mass. at 6 (Sept. 6, 2011) (Exhibit 53); Independent Monitor Report, Manassas, Va. at 8 (Sept. 22, 2011) (Exhibit 23); Independent Monitor Report, Youngstown, Ohio at 5 (Oct. 14, 2011) (Exhibit 27); Independent Monitor Report, Oklahoma City, Okla. at 6 (Nov. 4, 2011) (Exhibit 54); Independent Monitor Report, Mishawaka, Ind. at 6 (Oct. 5, 2012) (Exhibit 40); Independent Monitor Report, Brockton, Mass. at 6 (Nov. 9, 2012) (Exhibit 55); Independent Monitor Report, Denver, Colo. at 7 (Dec. 7, 2012) (Exhibit 56). The 44% figure was calculated by averaging the CSHM score and the Independent Monitor score for each doctor in the listed reports. The difference was found between each score, which resulted in 44% higher average in CSHM scores than Independent Monitor scores.

<sup>72</sup> *Id.* at 8.

<sup>73</sup> See Small Smiles Clinic, Oxon Hill, Md. Photograph of signs (Exhibit 37).



that our patients' private medical information stays confidential. This center is compliant with all privacy protection measures guaranteed to patients under HIPAA.  
Every patient seen at this clinic has the right to understand how we protect your privacy. For questions about HIPAA or our center's privacy practices, ask for our Notice of Privacy Practices at the front desk.

If you would like to accompany your child during treatment, please notify the Dentist or Assistant.  
Limit one parent per child in the treatment area.  
Thank you.

Si desea acompañar a su hijo durante el tratamiento, por favor notifique al Dentista o Asistente.  
Favor de acotar un acompañante por paciente en el área de tratamiento.  
Gracias

Committee staff was given the opportunity to sit in with the Independent Monitor during the interview of three employees of the clinic and ask supplemental questions.

The first employee interviewed was the clinic's Office Manager/Compliance Liaison.<sup>74</sup> The role of the Compliance Liaison is to keep up-to-date with CSHM compliance policies and ensure that staff is knowledgeable and well-trained in compliance policies.<sup>75</sup> For example, the Compliance Liaison is responsible for regularly checking the company's web portal to see if there are any new compliance trainings on topics such as X-ray safety, record management, and billing practices.<sup>76</sup> During questioning, it became increasingly clear that the Compliance Liaison was simply too busy running the clinic to keep up with his compliance duties. This particular clinic treats as many as 70 children each day, and makes appointments for well over 100.<sup>77</sup>

The Compliance Liaison also indicated that he was previously the Office Manager and Compliance Liaison at yet another troubled Small Smiles clinic in Manassas, Virginia.<sup>78</sup> When asked whether he thought there were any problem areas with the Manassas clinic, he responded that he did not think so.<sup>79</sup>

The next employee interviewed was the Clinical Coordinator. The Clinical Coordinator is typically a facilitator—making certain that the busy treatment area operates efficiently. The Clinical Coordinator maintains and orders supplies, monitors patient flow, and keeps things moving. During the interview, it was clear that the Clinical Coordinator was not knowledgeable about important safety and compliance policies. For example, when the Independent Monitor asked what should be done when a child has evidence of tooth decay, but will not sit still for X-rays, the Clinical Coordinator responded that the dental assistant or available staff should sit with the child in the X-ray area and hold the child still.<sup>80</sup> However, pediatric dental education literature emphasizes that given “associated risks and possible consequences of [protective stabilization], the *dentist* is encouraged to evaluate thoroughly its use on each patient and possible alternatives.”<sup>81</sup> A dentist must consider the following factors prior to using protective stabilization: “1. alternative behavior guidance modalities; 2. dental needs of the patient; 3. the effect on the quality of dental care; 4. the patient's emotional development; [and] 5. the patient's medical and physical considerations.”<sup>82</sup> The Clinical Coordinator was terminated.

Finally, Committee staff questioned the “owner dentist” of Oxon Hill Small Smiles, who was also the Lead Dentist. The “owner dentist” appeared nervous when speaking with the Independent Monitor and Committee staff, but appeared genuinely passionate about

<sup>74</sup> See generally Interview with Marty Reyes, CDA, EFDA, Office Manager and Compliance Liaison of Small Smiles Clinic Oxon Hill, Md. (Mar. 7, 2012).

<sup>75</sup> See CSHM Office Manager's Manual, v. 06–2011, at 15 (Dec. 17, 2010) (Exhibit 17).

<sup>76</sup> See Interview with Marty Reyes, CDA, EFDA, Office Manager and Compliance Liaison of Small Smiles Clinic Oxon Hill, Md. (Mar. 7, 2012).

<sup>77</sup> See Daily Patient Flow at 5 (Apr. 13, 2011) (Exhibit 18).

<sup>78</sup> Interview with Marty Reyes, CDA, EFDA, Office Manager and Compliance Liaison of Small Smiles Clinic Oxon Hill, Md. (Mar. 7, 2012); see discussion at Parts E.2.

<sup>79</sup> *Id.*

<sup>80</sup> *Id.*

<sup>81</sup> 34 AM. ACAD. OF PEDIATRIC DENTISTRY, REFERENCE MANUAL: GUIDELINE ON BEHAVIOR GUIDANCE FOR THE PEDIATRIC DENTAL PATIENT 176 (1990) (emphasis added) (Exhibit 19).

<sup>82</sup> *Id.*

dental care for underprivileged children. When asked about the details of her compensation, the “owner dentist” stated that she receives a salary, and an additional flat payment for being the “owner dentist.”<sup>83</sup> When asked how many Small Smiles Dental Centers she owned, she stated that she owned five clinics and had just recently become the owner of the Manassas, Virginia clinic.<sup>84</sup> She was then asked if she received an additional flat fee payment for each clinic that she owned, and she stated that she did not.<sup>85</sup> Following up on that question, she was asked why she chose to become the owner of the troubled Manassas<sup>86</sup> clinic for no additional compensation, and she stated that she was told it would have to close if she did not agree to become the owner.<sup>87</sup> The “owner dentist” was then asked if she could name any of the dentists under her employ at the Manassas clinic she purported to own.<sup>88</sup> She could not name a single dentist at that facility. When asked if she had ever been to the Small Smiles clinic in Manassas, she replied that she had not.<sup>89</sup> When asked whether she knew the names of any of the dentists at another Maryland clinic she purported to own, she struggled for some time before recalling one dentist’s first name.<sup>90</sup>

The next line of questioning for the “owner dentist” was regarding her control over operations at the clinics she supposedly owns. She was adamant that all medical decisions remain under her control. However, she conceded that CSHM receives 100% of the proceeds of the business, pays all of the staff salaries at her clinic, pays her salary, dictates the number of patients to be scheduled for each day, sets the budget for supplies, rents the space the clinic uses, and has complete control over all hiring and firing decisions.<sup>91</sup> When pressed further regarding her ability to hire additional staff should the clinic need an additional dentist to keep up with demand and provide quality care, she did not wish to engage in the hypothetical discussion, but conceded that she had never hired or fired anyone without the permission of CSHM.<sup>92</sup>

Despite the language in the management services agreement regarding the payment structure and management fees paid to CSHM, it is clear that the “owner dentists” have no idea where the money from the procedures for which they bill Medicaid actually ends up. “Owner dentists” are merely paid a salary by CSHM and receive a flat fee to assert ownership to their respective state, but they exercise none of the traditional elements of ownership.

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<sup>83</sup> Interview with Gillian Robinson-Warner, DDS, Lead Dentist of Small Smiles Clinic Oxon Hill, Md. (Mar. 7, 2012).

<sup>84</sup> *Id.*

<sup>85</sup> *Id.*

<sup>86</sup> See discussion at Parts E.2.

<sup>87</sup> *Id.*

<sup>88</sup> Interview with Gillian Robinson-Warner, DDS, Lead Dentist of Small Smiles Clinic Oxon Hill, Md. (Mar. 7, 2012).

<sup>89</sup> *Id.*

<sup>90</sup> *Id.*

<sup>91</sup> *Id.*

<sup>92</sup> *Id.*

## **E. CSHM Repeatedly Fails to Meet Quality and Compliance Standards**

The Department of Health and Human Services Office of Inspector General and the Independent Monitor have closely monitored Small Smiles clinics and their corporate owners since 2010. Monitoring has included audits, site visits, fines, penalties, and changes to management, and yet CSHM repeatedly fails to meet basic quality and compliance standards. According to Independent Monitor reports, the company is still rushing through dental treatments, providing substandard and in some cases dangerous care, performing medically unnecessary treatments, and risking the safety of children—all of which are ultimately financed by taxpayers through the Medicaid program.<sup>93</sup>

Each time the company fails to meet its obligations or the Independent Monitor uncovers problems, the company promises to do better, and HHS OIG gives CSHM another chance. The following sections outline the major failures of CSHM during the monitoring period, and the seemingly endless capacity for the government to grant the company more chances.

### *1. Phoenix, Arizona Independent Monitor Report*

The Independent Monitor visited a Small Smiles clinic in Phoenix, Arizona on December 23, 2010, relatively early on in the monitoring period. At this clinic, the Lead Dentist informed the Independent Monitor that she automatically performed pulpotomies on primary anterior teeth that received a NuSmiles crown.<sup>94</sup> A NuSmiles crown is a stainless steel crown (SSC) with a natural-looking, tooth-colored coating.<sup>95</sup> According to the Lead Dentist, “the amount of tooth structure removal necessary to prepare the teeth for the crowns endanger the pulp and necessitated pulpotomies.”<sup>96</sup> However, a pulpotomy is only necessary when the nerve is exposed, and is typically only indicated in one-third of patients.<sup>97</sup> Therefore, if the patient population is typical, two-thirds of the pulpotomies that the Lead Dentist in Phoenix performed were potentially unnecessary, at a total cost of approximately \$5,300 per 100 Medicaid patients.<sup>98</sup> Not only is this a quality of care issue, with children receiving unnecessarily prolonged treatments, but it is also a drain on the Medicaid system. When dentists perform unnecessary pulpotomies, it is the Medicaid system that initially foots the bill, and then ultimately the taxpayers. It is unclear whether outside influence or information compelled the dentist to do pulpotomies every single time, but this case illustrates that the trainings and compliance programs necessitated by the CIA were largely ineffectual.

Of the 30 records reviewed by the Independent Monitor, 15 documented children being strapped down to a papoose board during

<sup>93</sup> See IMR Oxon Hill, Md. at 27 (Exhibit 16).

<sup>94</sup> Independent Monitor Report Phoenix, Ariz. at 3 (Dec. 23, 2010) (Exhibit 20).

<sup>95</sup> NuSmile, Pediatric Crowns, <http://www.nusmilecrowns.com> (last visited Mar. 22, 2013).

<sup>96</sup> IMR Phoenix, Ariz. at 3 (Exhibit 20).

<sup>97</sup> Thikkurissy, Sarat, et al., *Pulpotomy to Stainless Steel Crown Ratio in Children With Early Childhood Caries: A Cross-sectional Analysis Pediatric Dentistry*, *Pediatric Dentistry*, vol. 33 n. 7, 496, (Nov./Dec. 2011) (Exhibit 21).

<sup>98</sup> Arizona Health Care Cost Containment System—Schedule of Dental Rates (Jan. 1, 2007) (Exhibit 22). Each pulpotomy costs \$81. *Id.* at 2.

treatment.<sup>99</sup> However, none of these patients received nitrous oxide/oxygen anesthesia, which is the preferred method of calming young dental patients.<sup>100</sup> Furthermore, one child was documented as being on the papoose board for 1 hour and 45 minutes, without monitoring of vital signs or a bathroom break.<sup>101</sup> This is a clear violation of CSHM's policies and is dangerous and distressing for the child.<sup>102</sup>

This early Independent Monitor report demonstrates that many of the problems identified in prior news reports and flagged by DOJ in 2007 and 2008 were still common practice at Small Smiles in late 2010, including unnecessary procedures, overuse of the papoose board on distressed children, and a general lack of understanding by Small Smiles dentists regarding how children should be treated.

## 2. Manassas, Virginia Independent Monitor Report

The Independent Monitor visited a Small Smiles clinic in Manassas, Virginia on September 22, 2011—nearly one year after the initiation of compliance programs, training, and monitoring by the government. The Independent Monitor found many of the same problems, and nearly an identical case involving the misuse of a papoose board. Both dentists at the clinic scored lower on the Independent Monitor's evaluation than on a previous internal audit conducted by CSHM. These dentists did not follow proper protocols for implementing and documenting dental procedures, and this ultimately resulted in one dentist receiving an automatic failure from the Independent Monitor.<sup>103</sup> This fact is critical. The purpose of the monitoring period is that, at the end of 5 years, CSHM should be able to use its own internal monitoring and compliance programs. In numerous Independent Monitor reports, however, CSHM's audits have given dentists passing grades, while the subsequent Independent Monitor's review found that these same dentists clearly failed.<sup>104</sup> Therefore, despite the passage of time and ample guidance from the government, CSHM is still unable to rely on its own internal monitoring and compliance programs.

Just like the Phoenix clinic, one dentist at the Manassas clinic utilized a papoose board on a patient for 1 hour and 45 minutes, a violation of CSHM use of restraint policy,<sup>105</sup> and in violation of generally recognized standards from the American Academy of Pediatric Dentists.<sup>106</sup>

<sup>99</sup> IMR Phoenix, Ariz. at 17 (Exhibit 20).

<sup>100</sup> *Id.* at 18.

<sup>101</sup> *Id.* at 17.

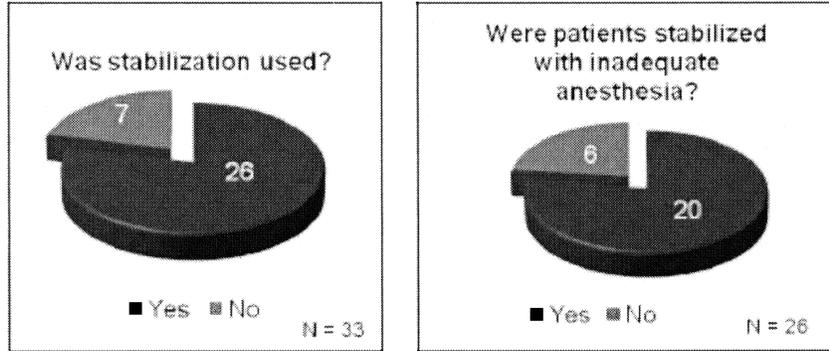
<sup>102</sup> *Id.* at 17–18.

<sup>103</sup> Independent Monitor Report Manassas, Va. at 2 (Sept. 22, 2011) (Exhibit 23).

<sup>104</sup> Independent Monitor Report, Worcester, Mass. at 5 (Jan. 4, 2011) (Exhibit 46); Independent Monitor Report, Thornton, Colo. at 6 (Feb. 4, 2011) (Exhibit 47); Independent Monitor Report, Santa Fe, N.M. at 6 (Mar. 7, 2011) (Exhibit 48); Independent Monitor Report, Albuquerque, N.M. at 5 (Apr. 8 2011) (Exhibit 49); Independent Monitor Report, Myrtle Beach, S.C. at 6 (May 9, 2011) (Exhibit 50); Independent Monitor Report, Augusta, Ga. at 6 (July 1, 2011) (Exhibit 51); Independent Monitor Report, Mattapan, Mass. at 6 (Sept. 6, 2011) (Exhibit 53); Independent Monitor Report, Manassas, Va. at 8 (Sept. 22, 2011) (Exhibit 23); Independent Monitor Report, Youngstown, Ohio at 5 (Oct. 14, 2011) (Exhibit 27); Independent Monitor Report, Oklahoma City, Okla. at 6 (Nov. 4, 2011) (Exhibit 54); Independent Monitor Report, Mishawaka, Ind. at 6 (Oct. 5, 2012) (Exhibit 40); Independent Monitor Report, Denver, Colo. at 7 (Dec. 7, 2012) (Exhibit 56).

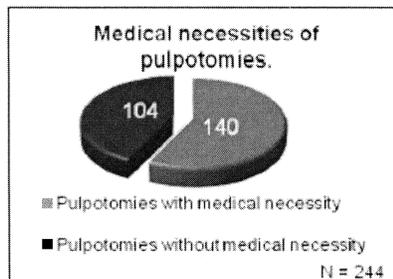
<sup>105</sup> CSHM Policy on Protective Stabilization at 3 (Jan. 14, 2012) (Exhibit 24).

<sup>106</sup> *Guideline on Behavior Guidance for the Pediatric Dental Patient*, American Academy of Pediatric Dentistry, vol. 33 no. 6, 167–68 (2011/2012) (Exhibit 25).

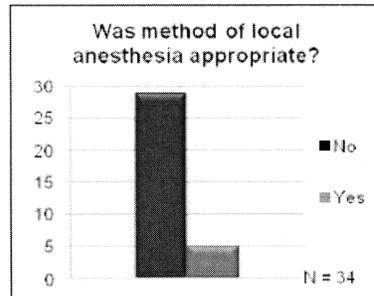


Source: IMR Manassas, Va. at 32 (Exhibit 23).

Another example includes one dentist automatically failing due to the lack of documentation for medical necessity.<sup>107</sup> Manassas clinic dentists billed Medicaid for reimbursement of X-rays even though the Independent Monitor’s audit found no evidence that the X-rays were actually performed.<sup>108</sup> Five records revealed patients receiving treatment for 8 to 12 teeth during a single visit without the proper amount of anesthesia being administered. Of 244 pulpotomies performed, 104 “were not medically necessary,”<sup>109</sup> costing taxpayers and the Medicaid program a total of \$8,391.<sup>110</sup> This audit also revealed that CSHM’s chart audit tool failed to uncover several documentation errors and improper anesthesia use.<sup>111</sup>



Source: IMR Manassas, Va. at 30 (Exhibit 23).



Source: IMR Manassas, Va. at 31 (Exhibit 23).

Allegations of abuse plagued the Manassas clinic, leading to its eventual closure by CSHM. The Committee staff have received information that the Virginia Department of Health Professions will be reviewing the dentists who practiced at the Manassas clinic. Contrary to assertions that a vulnerable population would go un-

<sup>107</sup> See IMR Manassas, Va. at 2 (Exhibit 23).  
<sup>108</sup> *Id.*  
<sup>109</sup> *Id.* at 3.  
<sup>110</sup> Virginia Smiles for Children—Schedule of Allowable Fees (Exhibit 66). Each pulpotomy costs \$80.69.  
<sup>111</sup> *Id.*

treated without Small Smiles, the patients of the Manassas clinic and other clinics closed by CSHM have been absorbed into other practices with little difficulty.<sup>112</sup>

### 3. Oxon Hill, Maryland Small Smiles Clinic

The report issued by the Independent Monitor after the site visit at the Oxon Hill Small Smiles confirms the findings of the Committee staff who observed the clinic with the Independent Monitor.

First, the Independent Monitor discovered numerous quality of care issues. It found that the clinic was inappropriately documenting and administering local anesthetics and nitrous oxide.<sup>113</sup> Notably, the Independent Monitor observed that “[t]he maximum dose of local anesthetic was not calculated for patients treated by the Lead Dentist before she administered local anesthetic.”<sup>114</sup> Rather, local anesthetic calculations were performed and filled in after the fact.<sup>115</sup> Moreover, the clinic was found to be substituting the papoose board for anesthesia or nitrous oxide.<sup>116</sup> This means that the child was both experiencing pain while also being restrained. Out of 30 records, there were six instances in which a child *younger than 5 years old* was restrained during treatment without the use of local anesthetic, and seven instances in which primary teeth fillings on children younger than 7 years old were administered without local anesthesia or nitrous oxide.<sup>117</sup>

Second, the Independent Monitor found alarming practices that had threatened patient safety at Oxon Hill, Maryland clinic. One notable incident involved a child treated with a pulpotomy and a stainless steel crown who was restrained using a patient stabilization device (PSD):

[C]hild screamed and fought the entire time. The patient kept moving her head, making it difficult to keep it secured. *She vomited approximately half way through the procedure.* The dentist immediately turned the patient on her side and suctioned her mouth and throat. This child’s airway was in jeopardy because the mouth prop opened her mouth so wide it restricted her ability to swallow and protect her airway. The patient was screaming and gasping, leaving her airway open and vulnerable. Cotton pellets used during the pulpotomy were placed and removed while SSC’s were fitted and removed on a moving, combative, and hysterical child with no methods employed to protect the airway.<sup>118</sup>

Notably, the dentist resumed treatment despite the child’s vomiting.

Most shocking was the Independent Monitor’s final observation regarding the clinic:

Treatment was provided to restrained children who were fighting, crying, and basically hysterical, using large mouth props

<sup>112</sup> See Interview with Church Street Health Management, in Washington, D.C. (Feb. 21, 2012).

<sup>113</sup> See IMR Oxon Hill, Md. at 27 (Exhibit 16).

<sup>114</sup> *Id.* at 36.

<sup>115</sup> *Id.*

<sup>116</sup> *Id.*

<sup>117</sup> See *id.* at 27.

<sup>118</sup> *Id.* at 36 (emphasis added).

that overextended their mouths, compromising their ability to swallow and protect their airways. Water spray from hand pieces, cotton pellets used for pulpotomies, and stainless steel crowns (SSCs) that are fitted and removed all presented potential risk to these children's airways.

Preparedness and anticipation was lacking on the part of the dental assistants during procedures on uncooperative young children.<sup>119</sup>

Third, the Independent Monitor found instances in which no medical necessity was provided for treatments performed. In 9 of the 30 records reviewed by the Independent Monitor, no documentation or X-rays were provided to support the medical necessity of treatments provided to patients.<sup>120</sup> Therefore, in 30% of the records reviewed, the Medicaid program was billed for unjustified and potentially unnecessary treatments. Larger sampling at this and other clinics could reveal massive overpayments by the government to CSHM.

#### *4. Oxon Hill, Maryland Small Smiles Overpayment*

At the Oxon Hill Small Smiles Center, mentioned above, HHS OIG was alerted to an \$852,492.74 overpayment.<sup>121</sup> Not only was this clinic providing substandard care, according to the Independent Monitor, it was also providing unnecessary treatments and getting excessive payments from Medicaid. Shortly after the overpayment was identified, CSHM satisfied its obligations under the CIA to refund the overpayment.<sup>122</sup>

#### *5. Youngstown, Ohio Clinic*

Similar problems occurred at the Youngstown, Ohio clinic, where the Independent Monitor found that the clinic provided unnecessary care and also had billing, reimbursement, and records management issues. HHS OIG even went as far as to demand that Small Smiles pay a \$100,000 stipulated penalty and issued a Notice of Material Breach and Intent to Exclude to the Youngstown clinic. Such notices signal that HHS OIG intends to exclude a facility from the Medicaid program. Exclusion would prohibit a facility from treating Medicaid beneficiaries and seeking state and Federal reimbursement. HHS OIG cites the Independent Monitor report findings as the primary reason to exclude the Youngstown facility from participating in the Medicaid program.<sup>123</sup>

Specifically, 7 of the 15 records reviewed by the Independent Monitor revealed a lack of documentation or radiographic evidence to support medical necessity for treatments provided by Small Smiles.<sup>124</sup> Of those 7 records, 6 revealed pulpotomies were performed without medical necessity, while one record showed no X-

<sup>119</sup> *Id.* at 5.

<sup>120</sup> *Id.* at 29.

<sup>121</sup> See Letter from CSHM to HHS OIG, re: Reporting of Substantial Overpayment to Small Smiles Dental Centers of Oxon Hill at 2 (May 22, 2012) (Exhibit 57).

<sup>122</sup> See *id.*

<sup>123</sup> Letter from HHS OIG to CSHM, re: Demand for Stipulated Penalties and Notice of Material Breach and Intent to Exclude (June 22, 2012) (Exhibit 26).

<sup>124</sup> *Id.* at 4-5.

rays or photographs were taken to support the medical necessity for treatment provided.”<sup>125</sup>

The Independent Monitor report found “poorly performed fillings and stainless steel crowns, undiagnosed recurrent decay or faulty restorations, lack of rationale for extractions, no use of local anesthesia for placement of fillings in teeth with deep decay, use of multiple surface fillings without any substantiation as to why stainless steel crowns were not used.”<sup>126</sup> In perhaps the most troubling violation observed by the Independent Monitor, the report describes:

A combative 4-year-old child received a cut to the tongue while three teeth were being treated with fillings, a pulpotomy and a [stainless steel crown]. The documentation in the patient’s record did not record the size of the cut and reported the patient was “very strong and vocal.” Four people were required to help manage the patient. Documentation also showed that a protective stabilization device (PSD) was used and the patient was “double wrapped” in order to provide treatment. The e-mail communication related with this case did not show that X-rays were requested; therefore, **it appeared there was no evaluation to determine whether the treatment rendered was medically necessary.**<sup>127</sup>

On July 3, 2012, HHS OIG received confirmation that CSHM paid the \$100,000 stipulated penalty.<sup>128</sup> On August 23, 2012, HHS OIG sent a letter to CSHM stating that it determined that CSHM “cured the breaches identified in the OIG’s Notice, and will not proceed with an exclusion action against CSHM’s Small Smiles Dental Centers of Youngstown at this time.”<sup>129</sup> CSHM advised HHS OIG of its effort to cure the specific breaches through various actions, including: (1) evaluation and termination of nine staff people; (2) the temporary, 2-day closure to conduct training; and (3) the development of an ongoing oversight and monitoring plan by the Chief Compliance Officer, Chief Dental Officer, the Regional Director, and the Senior Vice President of Operations.<sup>130</sup>

#### **F. Health and Human Services Office of Inspector General Notice of Intent to Exclude**

On March 8, 2012, HHS OIG sent a Notice of Material Breach and Intent to Exclude to CSHM. HHS OIG states in its letter that due to CSHM’s “repeated and flagrant violation of certain provisions” of the CIA, the OIG is exercising “its right under the CIA to exclude CSHM from participation in the Federal health care programs.”<sup>131</sup> HHS OIG largely cites violations occurring at the Manassas, Virginia clinic as primary reasons for its intent to exclude. Specifically, HHS OIG points to five main areas in which CSHM

<sup>125</sup> *Id.*

<sup>126</sup> *Id.* at 5.

<sup>127</sup> Independent Monitor Report Youngstown, Ohio at 11 (May 25, 2012) (Exhibit 27) (emphasis added).

<sup>128</sup> See Letter from HHS OIG, to CSHM, re: Resolution of the Stipulated Penalties and Notice of Material Breach and Intent to Exclude Matter at 2 (Aug. 23, 2012) (Exhibit 28).

<sup>129</sup> *Id.* at 1.

<sup>130</sup> See *id.*

<sup>131</sup> Letter from HHS OIG to CSHM, re: Notice of Material Breach and Intent to Exclude at 1 (Mar. 8, 2012) (Exhibit 29).

violated the terms of the CIA: (1) management certifications and accountability; (2) policies and procedures requirements; (3) change to termination policy and procedure; (4) CSHM review of pulp-to-crown ratios and provision of medically unnecessary services at other CSHM facilities; and (5) quality of care reportable event requirements.<sup>132</sup>

Part of complying with the CIA requires CSHM to certify that each employee knows and understands his/her responsibilities and duties under Federal law, state dental board requirements, and professionally recognized standards of care. The certification also requires the employee to “attest that his/her job responsibilities include ensuring compliance with regard to the area under his/her supervision. . . .”<sup>133</sup> On March 15, 2011, CSHM submitted a report to the HHS OIG, including a certification for LaTanya O’Neal, the Lead Dentist in the Manassas, Virginia clinic. On November 16, 2011, HHS OIG conducted a site visit to the Manassas Clinic to gauge if the clinic was in compliance with its obligations under the CIA. During this site visit, the OIG interviewed Ms. O’Neal to ascertain her level of compliance and discuss her oversight role as Lead Dentist. Unfortunately, Ms. O’Neal was not able to address “any compliance-related obligations that she oversaw at Manassas Center.”<sup>134</sup> Additionally, Ms. O’Neal could not “recall signing an annual certification or any specific steps that she took to evaluate compliance at Manassas Center for purposes of signing that certification.”<sup>135</sup> Ultimately, HHS OIG found Ms. O’Neal’s certification to be false.<sup>136</sup> CSHM responded that it could not cure the breach of having submitted a false certification, but indicated that the Certifying Employee who signed the false certification is no longer employed by CSHM. Additionally, CSHM “implemented significant training and revamped [its] process for certifications.”<sup>137</sup> These two actions were enough to satisfy HHS OIG.

Section III.B.2.u of the CIA requires CSHM to have written Policies and Procedures in place to terminate employees who have been found to have violated professionally recognized standards of health care.<sup>138</sup> In January 2012, CSHM revised its “Adverse Events, Quality of Care Reportable Events, and OMIG Patient Care Matters” policy which states the following:

Practitioners who have violated professionally recognized standards of healthcare, including the AAPD Guidelines, the CSHM Clinical Policies and Guidelines for CSHM Associated Dental Centers, and any applicable state or local standards or guidelines, and whose violation has been deemed by the Chief Dental Officer to be a Quality of Care reportable event *will be terminated or will undergo a remediation plan developed by the Chief Dental Officer with approval of the OIG.*<sup>139</sup>

<sup>132</sup> *Id.* at 2–8.

<sup>133</sup> *Id.* at 2.

<sup>134</sup> *Id.* at 3.

<sup>135</sup> *Id.*

<sup>136</sup> See Letter from HHS OIG to CSHM, re: Notice of Material Breach and Intent to Exclude at 3 (Mar. 8, 2012) (Exhibit 29).

<sup>137</sup> Letter from HHS OIG, to CSHM, re: Notice of Material Breach and Intent to Exclude at 2–3 (Mar. 13, 2012) (Exhibit 30).

<sup>138</sup> *Id.*

<sup>139</sup> *Id.* at 6 (emphasis added).

The CIA does not allow for the Chief Dental Officer to dismantle the termination process with a remediation plan. Therefore, HHS OIG found this revision to directly contradict the requirements of the CIA because it allowed the Chief Dental Officer to avoid the termination requirement with his/her own remediation plan.<sup>140</sup>

Part of every audit conducted under the CIA includes a desk audit report. Included in each desk audit is a review of all of the dental work associated with that clinic. The Manassas, Virginia clinic desk audit report “indicated that of 244 pulpotomies reviewed by the Monitor, 104 were medically unnecessary.”<sup>141</sup> The desk audit also found that as a result, CSHM improperly billed the Medicaid program. CSHM issued a response to the findings on October 31, 2011, stating that it “agrees that pulpotomies were performed that were not medically necessary . . . [and that] CSHM’s systems were ineffective in identifying this issue.”<sup>142</sup>

Included in the October 2011 response, CSHM also identified 13 dentists with high pulp-to-crown ratios similar to those at the Manassas Clinic in its response to the desk audit.<sup>143</sup> CSHM was planning on addressing these 13 dentists by “monitor[ing] the pulp-to-crown ratio for each of these 13 individuals” and providing “indirect pulp therapy as an alternative to pulpotomies.”<sup>144</sup> After its October 2011 response, CSHM clarified that it had identified 12 dentists, and not 13 dentists, who exhibited high pulp-to-crown ratios.<sup>145</sup> However, HHS OIG was not able to determine whether CSHM “had performed or planned to perform a financial review of claims it submitted on behalf of the 12 identified dentists to determine whether CSHM had any overpayment or other liability for claims that were associated with high pulp-to-crown utilization.”<sup>146</sup> HHS OIG determined this was a breach of CSHM’s duty to develop and implement a policy to promptly and appropriately investigate compliance issues.<sup>147</sup>

CSHM had 30 days to demonstrate to HHS OIG that its material breach had been cured. CSHM submitted a written response on March 12, 2012, and met with HHS OIG on March 13, 2012.<sup>148</sup> Later that day, on March 13, 2012, HHS OIG sent CSHM a letter formalizing the terms of the agreement with CSHM whereby the OIG would not proceed with an exclusion action for the CIA breaches identified in the March 8, 2012 notice.<sup>149</sup>

With respect to the Manassas facility, HHS OIG agreed not to pursue an exclusion action that would apply to the entire company if CSHM agreed to: (1) a voluntary exclusion of Manassas Center within 90 days of the date of March 13, 2012, letter; and (2) comply with additional program integrity-related obligations that will be

<sup>140</sup> Letter from HHS OIG to CSHM, re: Notice of Material Breach and Intent to Exclude at 6 (Mar. 8, 2012) (Exhibit 29).

<sup>141</sup> *Id.*

<sup>142</sup> *Id.*

<sup>143</sup> *Id.* at 7.

<sup>144</sup> *Id.*

<sup>145</sup> *See id.*

<sup>146</sup> Letter from HHS OIG to CSHM, re: Notice of Material Breach and Intent to Exclude at 7 (Mar. 8, 2012) (Exhibit 29).

<sup>147</sup> *Id.* at 7–8.

<sup>148</sup> Letter from CSHM, to HHS OIG, re: Notice of Material Breach and Intent to Exclude (Mar. 12, 2012) (Exhibit 64).

<sup>149</sup> Letter from HHS OIG, to CSHM, re: Notice of Material Breach and Intent to Exclude (Mar. 13, 2012) (Exhibit 30).

incorporated as an amendment to the CIA by the March 13, 2012 letter. On June 4, 2012, CSHM sold the Manassas Clinic to a third party buyer, satisfying the first requirement.

The additional integrity-related provisions HHS OIG placed on CSHM include the following:

1. *Compliance Program Onsite Reviews of CSHM Facilities.* “Within 30 days CSHM shall develop and implement a process by which the Chief Dental Officer, the Compliance Officer, and Regional Dentists shall conduct at least one onsite review each month to a CSHM facility for the purpose of evaluating and ensuring compliance with all Federal health care program requirements, state dental board requirements, and the obligations of the CIA. The OIG will require CSHM to recruit Regional Pediatric Dentists who will assist with the Onsite Reviews. . . .”<sup>150</sup>

CSHM has completed its hiring of Regional Pediatric Dentists.<sup>151</sup>

2. *Quality Improvements Initiatives.* “Within 30 days, CSHM shall develop and implement a process by which CSHM identifies specific risk areas and relevant quality benchmarks, taking into account the recommendations of the Independent Monitor. . . .”<sup>152</sup>

CSHM fulfilled this requirement within the allocated time frame set forth by the HHS OIG.<sup>153</sup>

3. *Referral Process.* “Within 30 days, CSHM shall develop and implement guidance for each CSHM facility regarding patient referrals from CSHM facilities to other facilities better equipped to treat a patient in specific circumstances involving concerns for patient safety, including but not limited to anesthesia requirement[s] and behavior guidance techniques.”<sup>154</sup>

CSHM fulfilled this requirement within the allocated time frame set forth by the HHS OIG.<sup>155</sup>

4. *Certifying Employee Certifications.* “Within 30 days, CSHM shall develop a process by which Certifying Employees shall perform a comprehensive assessment of the areas of his/her responsibility under Federal law, state dental board requirements, and the obligations under the CIA.”<sup>156</sup>

<sup>150</sup> *Id.* at 3.

<sup>151</sup> E-mail chain between Committee Staff and HHS OIG re: Reporting Substantial Overpayments to Small Smiles Dental Centers of Oxon Hill (Mar. 7, 2013) (Exhibit 59).

<sup>152</sup> Letter from HHS OIG, to CSHM, re: Notice of Material Breach and Intent to Exclude at 4 (Mar. 13, 2012) (Exhibit 30).

<sup>153</sup> E-mail chain between Committee Staff and HHS OIG re: Reporting Substantial Overpayments to Small Smiles Dental Centers of Oxon Hill (Mar. 7, 2013) (Exhibit 59).

<sup>154</sup> Letter from HHS OIG, to CSHM, re: Notice of Material Breach and Intent to Exclude at 4 (Mar. 13, 2012) (Exhibit 30).

<sup>155</sup> E-mail chain between Committee Staff and HHS OIG re: Reporting Substantial Overpayments to Small Smiles Dental Centers of Oxon Hill (Mar. 7, 2013) (Exhibit 59).

<sup>156</sup> Letter to CSHM, from HHS OIG, re: Notice of Material Breach and Intent to Exclude at 4–5 (Mar. 13, 2012) (Exhibit 30).

CSHM fulfilled this requirement within the allocated time frame set forth by the HHS OIG.<sup>157</sup>

5. *Pulp-to-Crown Medical Necessity Review*. “Within 120 days, CSHM shall review claims by those dentists with high ‘pulp-to-crown ratios’ to determine whether such documentation supports the medical necessity of the services.”

The Independent Monitor will give CSHM the appropriate pulp-to-crown ratio and CSHM will compare all dentists to that standard.<sup>158</sup> HHS OIG has directed CSHM to conduct a new and more expansive review of the pulp-to-crown Medical Necessity Review requirement, due in part to the change in ownership in 2012.<sup>159</sup>

During the course of the breach, CSHM emerged from bankruptcy in June 2012 and began operating under a new owner, a new Board of Directors, and a new senior management team. The new senior management team consists of a new Chief Executive Officer, Chief Compliance Officer, Chief Dental Officer, and new General Counsel. HHS OIG has stated that “The [Independent] Monitor has further indicated to OIG that the onsite visits to CSHM’s facilities under the new ownership structure have all been positive.”<sup>160</sup>

#### **G. Continuation of Abuses Following the Health and Human Services Office of Inspector General Notice of Intent to Exclude and New Ownership**

The new owners have only been in place a relatively short time, but the issues involving quality of care and abuse of taxpayer dollars still remain. Time and time again, CSHM has demonstrated that its Small Smiles clinics do not operate in compliance with the CIA. The core of the problem appears to be structural. The new CSHM ownership acquired and has maintained their predecessors’ flawed management services agreements, which remove traditional ownership authority from dentists. These agreements fundamentally limit the ability of the dentists to exercise independent clinical judgment.<sup>161</sup> Despite management changes and assurances that the company is improving, the same problems that were uncovered in 2008 and ultimately led to the CIA persist. It is unacceptable that this type of activity has been allowed to continue for 4 years despite aggressive oversight by the Independent Monitor and HHS OIG.

As stated above, in October 2012 HHS OIG declared that “The Monitor has further indicated to OIG that the onsite visits to CSHM’s facilities under the new ownership have all been posi-

<sup>157</sup> E-mail chain between Committee Staff and HHS OIG re: Reporting Substantial Overpayments to Small Smiles Dental Centers of Oxon Hill (Mar. 7, 2013) (Exhibit 59).

<sup>158</sup> Letter from HHS OIG, to CSHM, re: Notice of Material Breach and Intent to Exclude at 5 (Mar. 13, 2012) (Exhibit 30).

<sup>159</sup> E-mail from Hinkle of HHS OIG, to CSHM from re: Reporting of Substantial Overpayment to Small Smiles Dental Centers of Oxon Hill (Mar. 7, 2013, 11:22 a.m.) (Exhibit 58).

<sup>160</sup> Letter from Dep’t Health and Human Services, OIG, to Senators Baucus and Grassley, re: Corporate Integrity Agreement with CSHM, w/attach. at 5 (Oct. 4, 2012) (Exhibit 14).

<sup>161</sup> See Letter from Theodore Hester, Attorney at King & Spalding, to Senators Baucus and Grassley, at 1–2 (Nov. 29, 2011) (Exhibit 5).

tive.”<sup>162</sup> However, a review of Independent Monitor Reports following the establishment of new CSHM ownership in June 2012 and the subsequent Notice of Intent to Exclude, paints a very different picture—the abuses that plagued Small Smiles clinics have yet to subside. Although documenting different locations, the Independent Monitor’s reviews of CSHM clinics under new ownership from late 2012 reveal findings of the same violations that plagued the Oxon Hill, Manassas, and other aforementioned clinics. Curiously, despite having previously received numerous Independent Monitor reports of misconduct at CSHM facilities, in October 2012 HHS OIG nonetheless proceeded to relay and seemingly endorse an inaccurate Monitor assertion that new CSHM ownership had begun to implement changes. Below are a few examples of the glaring errors that HHS OIG considers positive.

### *1. Florence, South Carolina Independent Monitor Report*

In 2011, the Independent Monitor conducted a desk audit of the Florence, South Carolina Small Smiles clinic. A desk audit does not involve an onsite audit but instead involves an exchange of documents followed by a review. The desk audit report laid out a number of findings and recommendations for the staff.<sup>163</sup>

On July 3, 2012, the Independent Monitor followed up with an onsite visit of the Small Smiles clinic in Florence, South Carolina. This site visit occurred almost 4 months after HHS OIG issued its Notice of Material Breach and Intent to Exclude to CSHM. When the Monitor interviewed the staff and dentists, it was clear that none of them was aware of the findings or recommendations from the desk audit:

The Compliance Liaison reported she had been in communication with several members of CSHM’s management team and determined from their questions there was a report. However, when she asked about it, she was told it had been divided and distributed by department.<sup>164</sup>

Additionally, the Independent Monitor found that the clinic continued to perform unnecessary procedures, while failing to diagnose and treat other problems. In three recorded cases, pulpotomies were performed without removing the required amount of pulpal tissue, and two patients were fitted with oversized crowns.<sup>165</sup> The records also indicated that a patient’s mesial decay went undiagnosed and a single surface occlusal amalgam filling was placed on the tooth leading to further decay and the need for a stainless steel crown.<sup>166</sup> Moreover, the Independent Monitor noted that one associate dentist administered Septocaine to a child younger than 4 years of age—a practice that has not been approved by the FDA.<sup>167</sup>

<sup>162</sup> Letter from Dep’t Health and Human Services, OIG, to Senators Baucus and Grassley, re: Corporate Integrity Agreement with CSHM, w/attach. at 5 (Oct. 4, 2012) (Exhibit 14).

<sup>163</sup> Independent Monitor Report Florence, S.C. at 2–3 (July 3, 2012) (Exhibit 38).

<sup>164</sup> *Id.*

<sup>165</sup> *See id.* at 3.

<sup>166</sup> *See id.*

<sup>167</sup> *See id.*

## 2. Lynn, Massachusetts Independent Monitor Report

A month after the Florence report, the Independent Monitor found similar issues with the Lynn, Massachusetts clinic. After reviewing the post-operative X-rays, the Monitor found five poorly performed pulpotomies, where the tissue from the pulp chamber was not properly removed.<sup>168</sup> There was also one record that showed a failure to use a local anesthesia when it was required, and two instances where the wrong anesthetic was used.<sup>169</sup>

Similar to the report from Akron, the Monitor found that 10 records did not justify using surface fillings over stainless steel crowns.<sup>170</sup> The Monitor also found 11 records where the same teeth were treated multiple times.<sup>171</sup> As was reported in Akron, failing to use the proper filling can result in further decay and multiple treatments to the same tooth.

Despite the continued attention from HHS, the clinic has yet to fulfill all of the recommendations from the initial 2011 Independent Monitor review. Following its interviews, document review, and treatment observations, the Independent Monitor determined that “CSHM had successfully met and implemented 19 of the 29 recommendations” from the Independent Monitor’s previous report.<sup>172</sup>

## 3. Mishawaka, Indiana Independent Monitor Report

On October 5, 2012, the Independent Monitor’s findings from its review of the Mishawaka Small Smiles clinic revealed evaluation discrepancies, patient safety concerns, and questions involving medical necessity. As part of its desk audit, the Independent Monitor examined a 2012 internal CSHM chart audit by replicating the testing parameters and initiating its own assessment.<sup>173</sup> The CSHM chart audit ultimately issued passing scores for all three audited dentists.<sup>174</sup> While concurring in the finding that two dentists passed,<sup>175</sup> the Independent Monitor issued an automatic failure to the third dentist based on a “lack of documentation and radiographic evidence to support the medical necessity for treatment.”<sup>176</sup> Notably, prior to the Independent Monitor’s replicated audit, CSHM had given this very same dentist a score of 100%, the highest score of all three audited dentists.<sup>177</sup>

More disturbing than the discrepancies in the CSHM evaluations of dentists are the incorrect calculations for administering anesthesia. In 4 of 15 records reviewed, the Independent Monitor found miscalculations of the anesthesia dosage, and, while finding that the administered dosage never exceeded the prescribed maximum, the miscalculations “allowed for the possibility of patient harm.”<sup>178</sup> Furthermore, in three of these four miscalculations, a review revealed the use of anesthesia “without the recognition of a total

<sup>168</sup> See Independent Monitor Report Lynn, Mass. at 3 (Aug. 2, 2012) (Exhibit 39).

<sup>169</sup> See *id.*

<sup>170</sup> *Id.*

<sup>171</sup> *Id.*

<sup>172</sup> *Id.* at 9–10.

<sup>173</sup> Independent Monitor Report Mishawaka, Ind. at 6 (Oct. 5, 2012) (Exhibit 40).

<sup>174</sup> See *id.*

<sup>175</sup> See *id.* (“The Monitor also identified instances of under-treatment and over-treatment that resulted in lower scores for the Clinic and passing dentists.”)

<sup>176</sup> *Id.*

<sup>177</sup> See *id.*

<sup>178</sup> *Id.* at 23.

maximum allowable dose . . . regardless of patient weight or age” and “no evidence of calculation adjustments for overweight patients based on their healthy weight range.”<sup>179</sup>

The Independent Monitor’s findings also raised questions about the medical necessity of performed care. In 1 of 15 records reviewed, it was discovered that neither documentation nor X-rays were provided to justify the medical necessity for a performed pulpotomy.<sup>180</sup> In fact, the review found that along with a complete lack of X-rays to determine the depth of tooth decay, the patient’s file lacked a “descriptive narrative” and “the digital photographs did not support the need for a pulpotomy on [said] tooth.”<sup>181</sup> Approximately 6–7% of all pulpotomies performed by that clinic would be unnecessary if the records reviewed are a representative sample of the clinic’s business. Taxpayers needlessly spend \$100 in Indiana every time an unnecessary pulpotomy is performed on a Medicaid patient.<sup>182</sup>

#### 4. Colorado Springs, Colorado Independent Monitor Report

As late as November 15, 2012, the Small Smiles clinic in Colorado Springs was committing violations resembling those found at numerous other Small Smiles clinics: under-utilization of X-rays, inadequate documentation of medical necessity, questionable procedure rationale, and quality of care issues. First, out of 24 records reviewed, the Independent Monitor found 5 records containing medically unnecessary X-rays and 12 records revealed evidence of under-utilization of diagnostic X-rays.<sup>183</sup>

Second, questions of medical necessity also emerged from the Colorado Springs Small Smiles clinic. Notably, the Independent Monitor observed a trend of treatment being provided without diagnostic X-rays and further found 5 out of 24 patient records lacked “documentation and/or radiographic evidence to support the medical necessity for treatment[s]” which included pulpotomies, a stainless steel crown, and a 4-surface filling.<sup>184</sup>

Third, the Independent Monitor review exposed questionable rationales for performed procedures. Along with finding a trend of under-utilizing stainless steel crowns, the review revealed 5 out of 24 records lacked documentation for choosing to perform multiple surface filings and not stainless steel crowns.<sup>185</sup>

Fourth, the review confirmed that, much like its fellow Small Smiles clinics around the country, quality of care issues were evident in the Colorado Springs clinic. Out of 24 records reviewed, 2 patient records lacked an explanation as to why teeth with noted decay were left untreated.<sup>186</sup> Lastly, and of great concern, is that 3 out of 24 records revealed that treatment was administered without the requisite informed and documented consent.<sup>187</sup>

These five clinic findings reflect that, despite HHS OIG’s Intent to Exclude and the new ownership structure, CSHM has continued

<sup>179</sup> *Id.*

<sup>180</sup> *See id.*

<sup>181</sup> *Id.*

<sup>182</sup> Indiana Health Coverage Programs, IHCP Bulletin at 5 (Apr. 15, 2010) (Exhibit 62).

<sup>183</sup> *See* Independent Monitor Report Colorado Springs, Colo. at 16 (Nov. 15, 2012) (Exhibit 41).

<sup>184</sup> *Id.* at 18.

<sup>185</sup> *Id.* at 19.

<sup>186</sup> *Id.* at 20.

<sup>187</sup> *Id.*

to leave patients with decaying teeth untreated, while performing needless surgery on other patients. In other words, CSHM continues to treat a high volume of patients while sacrificing quality care and benefitting from the Medicaid system. The needless procedures ensure higher reimbursements, while mismanaged treatments ensure return visits that require more intensive treatments. What is most disconcerting from these reports is the timing in which these violations occurred. Although subpar dental treatment to children should never be tolerated, it is even more unforgivable when it follows admonishment from the Department of Justice and the Department of Health and Human Services Office of Inspector General.

### V. Dental Demographics

When the Committee staff started investigating dental management companies, a common refrain emerged: if their businesses did not employ dentists to provide care to those in need, the Medicaid population would go untreated. As such, we began to take a closer look into the demographics of today's dentists. Although it is undeniable that certain parts of our country, particularly rural areas, have a shortage of dental providers, this same problem plagues all areas where Small Smiles Clinics are found. Ultimately, the current model is not sustainable, and dentists will not be able to meet the growing demand for treatment. Thus, maybe it is time to begin discussing the incorporation of mid-level providers in order to alleviate the treatment needs of and provide dental care to patients. Mid-level dental providers' education and skill level would place them between a dentist and dental hygienist. They would be qualified and licensed to perform relatively minor, but common procedures, such as cavity fillings and simple teeth extractions.<sup>188</sup>

According to Oral Health America, the adequate ratio of dentists to population is 1 to 1,500.<sup>189</sup> Today, that ratio is 1 to 2,000 and in some states, such as Washington, the distribution is even greater having only one dentist for 12,300 people.<sup>190</sup> If this uneven distribution is not corrected, the problems will worsen. The U.S. Department of Labor, Bureau of Labor Statistics expects the dental profession to grow by 21% from 2010 to 2020.<sup>191</sup> The potential for a large gap between the number of dentists needed and the number of dentists practicing is due to a number of variables. First, there will be a need for more complicated dental procedures for the baby boom generation.<sup>192</sup> In addition, each generation is more likely to keep their teeth than the last, and studies continue to link dental

<sup>188</sup> See Phil Cauthon, *National advocates for mid-level dental providers meet in Kan.*, KHI NEWS SERVICE (Dec. 5, 2012), <http://www.khi.org/news/2012/dec/05/national-advocates-mid-level-dental-providers-meet/>.

<sup>189</sup> *Combating the Silent Epidemic: The Shortage of Dentists in America*, Staff Care, at 4, <http://www.staffcare.com/pdf/Dentistry-WhitePaper2007.pdf>.

<sup>190</sup> U.S. Dep't of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook, *Dentists Job Outlook*, <http://www.bls.gov/ooh/Healthcare/Dentists.htm#tab-6> (last visited Mar. 22, 2013); Clair Gordon, *Extreme Dentist Shortage Leads To 'Dental Therapists' Filling Cavities*, AOL Jobs [hereinafter *Gordon*] (Apr. 16, 2012, 2:14 PM), <http://jobs.aol.com/articles/2012/04/16/extreme-dentist-shortage-leads-to-dental-therapists-filling-ca/>.

<sup>191</sup> U.S. Dep't of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook, *Dentists Job Outlook*, <http://www.bls.gov/ooh/Healthcare/Dentists.htm#tab-6> (last visited Mar. 22, 2013). Nationwide there are 48.7 million Americans who live in areas with a shortage of dental care.

<sup>192</sup> See *id.*

health with overall health.<sup>193</sup> Also, 5.3 million more children will qualify for dental services under the Affordable Care Act.<sup>194</sup> However, “without changes in state policies, expanded coverage is unlikely to translate into more dental care for every child in need.”<sup>195</sup> Children’s susceptibility to tooth decay is particularly problematic, because dental problems starting at a young age will compound into larger problems through adulthood.

The lack of care for both children and adults has resulted in 27 percent of children and 29 percent of adults having untreated cavities in 2003 and 2004.<sup>196</sup> The risks of untreated dental conditions are not confined to poor oral health, but can have devastating effects on overall health. Many Americans end up in the emergency room from tooth abscesses that keep them from eating or cause an infection that can travel to the brain and kill.<sup>197</sup> This horrifying result of tooth decay was the impetus for the ABC–7 I–Team investigative report into the Small Smiles clinics. The report identified a 12-year-old Maryland boy, Deamonte Driver, who died of a brain infection resulting from tooth decay that was not properly treated.<sup>198</sup>

In 2009, more than 830,000 visits to the emergency room nationwide were the result of preventable dental problems.<sup>199</sup> In Florida alone the bill exceeded \$88 million.<sup>200</sup> Although many of these problems can be solved by preventive measures, the fundamental problems of lack of care and substandard care persist.<sup>201</sup>

As more dentists graduate from school with an average debt of \$181,000, with one out of five exceeding \$250,000,<sup>202</sup> it is less economical for dentists to open practices in rural areas. Compounding the problem is available data which suggests low dentist participation in Medicaid,<sup>203</sup> and the fact that some of those clinics that are providing care to Medicaid patients, such as Small Smiles, are doing so at a substandard level. The cost of correcting dental problems is much more expensive than the preventive measures, but

<sup>193</sup> See *id.*

<sup>194</sup> Dep’t of Labor, Dentists Job Outlook; *The State of Children’s Dental Health: Making Coverage Matter*, The Pew Center on the States (May 2011), 208, 209, and 210; Louis W. Sullivan, *Dental Insurance, but No Dentists*, N.Y. TIMES [hereinafter Sullivan], Apr. 8, 2012, [http://www.nytimes.com/2012/04/09/opinion/dental-insurance-but-no-dentists.html?\\_r=2&](http://www.nytimes.com/2012/04/09/opinion/dental-insurance-but-no-dentists.html?_r=2&).

<sup>195</sup> *The State of Children’s Dental Health: Making Coverage Matter*, The Pew Center on the States (May 2011).

<sup>196</sup> Gordon. The 2003 and 2004 data is the latest available when the article was written.

<sup>197</sup> Sullivan.

<sup>198</sup> I–Team: Small Smiles Investigation, <http://www.youtube.com/watch?v=pIoMaw4zC9Q> (last visited Mar. 22, 2013). In a similar news story a 24-year-old single father, Kyle Willis died of a brain infection that was the result of untreated tooth decay. Gretchen Gavett, *Tragic Results When Dental Care Is Out of Reach*, PBS (June 26, 2012, 9:50 PM), <http://www.pbs.org/wgbh/pages/frontline/health-science-technology/dollars-and-dentists/tragic-results-when-dental-care-is-out-of-reach/>.

<sup>199</sup> Sullivan.

<sup>200</sup> *Id.* Dental disease is the number one chronic child disease that creates more children needing medical care than asthma. *Id.* In Maine a recent report has indicated that 55 percent of MaineCare children go without dental care even though they have insurance, resulting in more money being spent on fixing dental problems that preventing them. *Report Details Dental Care Shortage in Rural Maine*, Boston Globe (Feb. 5, 2013), <http://www.boston.com/news/local/maine/2013/02/05/report-details-dental-care-shortage-rural-maine/NkYZrj1bb1OEMKGFQZ1E50/story.html>.

<sup>201</sup> Sullivan.

<sup>202</sup> Gordon.

<sup>203</sup> See U.S. GOV’T ACCOUNTABILITY OFFICE, GAO–11–96, ORAL HEALTH: EFFORTS UNDER WAY TO IMPROVE CHILDREN’S ACCESS TO DENTAL SERVICES, BUT SUSTAINED ATTENTION NEEDED TO ADDRESS ONGOING CONCERNS 12 (2010) (Exhibit 60).

clearly the cost of providing preventive measures is not cheap or easy in certain parts of our country.

To address dental care access problems, two states have taken novel approaches to immediately address the lack of dental care. Alaska and Minnesota have been training dental therapists who provide fewer services than a dentist and more than a dental hygienist.<sup>204</sup> These dental therapists are able to perform basic dental procedures that are in great demand, such as filling cavities and extracting childrens' primary teeth.<sup>205</sup> These training programs are shorter than dentistry school, and the therapists receive pay that is roughly half of what a dentist would receive. This program has opened up dental care in rural areas of Minnesota and Native villages in Alaska. The ADA has opposed these positions out of fear that mid-level providers will provide substandard care.<sup>206</sup>

## VI. Recommendations

**Recommendation 1: HHS OIG should exclude from participating in the Medicaid program CSHM, Small Smiles clinics, and any other corporate entity that employs a fundamentally deceptive business model resulting in a sustained pattern of substandard care.**

- Despite a change in ownership and repeated professed improvements, CSHM and Small Smiles clinics continue to operate under fundamentally deceptive contracts that circumvent state laws passed to ensure licensed dentists own dental practices, and thus, that the owners are held accountable to maintain a professional standard of care. As a result, Small Smiles clinics continue failing to meet basic quality and compliance standards, providing unjustified and deficient procedures, improperly withholding and recklessly administering anesthesia, and performing dubious internal audits. All of these actions strain the Medicaid system. Excluding CSHM and companies with similarly deceptive ownership structures from the Medicaid program would deter companies from engaging in similar egregious behavior in the future.

**Recommendation 2: States should enforce existing laws against the corporate practice of dentistry and, where appropriate, take enforcement action against those that violate the law.**

- State authorities have either ignored or been oblivious to dental management services agreements like those used by CSHM that allow companies to operate dental clinics under the guise of providing administrative and/or financial management support.

<sup>204</sup> *Sullivan*. Kansas, New Mexico, and Vermont are also debating legislation that would create similar training programs; *Gordon*.

<sup>205</sup> *Gordon*.

<sup>206</sup> See AM. DENTAL ASS'N, BREAKING DOWN BARRIERS TO ORAL HEALTH FOR ALL AMERICANS: REPAIRING THE TATTERED SAFETY NET 16 (2011); see also AM. DENTAL ASS'N, BREAKING DOWN BARRIERS TO ORAL HEALTH FOR ALL AMERICANS: THE ROLE OF WORKFORCE 11 (2011) ("[A] critical attribute that the ADA opposes unequivocally: *Allowing non-dentists to perform surgical procedures, often with little or no direct supervision by fully trained dentists.*").

- In the 22 states and the District of Columbia that ban corporate dentistry, appropriate action should be taken to eliminate such circumvention of the law.

**Recommendation 3: If states consider licensure of mid-level dental providers, such as dental therapists, the Federal Government should allow them to be reimbursed by the Medicaid program.**

- According to GAO findings, the dental profession has low Medicaid participation rates and thus has failed to provide needed care and treatment to lower-income individuals in Medicaid. While struggling to encourage the providers to adequately participate and serve the Medicaid program, the dental profession has done little to curb the abuses described in this report.
- States have already begun creating mid-level dental providers, such as dental therapists, and licensing them to practice in their states in order to better meet the unmet needs of their populations.
- Some in the dental profession argue that “low Medicaid reimbursement rates” are the root cause of the types of abuses described in this report. Yet, the dental profession has also opposed allowing mid-level providers into the program who could provide much of the needed care at the current reimbursement rates.

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# OTHER ISSUES

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7. SOFT RELINE COURSE- LORI ROSS, EFDA

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."

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## **INTRODUCTION**

Board of Dentistry Administrative Rule 818-042-0090 allows Expanded Function Dental Assistants (EFDAs) to place Denture Soft Reline under the following circumstances:

“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 apply Denture soft Reline under the indirect supervision of a dentist providing the patient is examined before the Denture soft relines are placed and the procedure being authorized by a dentist and the soft reline must be checked by a dentist prior to the patient’s dismissal.”

*“Indirect Supervision” means supervision requiring that a dentist authorize the procedures and that a dentist be on the premises while the procedures are performed. (ORS 679.010 (9))*

This Board approved course should offer instruction on the purpose, techniques and safety considerations of soft reline placement and the Expanded Function Dental Assistant’s role as the operator under indirect supervision of the dentist.

## **PREREQUISITES**

- 1) The attendee must be an Oregon Expanded Function Dental Assistant.
- 2) The attendee must provide a copy of their EFDA certification with course registration.

## **SUGGESTED TEXTS**

## **SOFT RELINE OUTLINE**

### **Course Outline**

The course should be presented in two part lecture/ Lab/clinic for for a total of at least 6 hours.

Lecture: To include the following in to regard’s to purpose, technique and safety issues for placing a soft Liner in dentures:

### **1) Patient Health history review**

- √ Is history current
- √ Noted allergies
- √ Medications
- √ Other health considerations

### **2) Infection control issues**

- √ Principles of disease transmission
- √ Need for safety glasses for patient

√ Universal precautions

**3) OSHA regulations**

√ Operator injury

√ Spill cleanup

**4) Use of dental equipment and instrument's**

√ Extraoral Use of #15 blade

**5) Indications/contraindications for soft relines**

√ denture loose fitting

√ sore spots on gums and can't wear dentures

**6) Appropriate technique**

√ mix the 10 ml of liquid and 4.0 ml powder

√ Fill tissue side  $\frac{3}{4}$  full

√ Place denture in Pt mouth for 10 min

**7) Materials**

√ Soft relines material (temporary reliner)

**8) Tray Set Up**

**9) Terminology**

**10) Current and future Trends**

**Written Exam:** Class participant's must take 15 question, multiple choice exam with a minimum passing score of 80% prior to commencing to lab portion of the course.

**Lab:** Attendee's should be provided with knowledge and skill to preform denture soft relines on denture models before preforming on a Patient. The laboratory work must be evaluated by the instructor.

## **Lori Ross**

Camas Valley , Oregon 97416

Phone # 541-844-5833

Email: [Bradloriross@yahoo.com](mailto:Bradloriross@yahoo.com)

### **Career Objective:**

Responsible Dental Assistant capable of delivering excellent care to  
Respectful communication and intuitive understanding of the Doctor's  
needs while assisting chair-side

### **Skills:**

Infection control	Operatory Disinfection	Eagle soft
Seating and Dismissing	Digital Charting	Front Office
Sterilization	Alginate impressions	Dentrix
Cerec	Implants	Invisiline
Dexis	Soft Reline	Clinical vision
Medical Billing	Answering phones	Scheduling

### **Certificates:**

★ Dental Radiology ★ Sealant Certificate ★ EFDA

★ Soft Reline Certificate ★ CPR ★ EFODA

★ HIPAA

★ Dental Radiology Instructor ★ Sealant Instructor

**Education:**

Graduate, Concorde Career College Portland, Oregon  
Diploma, 2008- Major ADA Accredited Dental Assisting Program  
Awards: Student of the term award, Honorable Mention award,  
Perfect attendance Award  
Lane Community College Eugene, Oregon  
Certificate 1997- Dental Radiology Health & safety  
Oregon Board of Dentistry :  
Dental Radiology Instructor Permit 2011-Present  
Pit and Fissure Sealant Instructor Permit -2012-Present

**Professional Experience:**

Advantage Dental	EFDA Dental Assistant
Aug 2009-Present	Lead Dental Assistant
May 2011-May 2012	Oral Surgery Assistant
May 2012-present	Back Office Manager

Assisted Dentist with procedures (Amalgam and composite filling, RCT, Crown and bridges, space maintainers, oral surgery), sealants, fluoride, Soft relines. Placed dental dams, tofflemeiers and bands. Temp fillings,



**OREGON BOARD OF DENTISTRY**  
**Dental Assistant**

118665

CERTIFICATE NUMBER

Lori A Ross

Expanded Functions Dental Assistant  
Expanded Functions Orthodontic Assistant  
Radiological Proficiency

Issued: February 04, 2009

## CERTIFICATION OF COMPLETION

This is to certify that

**Lori Ross**

Has competed an accredited  
Temporary Soft-Relines for Dentures course

**Oregon Dental  
Education Services**

Shelley Huser RDH  
Shelley Huser, RDH 08/02/09

**NEWSLETTERS  
&  
ARTICLES OF  
INTEREST**

**Nothing to report under this tab**

# LICENSE RATIFICATION

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## **16. RATIFICATION OF LICENSES**

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

### **Dental Hygiene**

H6561	GRETCHEN L MARCOULIER, R.D.H.	8/12/2013
H6562	MARGARET F HODGES, R.D.H.	8/12/2013
H6563	ELENA B HELLER, R.D.H.	8/12/2013
H6564	SHERRY L CANTLEN, R.D.H.	8/12/2013
H6565	MARA O ZANDER, R.D.H.	8/12/2013
H6566	CATHERINE M WILSON, R.D.H.	8/12/2013
H6567	HOLLY A MARSH, R.D.H.	8/12/2013
H6568	KAYLA L RODRIGUES, R.D.H.	8/12/2013
H6569	JESSICA A THOMPSON, R.D.H.	8/15/2013
H6570	DEREK T BLEVINS, R.D.H.	8/15/2013
H6571	KRISTEN M MITCHELL, R.D.H.	8/15/2013
H6572	BRITTANY D VIGOREN, R.D.H.	8/15/2013
H6573	MELISSA A JACOBSON, R.D.H.	8/15/2013
H6574	RACHELLE L MILNER, R.D.H.	8/15/2013
H6575	GERARDO REYNAGA-GONZALEZ, R.D.H.	8/16/2013
H6576	AMBER K BENSON, R.D.H.	8/22/2013
H6577	AMANDA S JOHNSON, R.D.H.	8/22/2013
H6578	BRIANNA K WINTER, R.D.H.	8/22/2013
H6579	TOMAS P NICACIO, R.D.H.	8/22/2013
H6580	ANN C ARCHER, R.D.H.	8/22/2013
H6581	KRISTEN M GALLAWAY, R.D.H.	8/22/2013
H6582	BRIANI C KOMODA, R.D.H.	8/22/2013
H6583	CAITLIN C CHAR, R.D.H.	8/22/2013
H6584	MELODY L MC GEE, R.D.H.	8/22/2013
H6585	TYFINI R BRYANT, R.D.H.	8/22/2013
H6586	ASHLEY N TOMANKA, R.D.H.	8/22/2013
H6587	MANDY E WENGERT, R.D.H.	8/23/2013
H6588	CAROLINE ROSS MAIER, R.D.H.	8/23/2013
H6589	OLGA A VOLODKINA, R.D.H.	8/23/2013
H6590	NICOLE R OSBORN, R.D.H.	8/23/2013
H6591	JENNA M BIEBER, R.D.H.	8/23/2013
H6592	KARI A HUNT, R.D.H.	8/23/2013
H6593	AMY N HUNTER, R.D.H.	8/23/2013
H6594	HAILEY R RAMBO, R.D.H.	8/23/2013
H6595	ANGELA J GORDON, R.D.H.	8/23/2013
H6596	JULIE HUYNH, R.D.H.	8/23/2013
H6597	JULIE Y BARNECK, R.D.H.	8/23/2013
H6598	VERONICA MENDEZ HERNANDEZ, R.D.H.	9/6/2013
H6599	PENNY L MOORE, R.D.H.	9/6/2013
H6600	CINDY L PAGE, R.D.H.	9/6/2013
H6601	BRITTA B WEHRLE, R.D.H.	9/6/2013
H6602	ALEXANDRA N FOX, R.D.H.	9/6/2013
H6603	KELSEY G WITTNER, R.D.H.	9/6/2013
H6604	ABIGAIL D ELLIS, R.D.H.	9/6/2013
H6605	TIANA L FERNANDEZ, R.D.H.	9/6/2013
H6606	MEGAN A SPEAKS, R.D.H.	9/6/2013

H6607	JENNIFER M SUMEGA, R.D.H.	9/6/2013
H6608	JENNIFER M JORDAN, R.D.H.	9/9/2013
H6609	KREA C FETTERS, R.D.H.	9/9/2013
H6610	AUBREY R PETERS, R.D.H.	9/9/2013
H6611	KRISTIN N KINTZ, R.D.H.	9/9/2013
H6612	AMIE M GRANGER, R.D.H.	9/9/2013
H6613	JASMIN E GOMEZ, R.D.H.	9/9/2013
H6614	OLGA I ZLATOVA, R.D.H.	9/9/2013
H6615	ERIN R SCHWARTZ, R.D.H.	9/9/2013
H6616	AMBER L MC GEE, R.D.H.	9/9/2013
H6617	SIERRA M BRANDON, R.D.H.	9/11/2013
H6618	KYLE R ISAACS, R.D.H.	9/16/2013
H6619	ANTONIA R HORNE, R.D.H.	9/16/2013
H6620	JAIME K HAYASHI, R.D.H.	9/18/2013
H6621	KATHERINE L MCALISTER, R.D.H.	9/18/2013
H6622	AMERICA M CABALLERO, R.D.H.	9/19/2013
H6623	MICHELLE D BUTTERFIELD, R.D.H.	9/19/2013
H6624	DANIELLE N BARS, R.D.H.	9/19/2013
H6625	DARIEN J SUMNER, R.D.H.	9/19/2013
H6626	LINZI D FLOOD, R.D.H.	9/19/2013
H6627	INGRID A SCHMIDT, R.D.H.	9/19/2013
H6628	ELZBIETA WIETRZYNSKA, R.D.H.	9/19/2013
H6629	CHELSEA J HANSON, R.D.H.	9/23/2013
H6630	KELLI M COOPER, R.D.H.	10/3/2013
H6631	KAREN PEREZ, R.D.H.	10/3/2013
H6632	STEPHANIE A SLIMAK, R.D.H.	10/3/2013
H6633	ROSA M ORTIZ MENDOZA, R.D.H.	10/3/2013
H6634	BRENNAN R SOUTHWICK, R.D.H.	10/3/2013
H6635	LINDSEY K REEVES, R.D.H.	10/3/2013
H6636	AMANDA M WATTENBARGER, R.D.H.	10/3/2013
H6637	LAUREN M MC CAULEY, R.D.H.	10/3/2013
H6638	NICOLE B BONNELL, R.D.H.	10/3/2013

### DENTISTS

D9940	JAMES P DURNIN, D.M.D.	8/5/2013
D9941	NICHOLAS R BACKOWSKI, D.M.D.	8/5/2013
D9942	JOSEPH W PECK, D.M.D.	8/12/2013
D9943	HEATHER D ROGERS, D.D.S.	8/12/2013
D9944	BRIAN H KIM, D.D.S.	8/12/2013
D9945	CHANG S PARK, D.M.D.	8/12/2013
D9946	RACHEL B ERICKSON, D.M.D.	8/12/2013
D9947	RICHARD S BOHNSTEDT, D.M.D.	8/12/2013
D9948	KELLI R FOWLES, D.M.D.	8/12/2013
D9949	WILLIAM R TREVOR, D.D.S.	8/12/2013
D9950	TYLER S WAY, D.M.D.	8/12/2013
D9951	AMBER L WATTERS, D.D.S.	8/12/2013
D9952	CAITLIN M DENNING, D.D.S.	8/12/2013
D9953	KYLE S DENNING, D.D.S.	8/12/2013
D9954	ANNE M FAUCHEU, D.M.D.	8/15/2013
D9955	DEEP KARAN S DHILLON, D.D.S.	8/23/2013
D9956	BRUCE L RICHARDSON, D.M.D.	9/3/2013
D9957	CHRISTINE NGUYEN, D.M.D.	9/6/2013

D9958	BRADLEY B FIELD, D.D.S.	9/6/2013
D9959	ANDREW S LAYBOURN, D.M.D.	9/9/2013
D9960	PAUL A BRANNEN, D.M.D.	9/9/2013
D9961	ANDREW M BROADSWORD, D.M.D.	9/11/2013
D9962	LEVI JAMES-OLIVER SHULL, D.M.D.	9/13/2013
D9963	AMANDA E DAY, D.D.S.	9/13/2013
D9964	KEVIN PRATES, D.D.S.	9/16/2013
D9965	JEFFREY STUART CASEBIER, D.M.D.	9/19/2013
D9966	KYLE A MALLOY, D.M.D.	9/19/2013
D9940	JAMES P DURNIN, D.M.D.	8/5/2013
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D9966	KYLE A MALLOY, D.M.D.	9/19/2013

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