

PUBLIC PACKET

**OREGON BOARD  
OF  
DENTISTRY**

**BOARD MEETING  
DECEMBER 20, 2013**



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# APPROVAL OF MINUTES

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**OREGON BOARD OF DENTISTRY  
MINUTES  
October 18, 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.  
James Morris  
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  
Stephen Prisby, Office Manager (portion of meeting)  
Daryll Ross, Investigator (portion of meeting)  
Harvey Wayson, Investigator (portion of meeting)  
Lisa Warwick, Office Specialist (portion of meeting)  
Bill Herzog, D.M.D., Consultant (portion of meeting)  
Michelle Lawrence, D.M.D., Consultant (portion of meeting)  
Rodney Nichols, D.D.S., Consultant (portion of meeting)

ALSO PRESENT: Lori Lindley, Sr. Assistant Attorney General

VISITORS PRESENT: Brad Fuller, D.D.S., Gentle Dental; Heidi Jo Grubbs, R.D.H., Beryl Fletcher, ODA; Lynn Ironside, R.D.H., ODHA; Gary Allen, D.M.D., Advantage Dental; Lisa Rowley, R.D.H., Pacific University; Tara Bannon, The Bend Bulletin; Steven Timm, D.M.D., ODA; Pamela Lynch, EPP, ODHA; Melanie Knupp, Pacific Dental Services.

**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 August 16, 2013 Board meeting be approved as amended. 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.

Ms. Davidson moved and Mr. Harvey seconded that the minutes of the September 5, 2013 Special Teleconference Board meeting be approved as presented. 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.

## **ASSOCIATION REPORTS**

### **Oregon Dental Association**

Dr. Steven Timm thanked Mr. Braatz and members of the Board for attending the ODA House of Delegates meeting held in Sun River in September. He added that the ODA was planning some upcoming meetings and that the Board would be kept updated on the timing of those. He also took the opportunity to remind everyone that December 13<sup>th</sup> is the last Risk Management presentation for the year.

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

Ms. Ironside had no report. She introduced Ms. Rowley; Ms. Rowley stated that the ODHA would be holding its Fall Dental Health Conference November 8-10 this year and that all information is available on the ODHA website.

### **Oregon Dental Assistants Association**

No one from the ODAA was present.

## **COMMITTEE AND LIAISON REPORTS**

### **WREB Liaison Report**

Dr. Magnuson stated there was an upcoming WREB Board meeting on November 1<sup>st</sup> so he had nothing new to report.

### **AADB Liaison Report**

Dr. Parker had nothing new to report but stated that the AADB Annual meeting, celebrating its 130<sup>th</sup> year, will be held in New Orleans at the end of October so a full report would take place at the December Board meeting.

### **ADEX Liaison Report**

Dr. Parker had nothing new to report and stated that the ADEX Annual meeting was coming up November 8-10. She would provide a full report at the December Board meeting.

### **NERB**

Dr. Hongo and Dr. Smith had nothing to report. There is a NERB meeting scheduled on January 7, 2014.

### **Dental Hygiene Committee Meeting Report**

Ms. Davidson reported that the Dental Hygiene Committee met October 10<sup>th</sup> and made the following recommendations.

### **Infection Control Continuing Education**

The Dental Hygiene Committee recommended that the Board consider adopting a rule requiring Infection Control for all licensees as part of their license renewal, in addition to what is considered 'medical emergencies.' Ms. Davidson moved and Dr. Parker seconded that the Board refer the Infection Control CE requirement, to the Rules Oversight Committee. 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.

### **Healthcare Provider Requirements**

Dr. Beck moved and Dr. Smith seconded that the Rules Oversight Committee review the option of adding healthcare provider requirements to all licensees. 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.

### **Infection Control Rule Language**

Ms. Davidson moved and Dr. Beck seconded that the Board send 818-012-0040(4) the revisions as presented to the Rules Oversight Committee. 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.

#### **Infection Control Revision to 818-012-0040(4)**

*(4) Heat sterilizing devices shall be tested for proper function ~~on a weekly basis~~ by means of a biological monitoring system that indicates micro-organisms kill **each calendar week in which patients are treated.***

### **Clarification 818-026-0055(c)**

Ms. Davidson moved and Dr. Schwindt seconded that the Board send OAR 818-026-0055(c) as presented to the Rules Oversight committee. 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.

*(c) An anesthesia monitor, in addition to the dental hygienist performing the authorized procedures, is present with the patient at all times **only if the dental hygienist does not hold a nitrous oxide permit or current BLS CPR card.***

### **Discussion Regarding Jurisprudence Exam Timeline**

Ms. Davidson stated that the committee recommends that the Board set a timeline and appoint a committee, possibly of educators, in order to update the Jurisprudence Exam.

Mr. Braatz stated that a committee will be formed and it should be updated in 2014, probably in the spring. Ms. Davidson asked that progress be reviewed at the December Board meeting.

### **Discussion Regarding House Bill 2611 – Cultural Competency CE for Licensees**

Ms. Davidson stated that the committee recommends that the Board discuss HB 2611 requirements for cultural competency education and decide if they want to implement any specific requirements for licensees. Mr. Braatz stated that currently under HB 2611, the law states that the Board MAY require but it does not have to. In addition, they have not defined cultural competency at this point.

### **Dental Hygiene Committee Meeting Dates**

Ms. Davidson also stated that the Dental Hygiene Committee set the next meeting dates for 2014. The dates are as follows: March 6, June 12, September 11 and December 11 with all meetings being scheduled in the evening.

## **EXECUTIVE DIRECTOR'S REPORT**

### **Budget Status Report**

Mr. Braatz stated that the Board would find attached the latest budget report for the 2013 - 2015 Biennium. This report, which is from July 1, 2013 through August 31, 2013, shows revenue of

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\$297,483.21 and expenditures of \$170,513.44. He stated that if Board members have questions on this budget report format that he was happy to answer any questions.

### **Customer Service Survey Report**

Mr. Braatz stated that the Board would find attached the latest chart which shows the OBD State Legislatively Mandated Customer Service Survey Results from July 1, 2013 through September 30, 2013. He stated that the results of the survey show that the OBD continues to receive positive comments from the majority of those that return the surveys. A booklet containing the written comments that are on the survey forms, which staff has reviewed, are available on the table for Board members to review

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

Friday, September 6, 2013 – Mr. Braatz made a presentation on “Updates from the OBD” to the Oregon Dental Association House of Delegates in Sun River, Oregon.

Wednesday, September 18, 2013 – Mr. Braatz made a presentation on “Updates from the OBD” to the Marion Dental Research Group in Salem, Oregon.

Monday, October 7, 2013 – Mr. Braatz made a presentation on “Updates from the OBD” to the Orthodontics Study Club in Portland, Oregon.

### **Office Lease Update**

Mr. Braatz stated that the Board has signed a lease for our new office space located in the Crown Plaza building. He added that we have a move date of December 6, 2013 with the Board being operational in the new space on December 9, 2013.

### **Annual Performance Report**

Mr. Braatz stated that he had attached the 2012 – 2013 Annual Performance Report for the OBD’s review.

### **Newsletter**

Mr. Braatz stated that we’re currently working on trying to get the newsletter to the publisher around November 1<sup>st</sup>.

## **UNFINISHED BUSINESS**

### **RULES**

#### **OAR 818-012-0005(3)**

Dr. Beck moved and Dr. Schwindt seconded that the Board amend 818-012-0005(3) as revised and make it effective January 1, 2014. 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.

**[3\) A dentist may utilize Botulinum Toxin Type A to treat a condition that is within the scope of the practice of dentistry after completing a minimum of 16 hours in a hands on clinical course\(s\) in which the provider is approved by the Academy of General Dentistry Program Approval for Continuing Education \(AGD PACE\) or by the American Dental Association Continuing Education Recognition Program \(ADA CERP\).](#)**

Dr. Magnuson wanted to go on record stating that he did not like the fact that we're going down the a path to require education for a procedure that is NOT permanent yet we allow others that are permanent to happen without education requirements.

Dr. Hongo wanted to go on record stating that this is an honor system requirement since it is not a certification or permit. It would only be if someone had a complaint filed against them that it would come into question.

**OAR 818-012-0040(4)**

Dr. Schwindt moved and Dr. Beck seconded that the Board amend 818-012-0040(4) as presented and make it effective January 1, 2014. 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.

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

**OAR 818-013-0001(16)-(22)**

Dr. Magnuson moved and Dr. Schwindt seconded that the Board amend 818-013-0001 as presented and make it effective January 1, 2014. 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.

**OAR 818-013-0005(3)**

Dr. Smith moved and Ms. Davidson seconded that the Board amend 818-013-0005 as presented and make it effective January 1, 2014. 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.

**OAR 818-026-0060(1)(A)**

Dr. Parker moved and Dr. Magnuson seconded that the Board amend 818-026-0060(1)(A) as published and make it effective January 1, 2014. 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.

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

**OAR 818-035-0030(1)(e)**

Dr. Parker moved and Ms. Davidson seconded that the Board amend OAR 818-035-0030(1)(e) and make it effective January 1, 2014. The motion failed with Dr. Schwindt, Dr. Beck, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Smith, and Mr. Tripp voting nay. Ms. Davidson and Dr. Parker were in favor.

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

### **OAR 818-042-0040(6)**

Dr. Magnuson moved and Dr. Schwindt seconded that the Board amend OAR 818-042-0040(6) and make it effective January 1, 2014. The motion failed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting nay.

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

### **OAR 818-042-0060(c)**

Dr. Magnuson moved and Dr. Schwindt seconded that the Board adopt the revised version of 818-042-0060 and amend rule 818-042-0060(c) as published and make it effective January 1, 2014. 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.

*(c) Passes a clinical examination approved by the Board and graded by the Dental Assisting National Board, Inc. (DANB), or any other testing entity authorized by the Board, consisting of exposing, developing and mounting a full mouth series of radiographs or by exposing and mounting a digital full mouth series of radiographic images (14 to 18 periapical and 4 bitewing radiograph[s]ic images) within one hour and under the supervision of a person permitted to take radiographs in Oregon. No portion of the clinical examination may be completed in advance; a maximum of three retakes is permitted (i.e., three individual radiographic exposures, not three full mouth series); only the applicant may determine the necessity of retakes. The radiograph[s]ic images should be [taken] acquired on an adult patient with at least 24 fully erupted teeth. The full mouth series [radiographs] must be submitted for grading within six months after [they are] it is taken.*

### **ART and EPP's**

Dr. Schwindt moved and Dr. Parker seconded that the Board send the idea of ART restorative technique for EPP hygienists to the Licensing Standards Committee. 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.

### **Anesthesia Committee Meeting Rules**

Dr. Schwindt moved and Dr. Parker seconded that since the post operative vital signs for N2O was removed. It appears pre-operative was left in by error and he'd like the Anesthesia Committee to review that. 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.

Dr. Schwindt moved and Dr. Beck seconded that the Board have the Anesthesia Committee revisit the definition of moderate sedation to discuss bringing Oregon's rules into line with the ADA language which bases it on level of consciousness versus drugs used. 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.

## **CORRESPONDENCE**

**The Board received a copy of the Joint Staff Report on the Corporate Practice of Dentistry**  
Released by the US Senate and submitted by James R. Moriarty.

## **OTHER BUSINESS**

### **Approval of Soft Reline Course**

Ms. Ross submitted her soft reline course for review and approval. Ms. Davidson moved and Mr. Tripp seconded that the Board approve the course as presented. 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.

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

Nothing to Report

**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**

Licenses appeared pursuant to their Consent Orders in case number **2005-0117**.

## **LICENSING ISSUES**

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

## **CONSENT AGENDA**

**2014-0046, 2014-0031, 2014-0047, 2014-0045, 2014-0027 and 2014-0020**

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

## **COMPLETED CASES**

**2014-0008, 2013-0183, 2012-0215, 2012-0193, 2012-0225, 2014-0017, 2012-0027, 2012-0021 and 2014-0015** Dr. Schwindt moved and Dr. Parker 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, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye. Dr. Magnuson recused himself from case 2013-0183 and Dr. Schwindt recused himself from case 2012-0215.

## **CROCKETT, BENJAMIN D., D.D.S. 2012-0212**

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Ms. Davidson 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 \$2,000.00 civil penalty, and complete the balance of the 40 hours of continuing education for the licensure periods 4/1/09 to 3/31/11 and 4/1/11 to 3/31/13, within 90 days of the effective date of this Order. As soon as possible following completion of the continuing education the licensee shall provide the Board with documentation certifying the licensee's completion. 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.

**GERHARDS, MICHAEL C., D.D.S. 2012-0194**

Mr. Harvey 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 \$3,000.00 civil penalty to be paid within 60 days, to make a restitution payment to patient MB in the amount of \$740.00, to complete 20 hours of Board approved community service to be completed within six months, and monthly submission of spore testing results for a period of one year from the effective date of the Order. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

**2011-0077**

Mr. Morris moved and Mr. Harvey seconded that the Board issue a Letter of Concern reminding the licensee that all prescriptions provided to the patient have a dental justification recorded in the chart, that when using SOAP as a means of documenting patient interaction each note contains adequate information to meet the PARQ requirements, that when a complication occurs there is proper documented discussion regarding the complication utilizing SOAP note format or PARQ, and that all periapical radiographs used for treatment be of adequate quality and timely proximity to treatment prior to initiating treatment. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Smith, and Mr. Tripp voting aye. Dr. Parker recused herself.

**HALD, TAMARA S., D.D.S. 2010-0068**

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

**2012-0201**

Mr. Tripp moved and Ms. Davidson seconded that the Board close the matter with a Letter of Concern addressing the issue of ensuring that the administration of nitrous oxide is appropriately documented, that all treatment that is provided is documented, and that every effort is made to place restorations with appropriate contour and finishing. 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.

**KIM, MICHAEL Y., D.D.S. 2012-0228**

Dr. Magnuson moved and Dr. Parker seconded that the Board issue a Notice of Proposed Disciplinary Action and offer the Licensee a Consent Order incorporating a reprimand, a \$11,000.00 civil penalty; 40 hours of Board approved community service to be completed within

one year; and monthly submission of weekly 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, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

**LIND, STEVEN, D.M.D. 2012-0105**

Dr. Parker moved and Dr. Smith seconded that the Board issue a Notice of Proposed Disciplinary Action and offer the Licensee a Consent Order incorporating a reprimand, a \$6,000.00 civil penalty, 40 hours of Board approved community service, monthly submission of spore testing results for a period of one year from the effective date of the Order, and a license restriction during which Licensee will place no implants until completion of a Board approved mentorship. 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.

**McDONALD, JOHN L., D.M.D. 2013-0169**

Ms. Davidson moved and Mr. Harvey seconded that the Board issue a Notice of Proposed Disciplinary Action and offer a Consent Order incorporating a reprimand and a civil penalty in the amount of \$2,000.00. 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.

**McKIM, JOHN P., D.M.D. 2011-0207**

Mr. Harvey moved and Ms. Davidson seconded that the Board issue a Notice of Proposed Disciplinary Action and offer the Licensee a Consent Order incorporating a reprimand, a \$11,000.00 civil penalty, refund ODS \$732.00 on behalf of patient PJ, complete three hours of Board approved continuing education in record keeping, complete 40 hours of Board approved community service, and monthly submission of spore testing results for a period of one year from the effective date of the Order. 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.

**MONTROSE, ALAN M., D.M.D. 2012-0210**

Mr. Morris moved and Dr. Beck seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand, a \$6,000.00 civil penalty and a completion of 40 hours of Board approved community service. In addition, for a period of one year of the effective date of the Order, licensee shall submit, by the fifteenth of each month, the results of the previous month's biological monitoring and testing of sterilization devices. The motion passed with Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye. Dr. Schwindt recused himself.

**NORDSTROM, MARC A., D.M.D. 2013-0001**

Dr. Smith 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 \$12,000.00 civil penalty, to make a restitution payment in the amount of \$1,091.00 to patient MG, 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, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Smith, and Mr. Tripp voting aye. Dr. Beck and Dr. Parker recused themselves.

**OGAWA, KEITH F., D.D.S. 2014-0013**

Dr. Beck 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 be reprimanded and pay a \$2,000.00 civil penalty within 30 days of the effective date of the Order. 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.

**2013-0214**

Mr. Tripp moved and Ms. Davidson seconded that the Board close the matter with a Letter of Concern reminding the Licensee that it is the Licensee's responsibility to assure spore testing is done on a weekly basis. Also, refer this case to the Oregon Department of Public Health for investigation. 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.

**O'SHEA, HOLLY L., D.M.D. 2012-0223**

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

**PHAM, JOHN, D.D.S. 2014-0023**

Dr. Parker moved and Mr. Morris seconded that the Board issue a Notice of Proposed Disciplinary Action and offer the Licensee a Consent Order incorporating a reprimand; surrender of his Oregon moderate sedation permit; a license restriction by which Licensee shall not provide implant or veneer treatments; successful completion of 22 hours of continuing education, "Dental Ethics and Conduct" offered by Behavioral Dental Resources.com within one (1) year of the effective date of this Order; and no petition to modify this Consent Order for a period of five (5) years. 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.

**RAFIA, KASRA D.D.S. 2013-0002**

Ms. Davidson 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 \$3,000.00 civil penalty within 30 days of the effective date of the Order, 20 hours of Board approved community service to be completed within six months, and monthly submission of spore testing results for a period of one year from the effective date of the Order. The motion passed with Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye. Dr. Schwindt recused himself.

**SABIN, MICHAEL J., D.M.D. 2012-0209**

Mr. Harvey moved and Ms. Davidson seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand, a \$3,000.00 civil penalty and a completion of 20 hours of Board approved community service. In addition, for a period of one year of the effective date of the Order, licensee shall submit, by the fifteenth of each month, the results of the previous month's biological monitoring and testing of sterilization devices. 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.

**SAFFARI, REZA M., D.M.D. 2014-0009**

The OBD staff is not clear as to the Board's motion regarding this case and the matter will be clarified at the December 20, 2013 Board meeting, before the minutes will be accepted.

**SAVAGE, JAMES D., D.D.S. 2013-0192**

Mr. Morris 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, pay a \$12,000.00 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, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

**SHADER, JOHN M., D.M.D. 2013-0080**

Dr. Smith moved and Dr. Beck seconded that the Board with regard to Respondent #1 issue a Notice of proposed Disciplinary Action and offer a Consent Order incorporating a reprimand, and a civil penalty in the amount of \$500.00; with regard to Respondent #2 close the matter with a Letter of Concern reminding the Licensee that it is Licensees responsibility to assure renewal of Licensees license to practice in a timely manner. 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.

**SHAMLOO, JAMSHEED J., D.M.D. 2014-0062**

Mr. Tripp moved and Dr. Parker seconded that the Board issue a Notice of Proposed License Revocation and issue the Notice only if Licensee has not paid the \$5,000.00 civil penalty by 11/1/13. 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.

**SMITH, GRANT M., D.D.S. 2013-0097**

Dr. Magnuson moved and Dr. Smith seconded that the Board ratify the inclusion of case 2013-0097 in the Notice of Proposed License Suspension issued 6/24/13, and the Final Default Order, dated 8/16/13. 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.

**STEBBINS, ROBERT L., D.D.S. 2012-0184**

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, pay a \$6,000.00 civil penalty to be paid within 90 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, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

**PREVIOUS CASES REQUIRING BOARD ACTION**

**BACHMAN, JAMES, V., D.M.D. 2012-0213**

Ms. Davidson moved and Dr. Magnuson seconded that the Board deny Licensee's request and affirm the Board's action of April 4, 2013. 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.

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

Mr. Harvey moved and Ms. Davidson seconded that the Board deny Licensee's request and affirm the Board's action of 8/16/13. 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.

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

Mr. Morris moved and Dr. Smith seconded that the Board deny Licensee's request and affirm the Board's action of 8/16/13. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye. Dr. Magnuson recused himself.

**2012-0111**

The OBD staff is not clear as to the Board's motion regarding this case and the matter will be clarified at the December 20, 2013 Board meeting, before the minutes will be accepted.

**GRUBBS, HEIDI J., R.D.H. 2011-0044**

Dr. Beck moved and Mr. Harvey seconded that the Board reinstate Licensee's dental hygiene license providing she agree to a Consent Order incorporating a reprimand, 80 hours of community service within one year, and enrollment in the State's Health Professionals' Services Program, per the Board's protocols. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker and Dr. Smith voting aye. Mr. Tripp recused himself.

**2008-0287**

Mr. Tripp moved and Dr. Magnuson seconded that the Board grant Licensee's request and release Licensee from the requirements of his Voluntary Diversion Agreement and his contract with HPSP. 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.

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

Dr. Magnuson moved and Dr. Beck seconded that the Board deny Licensee's request and affirm the Board's action of 8/16/13. The motion passed with Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye. Dr. Schwindt recused himself.

**LICENSURE AND EXAMINATION**

**Ratification of Licenses Issued**

Dr. Smith moved and Dr. Parker seconded, that licenses issued be ratified as published. 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.

**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 DURRIN, 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

**Nonresident Permit – R. Rutner, D.D.S.**

Dr. Parker moved and Dr. Magnuson seconded that the Board approve Dr. Rutner's Nonresident Permit. 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.

### **Orthodontic Specialty Examination**

Ms. Davidson moved and Dr. Schwindt seconded that the Board approve the exam as presented. 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.

### **Public Health Specialty Examination**

Mr. Harvey moved and Dr. Magnuson seconded that the Board approve the exam as presented. 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.

### **Request for Investigative Information**

Mr. Morris moved and Dr. Magnuson seconded that the Board approve the request for investigative files as presented. 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.

### **Announcement**

No announcements

### **ADJOURNMENT**

The meeting was adjourned at 1:06 p.m. Dr. Hongo stated that the next Board meeting would take place December 20, 2013.

Approved by the Board December 20, 2013.

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

# ASSOCIATION REPORTS

**Nothing to report under this tab**

# COMMITTEE REPORTS

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## AADB Report

### Program Committee

- Corporate dentistry
- Corporate sponsorship of dental education
- “Investor owned” practices
- Impairment
- Sleep dentistry
- Anesthesia
- Vaccinations (pharmacists and nurses allowed)
- e portfolios and its potential use in dental licensing for dental school grads and also in the future for maintenance of certification for dentists

### Annual Meeting

#### ADA President

- Electronic records
- SNODENT (Systemized Nomenclature of Dentistry) and WHO (World Health Organization) are working together using ADA diagnostic codes to compare with ICD-11 oral health codes
- Meaningful use – obtaining data to measure outcomes

#### Paul Kleinstaub

##### Electronic health records

#### Other topics

- Virtual dental home
  - Tele-health dentistry
  - Licensure issues with tele-health across state borders
  - Financing alternatives
- Teledentistry education
  - MOOCs (massive open online course) is an online course aimed at unlimited participation and open access via the web. In addition to traditional course materials such as videos, readings and problem sets, MOOCs provide interactive user forums that help build a community for the students, professors, and teaching assistants (TAs). MOOCs are a recent development in distance education

## Open Forum

WV – 2 hours of CE every two years on substance abuse

FL – Senate passed a law that mandates each licensing board to have a member who specializes in addiction

Maryland – established rules for EHRs; military pathway to licensure; 2 CE required on Rx and disposal of controlled substances

NM – sleep apnea treatment after medical dx; dental therapist similar to Alaska

Community Dental Health Coordinators

Reports from committees

Election and installation of officers

Board Attorneys roundtable

**EXECUTIVE  
DIRECTORS  
REPORT**

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## **EXECUTIVE DIRECTOR'S REPORT**

**December 20, 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 October 31, 2013, shows revenue of \$488,868.35 and expenditures of \$358,308.86. If Board members have questions on this budget report format, please feel free to ask me. **Attachment #1**

### **Customer Service Survey**

Due to the move and other issues I have not updated the OBD State Legislatively Mandated Customer Service Survey I will have it for the next meeting.

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

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

Dr. Kleinstub made a presentation on "Electronic Patient Record – Issues Facing Dental Boards" to the AADB Annual Meeting in New Orleans, Louisiana on Wednesday, October 30, 2013.

I made a presentation on "Updates from the OBD" to the DBIC Risk Management Program at the Oregon Convention Center on Friday, December 6, 2013 in Portland, Oregon.

Dr. Kleinstub and Stephen Prisby made a presentation on "Updates from the OBD" to the DBIC Risk Management Program at Eagle Crest on Friday, December 13, 2013 in Redmond, Oregon.

### **2013 RDH Renewal**

We completed the 2013 RDH Renewal on September 30, 2013. We sent out approximately 1,937 post cards to Oregon Licensed Dental Hygienists starting in July, and followed up with reminder post cards and blast e-mails. 1,829 Oregon Licensed Dental Hygienists renewed their licenses.

### **AADB & AADA Annual Meeting**

I attended both the American Association of Dental Administrators and the American Association of Dental Boards Meeting in New Orleans, Louisiana.

I will update the Board on the meetings and the upcoming issues that may impact the OBD.

I was asked once again to moderate the AADB Forum that is held each year and gives all the member boards the opportunity to report on what is going on in with their board and state. As of the date of developing my report the compilation of the written reports that were submitted and in some cases were presented at the meeting has not yet been made available, but when it does I will share it with the Board. **Attachment # 2**

## **Office Move**

The OBD moved on Saturday, December 7, 2013 to our new offices in the Crown Plaza Center 1500 SW 1<sup>st</sup> Ave, Suite 770.

If all has gone well you will be in the new room that will be used to hold OBD Board Meetings.

## **Senate Bill 633/OHA Administrative Rules**

Attached please find a copy of Senate Bill 633 and copies of the newly promulgated rules by the Oregon Health Authority regarding the implementation of the new legislation and the rules to enforce the law. I would like the Board to be aware of the changes and we might want to discuss how the OBD can inform licensees about the new legislation and rules and how the OBD might be asked to enforce these new rules. **Attachment # 3**

## **Oregon Pharmacy Board Proposed Practitioner Dispensing Outlets Rules**

Attached please find some proposed rules that the Pharmacy Board would like to promulgate that would require Licensees that dispense prescription drug to now have to register with the Oregon Board of Pharmacy. **Attachment # 4**

We recently did a survey monkey to see how many licensees might be impacted by this rule and the results are attached. **Attachment # 5**

I would like to discuss this matter in more detail with the Board and I have been working with the ODA about the possibility of seeking legislation to have dentistry not be a part of these new rules.

## **Common Credentialing Process**

I will update the Board on the Common Credentialing Process that has been undertaken by the Oregon Health Authority and how it may or may not impact the OBD.

## **Newsletter**

The most recent newsletter was mailed out during the Week of December 2, 2013. Thanks to Stephen Prisby for all of his hard work on the Newsletter.



**BOARD OF DENTISTRY**  
**Fund 3400 BOARD OF DENTISTRY**  
**For the Month of OCTOBER 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	17,245.00	447,082.00	0.00	-447,082.00	111,770.50	-22,354.10
0210	OTHER NONBUSINESS LICENSES AND FEES	850.00	1,600.00	0.00	-1,600.00	400.00	-80.00
0505	FINES AND FORFEITS	6,000.00	33,500.00	0.00	-33,500.00	8,375.00	-1,675.00
0605	INTEREST AND INVESTMENTS	384.55	1,438.14	0.00	-1,438.14	359.54	-71.91
0975	OTHER REVENUE	1,599.14	5,248.21	0.00	-5,248.21	1,312.05	-262.41
		<b>26,078.69</b>	<b>488,868.35</b>	<b>0.00</b>	<b>-488,868.35</b>	<b>122,217.09</b>	<b>-24,443.42</b>

**TRANSFER OUT**

<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>
2443	TRANSFER OUT TO OREGON HEALTH AUTHORITY	1,890.00	1,890.00	0.00	-1,890.00	472.50	-94.50
		<b>1,890.00</b>	<b>1,890.00</b>	<b>0.00</b>	<b>-1,890.00</b>	<b>472.50</b>	<b>-94.50</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	40,114.00	148,938.74	0.00	-148,938.74	37,234.69	-7,446.94
3170	OVERTIME PAYMENTS	525.06	675.27	0.00	-675.27	168.82	-33.76
3180	SHIFT DIFFERENTIAL	6.75	8.25	0.00	-8.25	2.06	-0.41
3210	ERB ASSESSMENT	8.25	33.00	0.00	-33.00	8.25	-1.65
3220	PUBLIC EMPLOYEES' RETIREMENT SYSTEM	5,458.67	21,605.23	0.00	-21,605.23	5,401.31	-1,080.26
3221	PENSION BOND CONTRIBUTION	2,351.63	8,922.83	0.00	-8,922.83	2,230.71	-446.14
3230	SOCIAL SECURITY TAX	3,058.79	11,243.61	0.00	-11,243.61	2,810.90	-562.18
3250	WORKERS' COMPENSATION ASSESSMENT	25.39	84.58	0.00	-84.58	21.15	-4.23
3260	MASS TRANSIT	210.59	833.43	0.00	-833.43	208.36	-41.67
3270	FLEXIBLE BENEFITS	8,288.14	33,152.56	0.00	-33,152.56	8,288.14	-1,657.63
		<b>60,047.27</b>	<b>225,497.50</b>	<b>0.00</b>	<b>-225,497.50</b>	<b>56,374.38</b>	<b>-11,274.88</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	3,529.30	11,497.24	0.00	-11,497.24	2,874.31	-574.86
4125	OUT-OF-STATE TRAVEL	4,553.71	8,306.35	0.00	-8,306.35	2,076.59	-415.32
4150	EMPLOYEE TRAINING	0.00	2,185.00	0.00	-2,185.00	546.25	-109.25

<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>
4175	OFFICE EXPENSES	1,639.56	7,995.80	0.00	-7,995.80	1,998.95	-399.79
4200	TELECOMM/TECH SVC AND SUPPLIES	903.91	2,805.62	0.00	-2,805.62	701.41	-140.28
4225	STATE GOVERNMENT SERVICE CHARGES	1,536.00	8,085.25	0.00	-8,085.25	2,021.31	-404.26
4250	DATA PROCESSING	266.75	1,249.50	0.00	-1,249.50	312.38	-62.48
4275	PUBLICITY & PUBLICATIONS	208.80	1,160.78	0.00	-1,160.78	290.20	-58.04
4300	PROFESSIONAL SERVICES	7,974.26	25,706.44	0.00	-25,706.44	6,426.61	-1,285.32
4325	ATTORNEY GENERAL LEGAL FEES	5,787.40	13,195.23	0.00	-13,195.23	3,298.81	-659.76
4400	DUES AND SUBSCRIPTIONS	257.95	3,923.95	0.00	-3,923.95	980.99	-196.20
4425	FACILITIES RENT & TAXES	6,971.71	27,335.07	0.00	-27,335.07	6,833.77	-1,366.75
4575	AGENCY PROGRAM RELATED SVCS & SUPP	2,045.94	32,410.19	0.00	-32,410.19	8,102.55	-1,620.51
4650	OTHER SERVICES AND SUPPLIES	146.30	6,296.82	0.00	-6,296.82	1,574.21	-314.84
4700	EXPENDABLE PROPERTY \$250-\$5000	0.00	443.06	0.00	-443.06	110.77	-22.15
4715	IT EXPENDABLE PROPERTY	47.70	677.70	0.00	-677.70	169.43	-33.89
		<b>35,869.29</b>	<b>153,274.00</b>	<b>0.00</b>	<b>-153,274.00</b>	<b>38,318.50</b>	<b>-7,663.70</b>

## SUMMARY TOTALS

3400

BOARD OF DENTISTRY

		<u>Month Activity</u>	<u>Biennium Activity</u>
REVENUES	REVENUE	26,078.69	488,868.35
	Total	26,078.69	488,868.35
EXPENDITURES	PERSONAL SERVICES	60,047.27	225,497.50
	SERVICES AND SUPPLIES	35,869.29	153,274.00
	Total	95,916.56	378,771.50
TRANSFER OUT	TRANSFER OUT	1,890.00	1,890.00
	Total	1,890.00	1,890.00

**ALASKA STATE BOARD OF DENTAL EXAMINERS**  
**FY 2013 ANNUAL REPORT**  
**NARRATIVE STATEMENT**

This year the Alaska Board of Dental examiners held meetings in Anchorage on September 7 and December 7, 2012. Meetings were also held in Anchorage February 8 and May 3, 2013. A teleconference was held February 20, 2013.

With a new full-time investigator, Angela Birt, we have updated all pending investigations with resolution of 22 older complaints. Currently, there are 21 cases under review. The oldest case dates from August, 2009. We commend Angela Birt for her excellent full-time service to the Alaska Board of Dental Examiners and thank Quinton Warren, Chief Investigator, for his support.

I would like to thank Debbie Kunow who has replaced Brenda Donohue as our Licensing Examiner. Debbie, with the support of Licensing Supervisor, Sher Zinn, has kept our board organized and focused. We have updated our regulation to have relative wording and changes that are consistent with the guidelines of the American Dental Association.

The Alaska Board of Dental Examiners has adopted the 2012 American Dental Association's Guidelines for the Use of Sedation and General Anesthesia. The Alaska Board of Dental Examiners is formulating guidelines for on-site inspections.

Regulation 12 AAC 28.952 establishing a Dental Specialty License (12/24/2006) was repealed effective December 31, 2012. There were no provisions to grandfather licensees who held only a Dental Specialty License. With re-applications and new applications for a dental license, approximately 36 specialists obtained a new or had their old dental license reinstated. I would like to thank the whole board and the administrative staff from Juneau for completing the Herculean task.

I would like to thank Drs. Deborah Stauffer and Doug White for their enthusiastic work over the past four years. To work efficiently, the board needs the participation of all members and Drs. White and Stauffer have done an admirable job.

Our non-dental lay member, Robyn Chaney, has been reappointed for a 2<sup>nd</sup> four year term and has accepted the position of secretary. We welcome two new members, Dr. Steven Scheller and Gail Walden, RDH, BSDH.



**ARIZONA STATE BOARD OF DENTAL EXAMINERS**  
4205 North 7th Avenue, Suite 300 • Phoenix, Arizona 85013  
Telephone (602) 242-1492 • Fax (602) 242-1445  
[www.azdentalboard.us](http://www.azdentalboard.us)

## **Report from the Arizona State Board of Dental Examiners**

During the last legislative session statutes were amended as follows:

- Defined a statute of limitation. Complaints in which the violation occurred more than six years before the complaint is received by the Board shall not be investigated.
- Registered business entity statutes now require that someone who is employed by a business entity must file a complaint with the business entity prior to filing with the Dental Board.
- Eliminated the age requirement for retired license status.
- A new section was added to allow the board to issue training permits for qualified military health professionals.

The Board attempted to pass legislation that would require mobile dental units to have two levels of informed consents; one upon initial treatment and the second for further treatment. This was pulled due to constituent concerns. However, AHCCCS (Medicaid) has amended their policies that will require this.

A significant accomplishment was the passing of amended rules for anesthesia/sedation permits. It changed the evaluation time from every 3 years to 5 and added a level of permit for those dentists wishing to bring in an anesthesiologist or CRNA. Many stakeholder meetings were held as some stakeholders did not believe CRNAs should be allowed to do this.

The Board is currently undergoing an audit by the Auditor General Office.



**Arkansas State Board of Dental Examiners Report**  
*for the period of October 1, 2012 to Current*

*The Arkansas State Board of Dental Examiners consists of nine Board members, which are:*

<b>Drew W. Toole, DDS, Pine Bluff</b>	<b>Robert H. Carter, D.D.S.</b>
<b>George Martin, DDS, Fayetteville</b>	<b>Robert D. Keene, D.D.S.</b>
<b>David E. Walker, DDS, Pine Bluff</b>	<b>Jennifer Lamb, RDH, Little Rock</b>
<b>David Bell, DDS, Arkadelphia</b>	<b>Sheila Castin, Little Rock</b>
<b>(Currently the Consumer Representative position is not filled)</b>	

Dr. George Martin is the President, Dr. Robert Keene is the Vice President and Dr. David Bell is the Secretary/Treasurer. They were elected at the Annual meeting of the Board held June 21, 2013; their one-year term of office ends September 1, 2014. Since October 1, 2012, the Board held six meetings.

Since October 1, 2012, the Board has issued licenses to 65 dentists, 99 dental hygienists, and 15 dental specialists. Of those licensed, 22 dentists were accepted for licensure by credentials having been licensed to practice and actively practicing elsewhere. Eight of the 99 dental hygienists were licensed by credentials. Forty-four new dental corporations were registered with the Board. Local anesthesia permits for qualified dental hygienists were issued to 75 applicants.

Currently licensed are 1,470 (1,262 practicing in Arkansas) dentists and 1,652 (1,503 practicing in Arkansas) dental hygienists. 3,107 (2,963 practicing in Arkansas) registered dental assistants hold permits, 190 dentists have anesthesia permits, 1476 corporations are registered and 1,347 hygienists hold local anesthesia permits.

Two Disciplinary Hearings were conducted resulting in:

**1 Dentist – License Revoked**  
**1 Dental Hygienist – Suspension Lifted**

Three Public Hearings were held on the following proposed Articles with both passing:

**Article VIII, concerning Requirements for Licensure**  
**Article XVII, concerning Dental Assistant Functions**  
**Article XIX, concerning Collaborative Care**

The Rules & Regulation Committee of the Board is currently working on new proposed Articles XIII concerning Anesthesia and XIV concerning Continuing Education.

*The Board staff currently consists of a director, an investigator and an administrative assistant. Utilizing a professional services contract, the Board retains an attorney. The Board office has been located in MainStreet Mall at 101 East Capitol, Suite 111, Little Rock, AR, since September 1994.*

## Dental Board of California (DBC)

### *Major Accomplishments for 2012-13*

- Updated and adopted the goals and objectives of the board's Strategic Plan for 2013 through 2015
- Completed the "Development and Validation of a Portfolio Examination for Initial Dental Licensure" report
- Revised the Orthodontic Assistant Permit Examination
- The board appointed a new Executive Officer
- The Governor appointed six new board members and reappointed three members
- The Enforcement Program's ongoing efforts to address unlicensed activity resulted in five search warrants, four felony arrests for unlicensed dentistry, and 17 criminal filings
- Provided educational presentations of the Board's licensing and enforcement roles to graduating dental students at four California universities

### *Major Legislation & Regulations for 2012-13*

#### Legislation:

- AB 1588 requires boards within the Department of Consumer Affairs (DCA), to waive the renewal fees, continuing education requirements, and other renewal requirements as determined by the board, of any licensee or registrant who is called to active duty as a member of the US Armed Forces or the CA National Guard if certain requirements are met. The bill prohibits a licensee or registrant from engaging in any activities requiring a license while a waiver is in effect. The bill requires a licensee or registrant to meet certain renewal requirements within a specified time period after being discharged from active duty service prior to engaging in any activity requiring a license. The bill also requires a licensee or registrant to notify the board of his or her discharge from active duty within a specified time.
- AB 1904 requires boards within DCA to expedite the licensure process for an applicant who holds a license in the same profession or vocation in another jurisdiction and is married to, or in a legal union with, an active duty member of the US Armed Forces who is assigned to a duty station in CA under official active duty military orders.
- AB 2570 prohibits a licensee who is regulated by DCA from including a provision in an agreement to settle a civil dispute that prohibits the other party in that dispute from contacting, filing a complaint with, or cooperating with the board, that requires the other party to withdraw a complaint from the board except as specified. A licensee in violation of the provisions would be subject to disciplinary action by the board. The bill also prohibits the board program from requiring its licensees in a disciplinary action that is based on a complaint or report that has been settled in a civil action to pay additional moneys to the benefit of any plaintiff in the civil action. This bill authorizes the board to adopt a regulation exempting agreements to settle certain causes of action from these provisions.
- SB 1575 made several non-controversial, minor, non-substantive, or technical changes to various provisions of the Business and Professions Code pertaining to healing arts boards within DCA. Specifically, this bill revised eligibility requirements for a person applying for a special permit with the board to allow for alternative eligibility for a person who completes an advanced education program accredited by the Commission on Dental Accreditation of the ADA or a national accrediting body approved by the board.

Regulations:

- A new regulation became effective in November 2012, that requires licensed dentists to provide conspicuous notification to consumers that they are licensed and regulated by the Dental Board of CA.
- A new regulation became effective in December 2012, establishing the application and registration requirements for the exemption for out-of-state licensed dentists to participate in sponsored free health care events on a short-term voluntary basis.

## Dental Hygiene Committee of California (DHCC)

On July 1, 2009, the autonomous Dental Hygiene Committee of California (DHCC) was created without the Dental Board's oversight. The DHCC is responsible for enforcement, licensure, and administration of clinical examinations, legislation and promulgating regulations.

In December 2012, a new regulation went into effect to allow the DHCC to issue a citation and fine up to \$5,000 for any violation of dental hygiene laws, including unlicensed practice, unprofessional conduct, failure to identify yourself in the patient record, refusal to release a patient's records, or even minor violations such as failure to notify the DHCC of a name change within 10 days or a mailing address change or email address change within 30 days.

Effective January 1, 2013, the following new laws went into effect:

- A registered dental hygienist licensed in another state can teach in a California dental hygiene college without being licensed in California if he or she is issued a special permit by the DHCC.
- New dental hygiene educational programs must provide a feasibility study to the DHCC demonstrating the need for a new program before seeking approval for initial accreditation from the Commission on Dental Accreditation (CDA).
- The DHCC has the authority to withdraw or revoke a dental hygiene approval if the CDA has indicated an intent to withdraw approval or has withdrawn approval.
- Any examinee for a registered dental hygienist license who fails to pass the California state or Western Regional Examining Board (WREB) clinical exam in three attempts or who fails to pass the state clinical or WREB examination as a result of imposing gross trauma on a patient, is not eligible for further examination until he or she successfully completes remedial education in a setting approved by the DHCC.
- Clarification of the requirement for all applicants to complete DHCC-approved courses in soft tissue curettage, administration of local anesthesia, and administration of nitrous oxide and oxygen for licensure.
- Extramural dental hygiene facilities associated with a dental hygiene program must register with the DHCC.
- Registered Dental Hygienists in Alternative Practice (RDHAP) may operate a mobile dental hygiene unit after applying for a permit.
- RDHAPs are required to register their place(s) of practice.
- RDHAPs who own more than one office location must obtain additional office permit(s) from the DHCC.
- The requirement to collect survey data from licensees as part of the initial licensure and any subsequent application for renewal of license now lives in DHCC statutes.
- To require licensees who change their physical address of record or e-mail address to notify the DHCC within 30 days of the change. Also, licensees who change their legal name must provide legal documentation of the change within 10 days.
- To deny a license to any person who is required to register as a sex offender.

The only changes that have taken place in the State of Delaware are the following:

- SB 96 passed – SB 96 created the provisional license to help the three FQHCs in Delaware that struggle to recruit dentists to serve their patient populations. The provisional license allows applicants who qualify for licensure in the State of Delaware to work at a FQHC for a up to two years while they take and pass the Delaware State dental exam to obtain full licensure.

<http://legis.delaware.gov/LIS/lis147.nsf/vwLegislation/SB+96?Opendocument>

- SB 114 passed – SB 114 added chaperone requirements for the treatment of minors. A minor is defined as a person 15 years of age or younger. A parent, legal guardian, or other caretaker, or adult staff member, must be present when a treatment door must be closed or anytime the minor is sedated. The patient's records must be noted with the name of the person present while such treatment was provided and a notice shall be provided in written form and be posted in the location of where services are provided.

<http://legis.delaware.gov/lis/lis147.nsf/vwlegislation/9ACDFBFF2F96B48185257B3A006>

[2F6B9](#)

- The Board is currently proposing to amend their Rules and Regulations. The addition defines unprofessional conduct within the practice of dentistry and dental hygiene and lists examples of such conduct. The hearing for this proposal is scheduled for October 24, 2013 at 3:30 p.m.

NEIL ABERCROMBIE  
GOVERNOR

SHAN TSUTSUI  
LIEUTENANT GOVERNOR



KEALI'I S. LOPEZ  
DIRECTOR

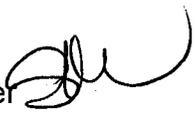
CELIA C. SUZUKI  
LICENSING ADMINISTRATOR

## BOARD OF DENTAL EXAMINERS

STATE OF HAWAII  
PROFESSIONAL AND VOCATIONAL LICENSING DIVISION  
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS  
P.O. Box 3469  
HONOLULU, HAWAII 96801  
[www.hawaii.gov/dcca/pvl](http://www.hawaii.gov/dcca/pvl)

September 25, 2013

TO: Rob Kapp, AADB

FROM: Sandra Matsushima, Executive Officer   
Hawaii State Board of Dental Examiners

SUBJECT: Open Forum at the AADB Annual Meeting

### Hawaii Report

The Hawaii Board of Dental Examiners ("Board") consists of 12 members, of whom 8 are dentists, 2 are dental hygienists, and 2 are public members. Each of the major islands (Hawaii, Maui, Kauai, and Oahu) are represented by at least one member. Currently we have licensed 1520 dentists, 1030 dental hygienists, 28 community service dentists, and 1 community service dental hygienists.

In regards to the Board's administrative rules, the Board approved a comprehensive draft of the proposed amendments which included updates of almost every section. It is presently under final review with the Attorney General in preparation for Governor's signature. The amendments being proposed are to ensure the safe practice standards for our oral health community as it relates to the health and welfare of the dental public consumer.

Some of the issues addressed by the Board in 2013 include the following:

- Licensure examination for dentists and dental hygienists;
- Rules amendments;
- Use of Botox and Dermal Fillers;

Thank you for the opportunity to share this information with the other state boards. We appreciate your tireless work and valuable time to facilitate meetings for our dental board members.

# STATE OF IDAHO



## BOARD OF DENTISTRY

AADB Annual Meeting  
Report of Idaho Dental Board Activities  
October 2013

Key changes/issues in Idaho since October 2012:

- The Board proposed revisions to IC 54-924(2)(3) regarding naming, ownership, and control of dental practices which was passed by the legislature and became law on July 1, 2013. The addition of subsection 14 clarifies what the Board believed the law already stated. Both the Professional Service Corporation Act and Idaho Uniform Limited Liability Company Act limit the rendering of professional services to the public by licensed professionals. Subsection 14 provides the statutory authority necessary for the Board of Dentistry to take action against a dentist who engages in the practice of dentistry, other than in a limited managed care plan, with a business entity in which a person not licensed to practice dentistry in this state holds an ownership interest.
- The Board completed a year-long comprehensive review of all statutes and rules and has proposed numerous revisions for consideration by the 2014 legislature. One notable proposal would allow a dentist to provide minimal sedation to children under 16 years of age or under 100 pounds only if a single enteral sedative dose is administered without the use of nitrous oxide.
- Current issues in Idaho include dental assistant scope of practice related to CAD/CAM technology, teledentistry and extended access care programs.

## **Kansas**

**1. Extended Care Permit III (ECP III).** During the 2012 Legislative Session, the Kansas Legislature approved the implementation of the ECP III for a dental hygienist. The Board formally approved an ECP III training course at UMKC School of Dentistry. An ECP III may be granted if the dental hygienist: (1) Has performed 2,000 hours of dental hygiene care within the past three years or has been an instructor at an accredited dental hygiene program for three academic years within the past four years; (2) completed a course of study of 18 seat hours approved by the Board which includes, but is not limited to, emergency dental care techniques, the preparation and placement of temporary restorations, the adjustment of dental care techniques, and appropriate pharmacology; (3) shows proof of professional liability insurance; and (4) is sponsored by a dentist licensed in the State of Kansas, including a signed agreement stating that the dentist shall not monitor more than five dental hygienists with an extended care permit. The first ECP III training course at UMKC recently concluded. The Board has already approved 14 ECP III applications. The ECP III hygienists are permitted to perform additional functions without the direct supervision of a dentist while in certain practice settings, such as an adult care home or foster home.

**2. Sale or Closure of a Deceased or Substantially Disabled Dentist's Practice.** During the 2012 Legislative Session, the Kansas Legislature approved a modification to the Board's law pertaining to the sale or closure of a deceased or substantially disabled dentist's practice. Prior to the modification in law, the sale or closure of the practice had to occur within one (1) year of the death or substantial disability. Now, the sale or closure can occur within the first 18 months, or up to 30 months with the approval of the Board, after the death or substantial disability of the dentist.

**3. Franchise Dentistry.** During the 2011 Legislative Session, the Kansas Legislature approved franchise dentistry. Now, a licensed dentist can enter into a dental office administrative services agreement wherein the dentist is responsible for providing dental treatment to patients and the dental office administrator is responsible for purchasing, billing, tax preparation, legal advice, payroll, advertising, training, recruiting, recordkeeping, quality assurance programs, and other similar functions. There are now 11 different franchises in Kansas with a total of 17 dentists working in the franchises.

**4. Special Volunteer Dental License.** During the 2012 Legislative Session, the Kansas Legislature approved a special volunteer dental license. The license is for those who are retired from active practice and wish to donate their expertise for the dental care and treatment of indigent and underserved persons in Kansas.

**Report for the AADB Forum**

**Annual Meeting**

**October 30, 2013**

**Kentucky Board of Dentistry Dental Hygiene Members:**

**Mara Beth Womack RDH MS CDA**

**Mary Ann Burch RDH**

**Dental Hygiene Accomplishments**

**During the 2010 Legislative session of the Kentucky General Assembly, the legislation to create the position of Public Health Registered Dental Hygienist was passed. The protocols were finalized in August, 2012. This allows RDH to work thru Health Departments, University based Mobile Vans or Schools affiliated with a Health Department to provide care to the underserved.**

**The Kentucky Board of Dentistry is composed of 7 dentists, 2 dental hygienists, 1 consumer, Ex-Officio members representing the Kentucky Dental Health Dept, the University of Louisville, the University of Kentucky and the Dental Hygiene schools in the state.**

**Respectfully submitted,**

**Mary Ann Burch RDH**

## Memorandum

To: Mr. Robb Kapp  
Administrator, American Association of Dental Boards

From: Laurie Sheffield-James, Executive Director  
Maryland State Board of Dental Examiners

Re: Open Forum at the AADB Annual Meeting

Date: September 23, 2013

Mr. Kapp: The following is a brief description of the more significant matters before the Maryland State Board of Dental Examiners:

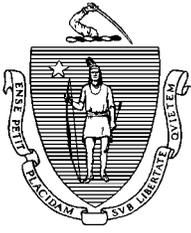
**1. Legislation: Veterans Full Employment Act of 2013:** Effective July 1, 2013. Provides that each health occupations board in Maryland, including the Dental Board, shall credit any training and education provided by the military and completed by a service member or veteran (defined as “discharged from active duty under circumstances other than dishonorable within 1 year before the date on which the application for a license, certificate, or registration is submitted”) toward any training or education requirements for licensure or certification, if the Board determines that such training or education was “substantially equivalent” to the training or education required by the Board. In addition, each Board is required to give credit for all relevant experience as a service member. (The Maryland Dental Board has been crediting military experience for many years). In addition, the law provides that each service member, veteran, or military spouse shall be assigned an advisor and be issued a license within 15 days of a completed application. Michelle Obama attended the bill signing in Annapolis on April 17, 2013. (SB 273 and HB 225).

**2. Legislation: Dental Hygienists – Provision of Services at a Community-Based Health Fair:** Effective October 1, 2013. Provides that a dental hygienist may, without the supervision of a dentist, provide at a community-based health fair, without compensation, the following services: preliminary dental examination, including charting cavities, restorations or missing teeth, oral health education, taking blood pressure, pulse rate, and respiration rate, and referrals to a dental home. A form for each encounter must be filed with the Office of Oral Health. (SB 459 and HB 1121).

**3. Regulations: Code of Maryland Regulations 10.44.22 Continuing Education: (Proper Prescribing and Disposal of Prescription Drugs)** Effective March 18, 2013. Requires all dentists to complete a 2-hour Board approved course on proper prescribing and disposal of prescription drugs as a condition of license renewal commencing in 2015. The Board will sponsor a live presentation of the course to 300 dentists on October 9, 2013 at no charge. A webinar will be made available to all Maryland licensees at a later date at no charge. Those who may be considering presenting a similar course in their state may contact Leslie Grant, D.D.S., Board Compliance officer at [leslie.grant@maryland.gov](mailto:leslie.grant@maryland.gov).

**4. Regulations: Code of Maryland Regulations 10.44.30 Record Keeping:** Effective April 29, 2013. The Board’s record keeping regulations were initially promulgated on June 11, 2012. The April 29, 2013 amendments added provisions dealing specifically with electronic record keeping requirements including: utilization of “best practices,” identification of users, audit trail function, attempted or successful unauthorized access or modification, when feasible, interference with application operations, ability to provide a hard copy, back-up, and if feasible, an off-site back-up.

*This is a cursory summary only and is not intended to be an exhaustive explanation of the laws and regulations. Reference should be made to the actual Maryland statutes and regulations.*



The Commonwealth of Massachusetts  
 Executive Office of Health and Human Services  
 Department of Public Health  
 Division of Health Professions Licensure  
 Board of Registration in Dentistry  
 239 Causeway Street, Suite 500, Boston, MA 02114

DEVAL L. PATRICK  
 GOVERNOR  
 JOHN W. POLANOWICZ  
 SECRETARY  
 CHERYL BARTLETT, RN  
 COMMISSIONER

Tel: 617-973-0971  
 Fax: 617-973-0980  
[www.mass.gov/dph/boards/dn](http://www.mass.gov/dph/boards/dn)

**AADB UPDATE – OCTOBER 16, 2013**

**I. COMPLAINT RESOLUTION (Oct. 17, 2012 to Oct. 16, 2013)**

Complaints Opened	203
Complaints Closed	172
Total Discipline	58
Probation	33
Reprimand	9
Voluntary Surrender	8
Suspension	7
Summary Suspension	1

**II. LICENSE APPLICATIONS APPROVED (Jan. 1, 2013 to Oct. 16, 2013)**

Dentists	211
Limited License Dental Faculty	72
Limited License Dental Interns	284
Dental Hygienists	205

**III. BOARD POLICIES**

A. Use of Lasers in Dentistry - *Adopted by the Board on April 3, 2013*

Delegation to dental auxiliaries may only occur when both the supervising dentist and registered dental hygienist obtain proper training on the use of dental laser devices, and use the devices within their licensed scope of practice, training and experience. Guidance for the profession for safe dental laser use is provided by American National Standards Institute Standard Z136.1 Safe Use of Lasers and Z136.3 Safe Use of Lasers in Health Care Facilities. Specific training is also available from manufacturers, and via independent providers of continuing education, including professional organizations and academic institutions. Continuing education programs/presenters should address and disclose possible conflicts of interest. At the present time, the ADA’s Commission on Dental Accreditation does not include laser education in its accreditation standards for dental education programs. However,

proposed educational standards are available (e.g., Academy of Laser Dentistry's Curriculum Guidelines and Standards for Dental Laser Education).

B. Use of Botulinum Toxins and/or Dermal Fillers by Dentists – *Adopted by the Board on March 6, 2013*

A licensed dentist may use botulinum toxins and/or dermal fillers with patients so long as it is part of the delivery of the patient's comprehensive dental treatment plan; is limited to the practice of dentistry; and the dentist holds ADA Board Certification in Oral and Maxillofacial Surgery or the dentist has successfully completed training of a minimum of eight (8) hours in administration of botulinum toxins and/or eight (8) hours in administration of dermal fillers that includes instruction in the anatomy of head and neck, neurophysiology, patient selection, pharmacological effects and contraindications, management of complications, informed consent, and hands-on training on the administration of such agents. The training must be accredited by the American Dental Association's Continuing Education Recognition Program (CERP), the Academy of General Dentistry's Program Approval for Continuing Education (PACE) or other nationally-recognized and accredited entity approved by the Board.

Compliance with the provisions and includes but is not limited to:

- i. obtaining the patient's medical and dental history;
- ii. conducting a clinical exam; and
- iii. obtaining specific informed consent before botulinum toxins and/or dermal fillers is administered.

C. Post-Graduate Year 1 (PGY-1) Workgroup

At the direction of the Board a workgroup was formed this summer to review legislation that has been filed at the Massachusetts Senate and House of Representatives creating an alternate path to licensure for dentists in the Commonwealth. The legislation, if passed, would permit dentists to become licensed to practice dentistry by demonstrating "proof of having successfully completed not less than one year of graduate dental training as a resident dentist in a PGY-1 program or other program accredited by the Commission on Dental Accreditation; provided, that at the end of such year of graduate dental training as a resident dentist, the supervising dentist provides documentation satisfactory to the board attesting to the resident's competency in all areas tested on the practical examination."

The workgroup is comprised of Board members, Board staff and the deans of the three dental schools located in the Commonwealth. The workgroup is currently reviewing the language of the proposed legislation and the regulations of other states, i.e. Connecticut, New York, Delaware, Minnesota and California, where some form of the post-graduate program currently exists.

#### D. Infection Control/Compliance Workgroup

At the direction of the Board a workgroup was formed this summer to review the policies and procedures currently in place with regards to site inspections conducted by the Office of Public Protection upon the filing of a complaint against a licensee.

The workgroup is comprised of Board members, Board staff and representatives from the dental profession, dental academia, CDC/OHSA and the Boston Public Health Commission. The workgroup is reviewing the inspection form currently used by the Board's dental investigators with an eye to revising and simplifying the process. Once the revised form is finalized by the workgroup and adopted by the Board, it will be posted on the Board's website for review by members of the dental profession and the public.

#### E. Open Meeting Law

The Massachusetts Legislature passed the Open Meeting Law, M.G.L. c. 30A, §§18-25, effective July 1, 2010, directing that all meetings of public bodies, such as the Board of Registration in Dentistry, shall be conducted in compliance with all requirements of the law.

In effect, this law has caused the Board to be cognizant of their responsibilities to the public by ensuring that all meetings are conducted only when the statutory quorum requirement is met and that all deliberations are conducted in public, as appropriate, and recorded for public review.

### **IV. BOARD MEMBER/STAFF CHANGES**

- A. Two new Board members were approved and sworn in by Governor Deval Patrick during the summer. Dr. David Samuels, a practicing periodontist and Ms. Jacyn Stultz, RDH, a dental hygiene faculty member of Mt. Ida College joined the Board and began serving their first five-year term.
- B. A new Executive Director, Barbara A. Young, RDH, began in July 2013.
- C. One remaining Board member position remains unfilled, the voting dental assistant member, but a nominee is currently being reviewed by the Governor and will join the Board this fall.

### **V. DENTAL ASSISTANT LICENSURE**

The final version of the proposed regulations for dental assistant licensure was submitted to the Mass. Executive Office of Health and Human Services and the Governor's office for approval in October 2013. Once approved, the regulations will be presented to Board for promulgation at its November 2013 meeting. It is expected that:

- A. An estimated 16,000 dental assistants will begin applying online in early 2014

- B. All dental assistants will be required to register including on-the-job-trained (OJT's), formally-educated, DANB-certified and expanded function dental assistants.
- C. Formal training or certification will not be required for licensure.
- D. Standards for dental assistant training and education are included.
- E. Standards for yearly dental assistant continuing education requirements, i.e. BLS/CPR certification, are also included.



STATE OF MICHIGAN  
 DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
 BUREAU OF HEALTH CARE SERVICES

RICK SNYDER  
 GOVERNOR

STEVE ARWOOD  
 DIRECTOR

September 27, 2013

Dr. Mark Christensen, President-Elect  
 American Association of Dental Boards  
 211 E. Chicago Ave.; Suite 760  
 Chicago, IL 60611

Dear Dr. Christensen

I am submitting the following summary for the **Michigan Board of Dentistry**, so that you may include this information in your AADB Annual Meeting Open Forum.

**Legislation:**

HB 4865 – Introduced on June 20, 2013 – Referred to the Committee on Health Policy. The bill would allow dental services in a mobile dental facility. Amends 1978 PA 368 (MCL 333.1101 - 333.25211) by adding Part 216.

**Administrative Rules:**

Draft administrative rules have been written and will be taken to a public hearing soon. The proposed rules will:

- Clarify the continuing education requirements for an applicant renewing a special retired volunteer dentist license.
- Remove the limitation on the amount of fines the Board can assess, and rely instead upon the limitations contained in the Public Health Code.
- Expand assignment of intra-oral procedures to RDAs.
- Clarify what must be included in dental records.
- Eliminate and replace the specialty license state-administered exam for oral and maxillofacial surgeons.
- Allow a prosthodontist to become licensed upon completion of only the written portion of the American Board of Prosthodontists (rather than requiring passage of the written and clinical).
- Eliminate the written portion of the state administered examination for the endodontist specialty license.

**Disciplinary Actions (9/1/12 to 8/31/13):**

<u>Action</u>	<u>Number of licensees</u>
Fine imposed	4
Limited/restricted	1
Probation	41
Reprimanded	2
Revoked	1
Suspended	14
Voluntarily surrendered	<u>12</u>
<b>Total</b>	<b>75</b>

Sincerely,

Norene Lind, Board Manager  
 LARA – Bureau of Health Care Services  
 PO Box 30670  
 Lansing, MI 48909



Jeremiah W. (Jay) Nixon  
Governor  
State of Missouri

Jane A. Rackers, Division Director  
DIVISION OF PROFESSIONAL REGISTRATION

Department of Insurance  
Financial Institutions  
and Professional Registration  
John M. Huff, Director

MISSOURI DENTAL BOARD  
3605 Missouri Boulevard  
P.O. Box 1367  
Jefferson City, MO 65102-1367  
573-751-0040  
573-751-8216 FAX  
800-735-2966 TTY  
800-735-2466 Voice Relay Missouri  
dental@pr.mo.gov  
<http://www.pr.mo.gov>

Brian Barnett  
Executive Director

## **2013 Missouri Dental Board Report**

### Rule Changes

- In February 2013, changes became effective to the Board's sedation rules. Some of the changes include requiring additional training for sedation team members responsible for monitoring sedated patients, clarifying and adding additional training requirements for licensees applying for sedation permits and creating a specific permit with specific training requirements for licensees wishing to sedate pediatric patients.
- Also in February 2013, rule changes enabling the Board to issue expanded function permits to dental assistants and dental hygienists became effective.
- In August 2013, a rule change became effective enabling the Board to require remediation for an applicant for licensure who fails a clinical competency exam twice. This rule change also enables the Board to deny the application if an applicant fails a clinical competency exam three times.

### Legislation

- No legislation having a significant or apparent impact on the Board passed in the most recent legislative session.

### Proposed Rule Changes

- The Board has not proposed any additional rule changes at this time.

### Changes in Board Members/Board Staff

- No new appointments have been made to the Board in the past year. The Board still has one dentist member position vacant.

October 21, 2013

To: Dr. Mark Christensen  
From: Montana Board of Dentistry  
Date: October 21, 2013  
Ref: Board Report to AADB

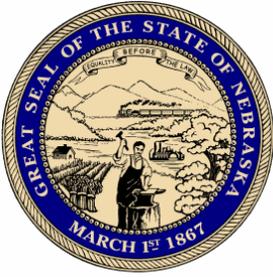
AADB:

The Montana Board of Dentistry (BOD) makes the following report to the AADB 2013 meeting.

- The Board has implemented 2 new standing committees: Dental Hygiene and Denturity Committee. Any issues concerning hygiene or denturity are referred to these committees, issues are discussed, and then the committee reports back to the full board. The board then acts on that issue.
- A primary issue is to allow denturist to place removable partial dentures over implants. That issue is still in committee and no action has taken place.
- The Montana Prescription Drug Registry has been fully implemented and is up and running at this time. Health care providers may contact the MPDR to help determine potential drug seekers.
- The BOD has a standing and very active anesthesia committee. Recently we have updated rules for mild, moderate, and deep sedation/general anesthesia. They are also addressing the inspection process for those offices offering sedation services.

Respectfully submitted,

Dale R. Chamberlain D.D.S.



## State of Nebraska Board of Dentistry

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### **Dental**

The Board of Dentistry has begun the process of changing the Anesthesia Sedation Statutes. Prior to reaching the State Legislators the changes will be reviewed by a Technical Committee, the State Board of Health and the Director of the Division of Public Health Department of Health and Human Services. Each group will determine if the proposed changes will improve the protection of the public when it comes to Anesthesia Sedation in Dentistry.

### **Hygiene**

On September 6, 2013 a new law for a Public Health Supervision Permit became effective for Dental Hygiene.

A Hygienist qualifies for a permit if he/she can provide the following: Hold a current Nebraska dental hygiene license, Provide a letter from his/her employer verifying that he/she has 3,000 hours of clinical experience in 4 of the preceding 5 calendar years and Carry professional liability coverage.

The following functions are allowed by a licensed hygienist: Oral prophylaxis for healthy children who do not require prophylactic antibiotic coverage (children only), Pulp vitality testing (children or adults), Application of fluorides (children or adults), Application of sealants and other topical agents for the prevention of oral disease (children or adults), Perform duties that any dental assistant is authorized to perform (children or adults)

### **Other Issues**

The Oral Health Task Force, separate from the Board of Dentistry, is working on a proposal for changing the levels of Dental Hygienists and Assistants in the State of Nebraska.

The proposed levels for Dental Hygienists are: Registered Dental Hygienist (RDH), Public Health Dental Hygienist (PHRDH) and Expanded Function Restorative Dental Hygienist (EFRDH).

Three tiers for Dental Assistants are being proposed: On the Job Trained, Licensed Dental Assistant

I'm aware that the date has past for submission of items for the AADB open forum, but I am sending a short update in the event that all materials have not been processed.

The state of Nevada dental hygienists association had a busy legislative year. There were several items on the agenda that they brought forth to add or change state regulations. The only successful item was a statutory change to NRS 631.287, Special Endorsement of licensee to practice Public Health Dental Hygiene.

An act: Relating to dental hygienists; exempting certain programs that provide public health dental hygiene from requirements relating to supervision by a licensed dentist; authorizing dental hygienists who are authorized to practice public health dental hygiene to perform procedures without the authorization or supervision of a licensed dentist as specified by regulations adopted by the Board of Dental Examiners of Nevada; and providing other matters properly relating thereto.

The statute was amended by adding the following section: The provisions of NRS 631.3452 requiring the designation of an actively licensed dentist as a dental director do not apply to a program for the provision of public health dental hygiene if:

1. The program is owned or operated by a dental hygienist who holds a special endorsement of his or her license to practice public health dental hygiene pursuant to NRS 631.287; and
2. Each dental hygienist employed to provide public health dental hygiene pursuant to the program holds a special endorsement of his or her license to practice public health dental hygiene pursuant to NRS 631.287.

There were some other small changes made within the statute but the above was the major amendment noted.

The state had only one disciplinary action involving a dental hygienist in 2012.

Sincerely,  
Theresa Guillen, RDH  
Nevada State Board of Dental Examiners

## New Mexico Board of Dental Health Care

### AADB Summary of 2012-2013

This year the NM Board of Dental Health Care participated in multiple rules changes and followed several legislative mandates to institute ground breaking changes for health care professionals in our state. We also experienced challenges regarding dental scope of practice with a Dental Therapist bill attempting to collaborate dental hygienists with an advocacy group to create a new mid-level dental provider in New Mexico.

Below is a summary of the changes/challenges for the past year:

- 1) New section to rules, "Adjunctive Dental Functions", Title 16, Chapter 5, Part 14, describes that the Dental Board does not issue permits for the administration of **Botox or dermal fillers**, but requirements were brought forth including setting a minimum of 16 hours of continuing education (CE), established standards of care for training and practice, and restricted delegating the injectables to hygienists or assistants.
- 2) Pursuant to the NM Pain Relief Act 2013, new section to rules, "Management of Pain with Controlled Substances," Title 16, Chapter 5, Part 57, describes guidelines for dentists to follow in **administering pain medication**, requires all dentists registered by the Federal DEA and the NM Board of Pharmacy to register in the Prescription Monitoring Program (PMP) for inquiry and reporting. CE requirements were set at 3 hours per triennial period for dentists relating to the problems of abuse, prescriptive responsibility, and basic pharmacology and management of pain medications.
- 3) Addition to current section, an RDH may administer **local anesthesia** under General Supervision, provided they have administered local anesthesia for at least 20 cases under indirect supervision of the same dentist during a two year period, and have a signed affidavit by the supervising dentist.
- 4) The Board decided to take "no action" on a request by the American Academy of Sleep Medicine to limit dentist's scope of practice on diagnosis and treatment of **sleep apnea**. Our Board agreed that dentists with the proper training are within their scope of practice to treat sleep apnea after a medical doctor establishes the diagnosis of sleep apnea or hypopnea.
- 5) The Board took a position on **dental whitening** that only licensed/certified/supervised dental professionals shall be permitted to work intra-orally to administer whitening materials. The Board's opinion is that non-dental professionals working in this capacity create a public safety issue when violations of OSHA, universal precautions, and chemical exposure can occur without proper monitoring.

On the agenda to approve in October 2013:

6. Addition to current section or new section, **laser treatment in periodontal** therapy is restricted to dentists and hygienists with proper CE and safety protocols. Guidelines for training and CE were established. Delegation to an assistant was prohibited.
7. Pursuant to the Dental Amalgam Act 2013, all NM dentists must comply with the law by the utilization of **amalgam separators** in their practices. A specific question on the triennial renewal application will address the compliance by self-report. Disciplinary actions will be enforced by the Dental Board in the event of a complaint.

Dental Therapist Bill: Health Action New Mexico (HANM, supported by grants from the Kellogg Foundation) continued their push for a new workforce model, mid-level dental provider. They had unsuccessfully lobbied in 2011 for a dental therapist based on the 2 year Alaska model, but brought the idea back for the 2013 session. HANM completely scrapped their long held Alaska 2-year model in favor of a "dental therapist hygienist" model (hygienist degree plus one year of therapy school). The bill was eventually defeated, but concerns regarding their return next year exist and efforts to repair the dentist-hygiene relationship continue.

## **Open Forum, AADB Meeting Report for NEW YORK STATE 2014**

### **LEGISLATIVE AND REGULATORY ITEMS INTRODUCED / IN PROGRESS**

- **A7866 / S5757** Signed into Law July 31, 2013; effective January 1, 2015. Allows Dental Hygienists to work within a Collaborative Practice Agreement with a Dentist in an Article 28 facility (diagnostic and treatment center).
  - **A2719 / S2190** Expands the Doctors Across New York program to include dentists.
  - **A05362 / S1918** This bill would amend the definition of the scope of practice of dentistry to authorize certain dentists who are qualified and certified to perform any procedure in the oral and maxillofacial area; and to amend the public health law and the civil practice law and rules, in relation to the discipline and liability of dentists who are so qualified and certified.
  - **A2932** An act to amend the public health law, in relation to prohibiting the use of live human subjects on the dental licensing examination. To require that the use of live human subjects on the state dental licensing examination, if continued, be subject to the provisions of the public health law.
  - **A1488 / S1945** Authorizes school district property to be used for not-for-profit dental clinics providing care to families in the district upon the approval of the trustees or board of education of a school district.
- 
- Chapter 281 of the laws of 2007, were amended in the 2013/2014 Governors Budget Bill to allow Dental Hygienists to perform and sign off on oral health assessments for the School Dental Health Certificates.
  - Revisions to the New York States Dental Anesthesia Regulations have been submitted to the State Education Department's Office of Counsel for review. The proposed changes will update terminology, in order to be consistent with the American Dental Association's terminology, and will revise existing anesthesia licensure requirements.
  - Effective August 27, 2013, most prescribers are now required to consult the Prescription Monitoring Program (PMP) registry when writing prescriptions for Schedule II, III, and IV controlled substances. The PMP registry allows practitioners to review their patients' recent controlled substance prescription history, at any time, to better evaluate a patient's treatment as it pertains to controlled substance prescribing.

## **Oklahoma Report**

The Oklahoma Board of Dentistry introduced and passed legislation in the 2013 legislative session. The Oklahoma Board of Dentistry is one of the few Boards that is not under Sunset Review so there have been no demands to change the law or the way the Board operates. However, this year, the Board took a proactive approach and looked at many areas of the Dental Act. The final language did not have the sweeping changes that the Board had hoped for but it was a beginning. The next step is to write rules for the new Dental Act.

Prior to the new legislation, a dentist could only employ the equivalent of two full time hygienists. The new language changed that number to three. Most states have no limitation on the number of dental hygienists that a dentist may employ so the hygienists and dentists were happy to be achieve this small change. Now they will watch the rule making process so that it does not take away the advances the new law has made.

The legislation also created a new type of dental assistant who may work only in the office of an oral surgeon. One of the rules being proposed will allow this assistant to be trained to insert an I.V. as well as other expanded duties. A dental hygienist by law, may do all of the duties of a dental assistant, therefore, these expanded duties will be open to dental hygienists as well.

**The Oklahoma Dental Hygienists' Association** introduced legislation in 2012 to place additional dental hygienists on the Board of Dentistry. The current make up of the Board is 8 dentists, 2 public members and one dental hygienist. There are approximately 2000 dental hygienists and 2000 dentists licensed in Oklahoma. There is a large workload for one hygiene member considering they are involved with clinical regional testing for dental hygiene as well as all of the business of the Board and the business that is particular to dental hygienists. The bill remained in Committee. The discussion with ODHA, the Dental Board and the Dental Hygiene Advisory Committee continues.

A case dealing with infractions of the Dental Act by an Oklahoma dentist lent credence to the necessity to register all dental assistants and anyone involved in direct patient care. The new law requires all dental assistants to register with the Board. Rules for the dental assistants' section are currently being written and should include mandatory continuing education, including infection control and jurisprudence. Only assistants with expanded duty permits had been registered previously.

Angela Craig, RDH, BSDH  
Oklahoma Board of Dentistry Member





# Oregon

John A. Kitzhaber, MD, Governor

**Board of Dentistry**  
1600 SW 4th Ave. Suite 770  
Portland, OR 97201-5519  
(971) 673-3200  
Fax: (971) 673-3202  
[www.oregon.gov/dentistry](http://www.oregon.gov/dentistry)

October 25, 2013

To: James Tarrant, Executive Director  
American Association of Dental Boards

From: Patrick D. Braatz, Executive Director

Re: 2013 ANNUAL REPORT TO THE AADB

## COMPLAINTS/DISCIPLINE

7/1/2012 – 6/30/13 216 Cases Opened, 195 Cases closed, 49 Disciplinary Orders Issued, 33 Letters of Concern, 66 cases closed for No Violation and 51 cases closed for No Further Action.

## LEGISLATIVE CHANGES

The Oregon Legislature in 2013 passed a number of Bills that have impact on the profession of Dentistry as well as the Oregon Board of Dentistry. One piece of legislation would create a new way to resolve potential consumer malpractice issues by using a new medication process that the results would not be reportable to the licensing board. A piece of legislation promoted by the Oregon Dental Association will allow the OBD to issue temporary licenses to dentists licensed in another country for educational purposes only. Require the OBD under special circumstances issue licenses to spouses of members of the armed forces.

## RULE CHANGES

The Board made a number of changes to its rules since the last meeting of the AADB. The following is a brief synopsis of those changes:

### Anesthesia

The Board adopted rules prohibiting a licensee who does not have a Moderate, Deep or General Anesthesia Permit from administering for anxiolysis or sedation Benzodiazepines or narcotics in children under 6 years of age.

Require End-tidal CO2 monitors when administering Moderate Sedation. Require End-Tidal CO2 monitors and Electrocardiograph monitors for Deep and General Anesthesia Sedation.

### Dental Hygiene

The Board adopted major changes regarding the timing of dental hygiene services as well as additional population groups that can be treated by Expanded Practice Permit (EPP) Dental Hygienists.

### Dental Assistants

The Board adopted allowing for digital radiographs to be part of the radiographic proficiency examination.



**Botulinum Toxin Type A (Botox)**

The Board adopted rules allowing all dentists to treat a condition that is within the scope of dentistry after completing 16 hours of hands on clinical course(s) in courses that have providers approved by the AGD PACE or the ADA CERP.

**Infection Control Guidelines**

The Board adopted rules requiring licensee to keep biological monitoring test results for current calendar year and two proceeding calendar years.

**DR. MARVIN C. KASTROP**

President  
3122 Ben Hogan Pl  
Billings, MT 59106

**DR. PAUL T. CASTEILEIN**

President-Elect  
129 North Main Street  
Princeton, IL 61356

**DR. ELADIO DELEON, JR.**

Secretary/Treasurer  
Georgia Regents University  
CDM Department of Orthodontics  
1120 15<sup>th</sup> Street, Augusta, GA 30912

**DR. STEVEN A. DUGONI**

Director  
1131 Mission Road  
South San Francisco, CA 94080

**DR. CHUN-HSI CHUNG**

Director  
University of Pennsylvania  
Department of Orthodontics  
240 S. 40<sup>th</sup> St., Philadelphia, PA 19104



**The American Board of Orthodontics**

CREATED BY THE AMERICAN SOCIETY OF ORTHODONTISTS, 1929

*The only orthodontic specialty board recognized by the American Dental Association and sponsored by the American Association of Orthodontists*

**DR. LARRY P. TADLOCK**

Director  
601 S. Main Street, Suite 240  
Keller, TX 76248

**DR. NICHOLAS D. BARONE**

Director  
1804 Mineral Spring Avenue  
North Providence, RI 02904

**DR. VALMY P. KULBERSH**

Director  
5555 Metro Parkway, Ste. 200  
Sterling Heights, MI 48310

**DR. SCOTT A. JAMIESON**

Immediate Past-President  
1029 Lincoln Avenue  
Marquette, MI 49855

**CHRISTINE L. EISENMAYER**

Executive Secretary  
401 N. Lindbergh Blvd., Ste. 300  
St. Louis, MO 63141-7839

Dear Dr. Mark Christensen,

Re: Request report to AADB from Specialty Boards

The American Board of Orthodontics (ABO) has made the premier pathway to board certification the Initial Certification Examination (ICE). Presently there are two ways to achieve board certification in the specialty of orthodontics, Beginning Certification Examination (BGCE) or ICE. Both require a written examination (given at Pearson Vue centers) and a clinical examination. The clinical examination (given in St. Louis at the ABO testing center) is a six case presentation, requiring specific types of malocclusions, which the examinee has treated with initial records prior to treatment and final records after completion of treatment. The cases are graded to a calibrated score by examiners. Another part of the examination is a board case oral exam where the examinee has to diagnosis and treatment plan. The third part of the clinical examination is an oral exam over the six cases the examinee treated. ICE examinees bring cases from their orthodontic program that they have treated with supervision. BGCE examinees bring cases from their orthodontic practice. After a successful examination, the board certified orthodontist is awarded a ten year certification. Every ten years the board certified orthodontist must be re-examined to maintain board certification. The first recertification examination requires three cases that must have been treated within the ten year time frame.

Technology has become a huge influence on our testing. The ABO is accepting electronic case submission with digital models, and CBCT scans which appeal to the younger orthodontists.

The primary purpose of the ABO is to elevate the level of orthodontic care for the public by encouraging excellence in clinical practice and specialty education. In its mission statement, the Board clearly defines four objectives: 1) to evaluate the knowledge and clinical skills of graduates of accredited orthodontic programs by conducting exams and conferring time-limited certificates; 2) to re-evaluate clinical knowledge and skills through administration of recertification exams throughout a Diplomates career; 3) to support the development of quality graduate, postgraduate and continuing education programs in orthodontics; and 4) to promote and encourage certification expertise throughout the world.

Regards,

Marvin "Buddy" Kastrop, D.D.S., M.S.

Nicholas D. Barone, D.D.S.

The Pennsylvania State Board of Dentistry welcomes the opportunity to present recent initiatives to the American Association of Dental Boards.

Regarding Botox and dermal fillers: The Board proposed publication of a policy statement that recognizes the use of dermal fillers and botulism toxin products (Botox) to treat areas around the mouth, jaws and associated structures as the “Practice of Dentistry” defined in the Dental Practice Act. The Board received negative public comments on the draft policy statement from the Robert H. Ivy Society of Plastic Surgeons, Pennsylvania Academy of Otolaryngology, and the Pennsylvania Medical Society. C. Richard Schott, MD, President of the Pennsylvania Medical Society, signed the letter to the board stating that, “Training and educational differences between medical and dental students differ vastly demonstrating that a general dentist is not conversant with the detailed principles of pharmacology and therapeutics...”

Regarding clinical periodontal testing requirement: The ADEX licensing examination, administered by NERB, now allows candidates to opt out of the clinical periodontal exercise. While the Board recognizes the value of periodontal therapy as a core skill in the practice of general dentistry, the Dental Practice Act merely requires “examination” as a condition of licensure. Individual skill sets are not detailed. Therefore, the Board determined that absent a regulatory change, the examination as administered by NERB is acceptable, and the clinical periodontal exercise is not required for licensure in Pennsylvania, at this time.

Regarding Scope of Practice for Public Health Dental Hygienist (PHDH): The Board declined to support a legislative initiative to expand the PHDH scope of practice to include direct supervisory authority.

*Plantation Pointe Dentistry*  
Cosmetic and General Dentistry

[www.plantationpointedental.com](http://www.plantationpointedental.com)

Charles F. Wade, D.M.D.

Mr. Kapp,

South Carolina is in the process of evaluating and revising our current laws regarding sedation in dentistry. Our State Board has reviewed legislation from other states and through an appointed committee is in the process of drafting sedation legislation for dentistry in our state. The committee received input from the South Carolina Dental Association, the Oral Surgeons Association, the Pedodontic and Periodontic Associations, and the South Carolina Academy of General Dentistry.

The Governor asked for all South Carolina agencies to establish a taskforce review to see if there were any procedures or functions that were impediments to businesses in the state. A possible fee change is being proposed by labor, licensing and regulation agency.

Sincerely,



Charles F. Wade, D.M.D.  
S. C. State Board President

The Texas Legislature in its 83rd Legislative Session enacted House Bill 3201, which will allow the Texas State Board of Dental Examiners to be more effective in overseeing the practice of dentistry by increasing efficiencies in the complaint process and providing needed funding for expert reviewers. Additionally, the bill increases parental rights for pediatric dental care and allows the board to collect certain information related to dental offices and dental service organizations.

### **Expert Review Panel**

The bill requires that the board utilize a panel of experts to review all standard of care complaints. Each complaint will be reviewed by at least two experts to determine whether the alleged acts of the dentist were below the standard of care.

### **Remedial Plan**

The bill authorizes the board to settle a complaint in a manner other than a dismissal or disciplinary action. The new Remedial Plan allows the board to take corrective action in cases where disciplinary action is not appropriate.

### **Investigation Efficiencies**

The bill requires that the board complete an initial inquiry into the complaint within sixty days and requires that notice of intent to take disciplinary action be given to licensees at least forty-five days in advance of the settlement conference.

### **Investigative Confidentiality**

The bill increases confidentiality of investigative files.

### **Collection of Information Related to Dental Service Organizations**

The bill requires the board to collect certain information from dentists related to ownership and agreements with Dental Service Organizations and information related to practice ownership, dentist employees and Medicaid participation.

### **Board Member Testimony**

The bill limits when a current board member can testify in a civil case.

### **Parental Rights**

The bill requires that a dentist allow the presence of a parent during the treatment of a child.

The Virginia Board of Dentistry does not have any new actions or activities to report for the Forum.



**STATE OF WASHINGTON**  
**DEPARTMENT OF HEALTH**  
**DENTAL QUALITY ASSURANCE COMMISSION**  
**2013 REPORT**

**LEGISLATION**

House Bill 1330, Dental Hygienists and Dental Assistants passed during the 2013 legislative session. The bill allows application of topical anesthetics for both dental hygienists, dental assistants, and expanded function dental auxiliaries under appropriate dentist supervision. The bill creates new practice setting/location for dental hygienists to provide services to homebound patients under general supervision of a dentist. The Dental Quality Assurance Commission will evaluate rule modification for WAC 246-817-550.

House Bill 1534, Dentist Impaired Practitioner Surcharge passed during the 2013 legislative session. The bill increases the dentists surcharge from \$25 to \$50. The increased fee is paid to the Washington Physicians Health Program (WPHP) to continue to provide services to impaired dentists. The Secretary is currently drafting rules for adoption.

Second Substitute Senate Bill 5620, Dental anesthesia assistant certification passed during the 2012 legislative session. The bill created certification of dental anesthesia assistants. Dental Anesthesia assistants will work under close and direct visual supervision of an oral and maxillofacial surgeon or a dental anesthesiologist. The Dental Quality Assurance Commission adopted rules to implement the new credential. Certification should begin in August 2013.

The 2012 Legislature passed Senate Bill 6290, Concerning military spouses or registered domestic partners occupational licensing status during deployment or placement outside Washington. The law created an inactive military status for spouses or registered domestic partners. The Secretary is currently drafting rules for adoption.

The 2011 Special legislative session passed Senate Bill 5969, Concerning the establishment of procedures for the professional licensing of military spouses after relocation to Washington for all professions passed. WAC 246-12-051 became effective December 28, 2012.

**RULEMAKING**

The rule moratorium ended December 31, 2012. The commission identified multiple rules for potential modification and prioritized them. The commission determined to continue rule

modifications for WAC 246-817-310, Maintenance and Retention of Records - provides licensed dentists with requirements for maintaining and retaining dental records. The commission identified the need to provide clarity in what should be contained in dental records. Treatment record requirements are necessary to evaluate standard of care for treatment provided.

The commission appreciates and encourages the participation of stakeholders in the rulemaking process.

## **ONGOING ACTIVITIES**

The Commission created the Educational Outreach Committee to recommend creative methods to communicate with practitioners and other stakeholders. The committee created and published a newsletter with three publications per year.

The Dental Corporate Practice Committee continues to meet to evaluate laws and practices of corporate/group dental clinics.

Washington State dentists continue to participate in several regional and national dental organizations.

- Dr. Paul Bryan is the representative for Western Regional Examining Board (WREB).
- The Western Conference on Licensure and Education (WCONF) is currently not meeting.
- Dr. John Carbery is the representative for American Association of Dental Boards (AADB).
- Dr. LouAnn Mercier is the representative for Central Regional Dental Testing Services (CRDTS).

## **OTHER**

The commission is finalizing an interpretive statement on the use of botulinum toxin injections and dermal fillers by dentists.

The use of botulinum toxin injections or dermal fillers in the soft tissues throughout the face can be within the scope of practice of a dentist licensed under chapter 18.32 RCW when:

- Used to treat functional or esthetic dental conditions and their direct esthetic consequences, and
- The treating dentist has appropriate, verifiable training and experience.

The use of botulinum toxin injections or dermal fillers outside the treatment of dental related conditions for purely cosmetic purposes is not within the scope of practice of dentists not

specialty trained as an oral and maxillofacial surgeon.

The Department of Health is currently evaluating a fee reduction for dentists. A preliminary positive fund balance for May 31, 2013 of \$3,702,490 from a beginning balance of \$658,268 on July 1, 2011. The Comprehensive Annual Financial Report publishes the state annual fund balances in late October.

As of June 19, 2013 there are 5,952 active dentists, 100 moderate sedation permits, 248 moderate sedation with parenteral agent permits, 191 general anesthesia permits, 12,598 active registered dental assistants, and 186 active expanded function dental auxiliaries (EFDAs). There are currently five EFDA education programs approved by the commission. Approved programs can be located on the department's website at

<http://www.doh.wa.gov/LicensesPermitsandCertificates/ProfessionsNewReneworUpdate/Dentist/SchoolApproval/ApprovedEducationPrograms.aspx>

Disciplinary statistics for fiscal year (FY) 2011 and 2012, dentists, expanded function dental auxiliaries, and dental assistants combined. Fiscal year 2013 statistics are not available until August 2013.

<u>FY 2011</u>		<u>FY 2012</u>	
Complaints received	583	Complaints received	650
Investigations authorized	341	Investigations authorized	387
Informal Discipline issued	29	Informal Discipline issued	31
Agreed Orders issued	16	Agreed Orders issued	18
Final Orders issued	6	Final Orders issued	7

Interested Parties e-mail notification system. Every dentist and dental professional in the state is encouraged to keep up to date with commission activities by signing up for the dental listserv. Listserv may be accessed at [www.listserv.wa.gov](http://www.listserv.wa.gov)

Continued recruitment for DQAC member positions. Dentists interested in appointment to the Dental Quality Assurance Commission may obtain an application online or directly from the Office of the Governor or the Department of Health. Positions are open for consideration each year prior to June 30th. <http://www.governor.wa.gov/boards/application/application.asp>

West Virginia Board of Dentistry AADB Open Forum information:

- 1) The new anesthesia law went into effect this year with the passage of the revised Dental Practice Act. One new provision calls for dentists with Class 2 anesthesia permits (anxiolysis) to have a defibrillator in their offices. Previously only dentists with general anesthesia and conscious sedation permits were required to have defibrillators.
- 2) All levels of anesthesia provided have the requirement for 'qualified monitors' and training requirements have been changed and updated.
- 3) The Board is proposing a new rule giving it authority to regulate mobile clinics and portable dental units. Mobile clinics have been drawing a great deal of attention recently, in part because of questions concerning their cleanliness, handling of instruments, x-ray machine calibration, and other clinical factors
- 4) Other rules proposed are requiring a written examination for orthodontic specialty certification, and adding the specialty of oral and maxillofacial radiology.
- 5) Dentists are now required to register and access the Controlled Substances Monitoring Program. Dentists are now required to take continuing education on 'best practices prescribing' and 'drug diversion training'. These requirements passed during the last session of the legislature.
- 6) The West Virginia Board of Dental Examiners is now officially the West Virginia Board of Dentistry

# WYOMING

## BOARD OF DENTAL EXAMINERS

2001 Capitol Avenue, Emerson Building, Room 104 ♦ Cheyenne WY 82002 ♦ (307) 777-7387 ♦ Fax: (307) 777-3508  
<http://plboards.state.wy.us/dental>

### AADB Open Forum Report

#### Wyoming Board of Dental Examiners

##### Legislation Issues:

Defeated a bill relating to Military Service Members and a companion bill related to Military spouses.

##### Dental Practice Act Issues:

Revised a chapter relating to Dental Axillaries, also including the use of lasers by Hygienists.

Currently working on a revision draft relating to Anesthesia administration.

Currently going through the entire Dental Practice Act to see if there are areas that need to be streamlined and clarified. This was a request from our Governor to all Professional Licensing Boards within the state.





## MINNESOTA BOARD OF DENTISTRY

University Park Plaza, 2829 University Avenue SE, Suite 450  
Minneapolis, MN 55414-3249 [www.dentalboard.state.mn.us](http://www.dentalboard.state.mn.us)  
Phone 612.617.2250 Fax 612.617.2260  
Toll Free 888.240.4762 (non-metro)  
MN Relay Service for Hearing Impaired 800.627.3529

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October 14, 2013

American Association of Dental Boards  
211 E Chicago Avenue, Suite 760  
Chicago, IL 60611  
Attn: Mark Christensen, Patrick Braatz

### **AADB OPEN FORUM 2013: MINNESOTA HIGHLIGHTS**

The **Minnesota Board of Dentistry** highlights for the past year have included:

- Successfully passed legislation requiring **criminal background checks** on all applicants for licensure (dental and other health professions). The background checks will begin in 2014.
- Minnesota has now issued **28 Dental Therapy licenses**; **3** of these dental professionals are also now certified as *Advanced Dental Therapists*.
- Since January, the Minnesota Board has been registering dental laboratories based in Minnesota, and requiring that for any lab cases *all* labs provide **comprehensive material content** and **place of origin** documentation for patient records. The registration does not include any direct regulatory authority, although dentists will be held accountable for compliance with use of appropriate labs and receipt of comprehensive material data and source disclosures for placement in patient records.
- New rules require that **radiographs** transferred to subsequent providers be of **diagnostic quality**... no more dark, blurry images that need to be retaken!

Handwritten signature of Neal U Benjamin in blue ink.

Neal U Benjamin, DDS  
President

Handwritten signature of Marshall Shragg in blue ink.

Marshall Shragg, MPH  
Executive Director



## State of Nebraska Board of Dentistry

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### **Dental**

The Board of Dentistry has begun the process of changing the Anesthesia Sedation Statutes. Prior to reaching the State Legislators the changes will be reviewed by a Technical Committee, the State Board of Health and the Director of the Division of Public Health Department of Health and Human Services. Each group will determine if the proposed changes will improve the protection of the public when it comes to Anesthesia Sedation in Dentistry.

**Hygiene** On September 6, 2013 a new law for a Public Health Supervision Permit became effective for Dental Hygiene. A Hygienist qualifies for a permit if he/she can provide the following: Hold a current Nebraska dental hygiene license, Provide a letter from his/her employer verifying that he/she has 3,000 hours of clinical experience in 4 of the preceding 5 calendar years and Carry professional liability coverage.

The following functions are allowed by a licensed hygienist: Oral prophylaxis for healthy children who do not require prophylactic antibiotic coverage (children only), Pulp vitality testing (children or adults), Application of fluorides (children or adults), Application of sealants and other topical agents for the prevention of oral disease (children or adults), Perform duties that any dental assistant is authorized to perform (children or adults)

### **Other Issues**

The Oral Health Task Force, separate from the Board of Dentistry, is working on a proposal for changing the levels of Dental Hygienists and Assistants in the State of Nebraska. The proposed levels for Dental Hygienists are: Registered Dental Hygienist (RDH), Public Health Dental Hygienist (PHRDH) and Expanded Function Restorative Dental Hygienist (EFRDH).

Three tiers for Dental Assistants are being proposed: On the Job Trained, Licensed Dental Assistant (LDA) and Expanded Function Dental Assistants (EFDA).

Respectfully Submitted,

Jane I. Lott, RDH, BS - Liaison for Nebraska

**STATEMENT OF NEED AND FISCAL IMPACT**

A Notice of Proposed Rulemaking Hearing or a Notice of Proposed Rulemaking accompanies this form.

Oregon Health Authority, Public Health Division

333

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Agency and Division  
Number

Administrative Rules Chapter

---

Patient notification by practitioners as required by the passage of SB 683 (2013)

Rule Caption

In the Matter of: Adopting Oregon Administrative Rules in chapter 333, division 072 relating to notice of patient choice and financial interest.

Statutory Authority: ORS 441.098, OL 2013, ch. 552

Other Authority:

Stats. Implemented: ORS 441.098

Need for the Rule(s):

The Oregon Health Authority, Public Health Division is proposing to adopt Oregon Administrative Rules relating to notice of patient choice and financial interest in response to the passage of SB 683 during the 2013 legislative session.

The Legislature delegated to the Oregon Health Authority rulemaking authority to implement SB 683's requirements for certain medical practitioners to provide notice of patient choice and notice of financial interest when making referrals for diagnostic tests, health care services or treatment.

The proposed rules provide for oral and written notice of patient choice and financial choice at designated times.

Implementation of the rules will ensure that health care consumers are aware of their rights to choose care providers and when their provider has a financial interest in a facility to which they are being referred.

Documents Relied Upon, and where they are available:

ORS 441.098: [https://www.oregonlegislature.gov/bills\\_laws/lawsstatutes/2011ors441.html](https://www.oregonlegislature.gov/bills_laws/lawsstatutes/2011ors441.html)

SB 683 (2013): <https://olis.leg.state.or.us/liz/2013R1/Measures/Text/SB683/Enrolled>

Fiscal and Economic Impact:

There will be a minimal fiscal impact to the Oregon Health Licensing Agency and the other boards responsible for enforcing these rules. There is no known fiscal impact to Oregon Health Authority or other agencies.

The Oregon Board of Medicine indicates that the use of physician notices similar to this is so common that no additional fiscal impact is anticipated for their licensees.

Statement of Cost of Compliance:

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

There is no known impact on state agencies, units of local government or the general public. According to the Oregon State Hospital, there is no impact due to existing specific and required referral policies for their patients.

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

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

According to the Oregon Health Licensing Agency there are an estimated 20 direct entry midwife and other midwife practices that may be considered small businesses. For the other provider types, the regulatory boards were unable to estimate the number of small business entities affected by this rule.

b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services:  
Health Practitioners may incur an initial cost to create a new form or to adapt current forms and adopt policies and procedures to comply with the rule. Integration into current practices may involve some costs for training and maintaining documentation of patient notification in practitioner records along with any existing patient notifications during referral.

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

The proposed rules are not expected to require any additional equipment, supplies, labor, or administrative costs, with the assumption that practitioner's already have basic business supplies.

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

A Rule Advisory Committee (RAC) was established and included representatives from the hospitals, Oregon Dental Association, Oregon Medical Association as well as representatives of affected practices, including Epic Imaging and Chehalem Physical Therapy Inc.

Administrative Rule Advisory Committee consulted?: Yes

Participants on the RAC included representatives from the Oregon Health Sciences University, Oregon Medical Association, Oregon Dental Association, Oregon Health Licensing Agency, Oregon Association for Hospitals and Health Systems, Oregon State Board of Nursing, Oregon Medical Board, Oregon Board of Medical Imaging, Providence Health System, Oregon Urology, Oregon Physical Therapists Association and from affected medical imaging and physical therapy providers.

---

Signature

Printed name

Date

**DRAFT DOCUMENT**  
**12/5/13**

**OREGON HEALTH AUTHORITY, PUBLIC HEALTH**  
**DIVISION**

**DIVISION 72**

**Health Care Practitioner Referrals**

**333-072-0200**

**Purpose**

The purpose of these rules is to establish notice requirements for patient choice and financial interest as required in ORS 441.098 when health practitioners refer patients for diagnostic testing or health treatment services.

**333-072-0205**

**Applicability**

These rules do not apply to a referral for a diagnostic test or health care treatment or service:

- (1) When a patient is receiving inpatient hospital services or emergency department services if the referral is for a diagnostic test or health care treatment or service to be provided while the patient is in the hospital or emergency department.
- (2) When a referral is made to a particular facility after the initial referral of the patient to that facility, when notice was provided at the initial referral in accordance with these rules.
- (3) When a patient has been directed or transferred to a facility for emergency department services.
- (4) When a patient is being directed back to the referring practitioner by the practitioner or facility who received the referral.

**333-072-0210**

**Definitions**

As used in 333-072-0200 through 333-072-0225 the following definitions apply:

(1) "Emergency department services" means services provided in the part of a licensed hospital facility open 24 hours a day to provide acute care treatment and services for a wide range of illnesses and injuries.

(2) "Facility" means a hospital, outpatient clinic owned by a hospital, ambulatory surgical center, freestanding birthing center as defined in ORS 442.015, or a facility that receives Medicare reimbursement as an independent diagnostic testing facility.

(3) "Financial interest" means the direct or indirect ownership interest of five percent or more held by a health practitioner or the practitioner's immediate family member.

(4) "Health practitioner":

(a) A physician, podiatric physician and surgeon, dentist, direct entry midwife, certified nurse practitioner, a licensed registered nurse who is certified by the Oregon State Board of Nursing as a nurse midwife nurse practitioner, licensed physician assistant or medical imaging licensee under ORS 688.405.

(b) Does not include a provider in health maintenance organizations as that term is defined in ORS 750.005.

(5) "Immediate family member" means a health practitioner's spouse, domestic partner, child, stepchild, mother, father or sibling.

(6) "Inpatient hospital services" means all medical and nursing services provided to persons who require 24-hour supervision because of acute or chronic medical or psychiatric illness.

(7) "Outpatient clinic owned by a hospital" means a satellite or mobile satellite indorsed under a hospital's license under OAR 333-500-0025.

(8) "Physician" has the meaning given that term in ORS 677.010.

(9) "Referral" means the direction of a patient to a facility for a diagnostic test or health care treatment or service.

### **333-072-0215**

#### **Requirements for notification of patient choice**

(1) A referral for a diagnostic test or health care treatment or service shall be based on the patient's clinical needs and personal health choices.

(2) A health practitioner shall not deny, limit or withdraw a referral solely because the patient chooses to have the diagnostic test or health care treatment or service at a facility other than the one recommended by the health practitioner.

(3) A health practitioner or the practitioner's designee shall provide notice of patient choice either every time the patient presents for treatment or at the time the referral is communicated to the patient.

(a) If notice will be provided every time the patient presents for treatment, notice of patient choice must be provided:

(i) Orally to all new patients at their first patient visit and to all current patients at a visit occurring within one year of the adoption of these rules; and

(ii) In writing each time a patient presents in person for treatment or services, regardless of whether the patient is subsequently referred. Such notice may be combined with other information routinely provided to patients.

(b) If notice will be provided at the time the referral is communicated to the patient, notice of patient choice must be provided:

(i) Both orally and in writing at the time of the initial referral; and

(ii) Either orally or in writing at the time of any subsequent referrals.

(c) If a referral is provided to a patient electronically or telephonically and the patient does not present for treatment in person or is not present at the time of the referral, the health practitioner or the practitioner's designee shall provide either written or oral notice to the patient at the same time the referral is communicated to the patient.

(4) The oral notice of patient choice shall clearly inform the patient:

(a) That when referred, a patient has a choice about where to receive services; and

(b) Where the patient can access the written notice containing more information about patient choice.

(5) The written notice of patient choice shall include language that clearly informs the patient that:

(a) The patient has a choice and when referred to a facility for a diagnostic test or health care treatment or service the patient may receive the diagnostic test or health care treatment or service at a facility other than the one recommended by the health practitioner;

(b) If the patient chooses to have the diagnostic test, health care treatment or service at a facility different from the one recommended by a practitioner, the patient is responsible for determining the extent of coverage or the limitation on coverage for the diagnostic test, health care treatment or service at the facility chosen by the patient.

(c) A health practitioner shall not deny, limit or withdraw a referral solely because the patient chooses to have the diagnostic test or health care treatment or service at a facility other than the one recommended by the health practitioner.

**333-072-0220**

**Requirement for notice of financial interest**

If a health practitioner refers a patient for a diagnostic test or health care treatment or service to a facility in which the health practitioner or an immediate family member has a financial interest of five percent or more, the practitioner or the practitioner's designee shall provide notice of that financial interest orally and in writing at the time of the referral.

### **333-072-0225**

#### **Violations and Enforcement**

(1) A health practitioner who fails to comply with these rules shall be subject to investigation and disciplinary action in accordance with ORS 441.098.

(2) When investigating an allegation that oral notice was not provided in accordance with ORS 441.098 and these rules, the Oregon Health Licensing Agency and a health professional regulatory board may:

(a) Review documentation of a health practitioner's policies and procedures for provision of oral notice and accept the policies and procedures as proof that oral notice was given in accordance with the policies.

(b) Rely on the practitioner's documentation of oral notice as proof that oral notice was given, if no policies or procedures exist.

DRAFT

**Board of Pharmacy  
Division 43  
Practitioner Dispensing**

Practitioner Dispensing Outlets

**855-043-0505**

Purpose and Scope

A practitioner who has been granted dispensing privileges from their licensing Board and dispenses from their practice site must register the dispensing site with the Board of Pharmacy (Board) as a Practitioner Dispensing Outlet (PDO).

Stat. Auth.: ORS 689.205

Stats. Implemented: ORS 689.155, 689.225, 689.305

Hist.:

**855-043-0510**

Registration

(1) A Practitioner who dispenses drugs must register their practice location with the Board as a PDO in the category of Retail Drug Outlet on a form provided by the Board, and must renew its registration annually on a renewal form provided by the Board.

(2) The initial application must state the location of the PDO and the name of the person applying for registration. When the person applying for registration is not the owner of the dispensing site, the application must disclose the name and address of the owner and the applicant's affiliation with the owner.

(a) If more than one individual owns the dispensing site, the names and addresses of the partners or persons holding the three largest ownership interests in the dispensing site must be disclosed on the application.

(b) If the owner is a corporation, the application must state the name of the corporation as filed with the Corporation Division of the Oregon Secretary of State, including the names of the corporation's officers.

(3) Upon request by the Board, the applicant must furnish such information as required by the Board regarding the partners, stockholders, or other persons not named in the application.

(4) An initial application must be accompanied by the fee established in Division 110 of OAR Chapter 855.

(5) A certificate of registration will be issued upon Board approval of the application.

(6) All registration renewal applications must be accompanied by the annual renewal fee established in Division 110 of OAR Chapter 855 and must contain the information required in sections (2) and (3) of this rule.

(7) The PDO registration expires March 31, annually. If the annual renewal fee referred to in section (6) of this rule is not paid by February 28 of the current year, the applicant for renewal must submit the delinquent fee established in Division 110 of OAR Chapter 855 with the renewal application.

(8) The registration is not transferable and the registration fee cannot be prorated.

(9) The registrant must notify the Board, within 15 days, of any substantial change to the information provided on the registration application. Substantial change shall include but not be limited to: change of ownership; change of business address; change of normal business hours; any disciplinary action taken or pending by any state or federal authority against the registrant, or any of its principals, owners, directors, officers, consultant pharmacist or supervising physician.

(10) A new registration form is required for a change of ownership or location and must be submitted to the Board with the fees as specified in Division 110 of OAR Chapter 855 within 15 days of the change.

Stat. Auth.: ORS 689.205

Stats. Implemented: ORS 689.155, 689.225, 689.305

Hist.:

855-043-0515

Policies and Procedures

The registered PDO must:

(1) Maintain written policies and procedures for drug management, including storage, security, integrity, access, dispensing, disposal, record keeping and accountability;

(2) Maintain all drug records required by federal and state law;

(3) Establish procedures for procurement of drugs; and

Stat. Auth.: ORS 689.205

Stats. Implemented: ORS 689.155, 689.225, 689.305

Hist.:

855-043-0520

Security

(1) All drugs must be kept in a locked drug cabinet or designated drug storage area that is sufficiently secure to deny access to unauthorized persons. The drug cabinet or designated drug storage area must remain locked and secured when not in use.

(2) No drug dispensing machine may be placed in a waiting room or an area that is accessible by the public.

Stat. Auth.: ORS 689.205

Stats. Implemented: ORS 689.155, 689.225, 689.305

Hist.:

855-043-0525

Storage of Drugs

All drugs, including drug samples, must be stored under conditions that ensure proper sanitation, temperature, light, ventilation, moisture control, and any other condition recommended by the manufacturer.

Stat. Auth.: ORS 689.205

Stats. Implemented: ORS 689.155, 689.225, 689.305

Hist.:

**855-043-0530**

**Labeling**

**(1) A prescription must be labeled with the following information:**

**(a) Unique identifier;**

**(b) Name of patient;**

**(c) Name of prescriber;**

**(d) Name, address, and phone number of the clinic;**

**(e) Date of dispensing;**

**(f) Name and strength of the drug. If the drug does not have a brand name, then the generic name of the drug and the drug manufacturer must be stated;**

**(g) Quantity dispensed;**

**(h) Directions for use;**

**(i) Initials of the dispensing practitioner;**

**(j) Cautionary statements, if any, as required by law; and**

**(k) Manufacturer's expiration date, or an earlier date if preferable, after which the patient should not use the drug; and**

**(l) Any dispensed prescription medication, other than those in unit dose or unit of use packaging, shall be labeled with its physical description, including any identification code that may appear on tablets and capsules.**

**(2) Notwithstanding any other requirements in this rule, when a drug is dispensed in the practice of an Expedited Partner Therapy treatment protocol, as described in OAR 855-041-4000 through 4005, the name of the patient may be omitted.**

**Stat. Auth.: ORS 689.205**

**Stats. Implemented: ORS 689.155, 689.225, 689.305**

**Hist.:**

**855-043-0535**

**Dispensing and Drug Delivery**

**(1) Drugs dispensed from PDO by a practitioner must be personally dispensed by the practitioner.**

**(2) Prior to dispensing a medication a drug utilization review must be performed by the practitioner which includes but is not limited to drug interactions, drug allergies and duplicate drug therapy.**

(3) The practitioner must orally counsel the patient concerning all new drugs, unless circumstances would render oral counseling ineffective.

(4) Any other requirement of State or federal law.

(5) A PDO must dispense a drug in a new container that complies with the current provisions of the Federal Consumer Packaging Act (Public Law 91-601, 91st Congress, S. 2162) and rules or regulations and with the current United States Pharmacopoeia/National Formulary monographs for preservation, packaging, storage and labeling.

(6) Drugs must be prepackaged by a pharmacy or manufacturer registered with the Board.

(7) A PDO may not accept the return of drugs from a previously dispensed prescription and must maintain a list of sites in Oregon where drugs may be disposed.

(8) Must have access to the most current issue of at least one pharmaceutical reference with current, properly filed supplements and updates appropriate to and based on the standards of practice for the setting.

Stat. Auth.: ORS 689.205

Stats. Implemented: ORS 689.155, 689.225, 689.305

Hist.:

#### 855-043-0540

##### Disposal of Drugs

Drugs that are outdated, damaged, deteriorated, misbranded, or adulterated must be documented, quarantined and physically separated from other drugs until they are destroyed or returned to their supplier.

Stat. Auth.: ORS 689.205

Stats. Implemented: ORS 689.155, 689.225, 689.305

Hist.:

#### 855-043-0545

##### Record Keeping

(1) A dispensing record must be maintained separately from the patient chart and kept for a minimum of three years. The record must show, at a minimum, the following:

(a) Name of patient;

(b) Unique identifier;

(c) Dose, dosage form, quantity dispensed and either the brand name of drug, or generic name and name of manufacturer or distributor;

(d) Directions for use;

(e) Date of dispensing; and

(f) Initials of person dispensing the prescription.

**(2) All records of receipt and disposal of drugs must be kept for a minimum of three years.**

**(3) All records required by these rules or by other State and federal law must be readily retrievable and available for inspection by the Board.**

**Stat. Auth.: ORS 689.205**

**Stats. Implemented: ORS 689.155, 689.225, 689.305**

**Hist.:**

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## Dentists - Dispensing Prescription Drugs

Healthcare

Design Survey | Collect Responses | Analyze Results

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### Response Summary

Need more responses?  
**Total Started Survey: 906**  
**Total Finished Survey: 891 (98.3%)**

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PAGE: 1

1. Are you currently practicing in Oregon?	Create Chart	Download
	Response Percent	Response Count
<b>Yes</b>	94.7%	818
<b>No</b>	5.3%	46
<b>answered question</b>		<b>864</b>
<b>skipped question</b>		<b>42</b>

[Show this Page Only](#)

PAGE: 2

2. Do you currently dispense prescriptions drugs from your dental office?	Create Chart	Download
	Response Percent	Response Count
<b>Yes</b>	42.0%	350
<b>No</b>	58.0%	483
<b>answered question</b>		<b>833</b>
<b>skipped question</b>		<b>73</b>

3. Do you dispense prescription drugs out of multiple dental offices?	Create Chart	Download
<b>answered question</b>		<b>835</b>
<b>skipped question</b>		<b>71</b>

3. Do you dispense prescription drugs out of multiple dental offices? [Create Chart](#) [Download](#)

	Response Percent	Response Count
<b>Yes</b>	5.6%	47
<b>No</b>	<b>94.4%</b>	<b>788</b>
<b>answered question</b>		<b>835</b>
<b>skipped question</b>		<b>71</b>

4. What is your type of practice? [Create Chart](#) [Download](#)

	Response Percent	Response Count
<b>Solo Practitioner</b>	<b>58.7%</b>	<b>497</b>
<b>Group Practice (Associate Dentist(s))</b>	19.9%	168
<b>Group Practice (Kaiser, Willamette, Gentle Dental etc.)</b>	13.4%	113
<b>Other (please specify)</b> <a href="#">Show Responses</a>	10.3%	87
<b>answered question</b>		<b>846</b>
<b>skipped question</b>		<b>60</b>

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UNFINISHED  
BUSINESS  
&  
RULES

**Nothing to report under this tab**

# CORRESPONDENCE

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December 10, 2013

Mr. Patrick Braatz  
Oregon Board of Dentistry  
1600 SW 4th Ave., Ste. 770  
Portland, OR

Dear Mr. Braatz:

I wanted to thank you for presenting at this year's AADB Annual Meeting. Your presentation provided our members with valuable information and I appreciate the time you took preparing for the meeting.

Thank you again for joining us in New Orleans.

Sincerely,

A handwritten signature in blue ink, which appears to read 'James Tarrant', is written over a light blue circular stamp.

James Tarrant  
Executive Director

cc: Executive Council

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# OTHER ISSUES

**Nothing to report under this tab**

**NEWSLETTERS**  
**&**  
**ARTICLES OF**  
**INTEREST**

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Circulating *current events and updates* to the NERB membership.



## Dr. Maxine Feinburg

THE NERB BOARD OF DIRECTORS AND  
THE ENTIRE NERB MEMBERSHIP SENDS

*congratulations*

ON YOUR ELECTION AS PRESIDENT-ELECT  
OF THE AMERICAN DENTAL ASSOCIATION!

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*by Guy Shampaine, DDS*

Pathways to Dental Licensure

*by David Perkins, DMD*

**Pg. 5:** ADEX DHEC Report

*by Nan Kosydar Dreves, RDH, MBA*

ASDA Letter

*by Stan Kanna, DDS*

**Pg. 7:** The Gies Report & Its Impact  
on Dental Licensure

*by David Perkins, DMD*

## Chairman's Report

*Guy Shampaine, DDS*

*Dear Colleagues:*

As we prepare to begin the 2014 CIF process, I wish to take the opportunity to inform the membership on the progress of many of the initiatives undertaken by the Board of Directors.

First, for the third straight year, we will be bringing on board at least one new member state. Florida has voted to join the NERB as a member state! We will be welcoming Florida at the opening session of our Annual Meeting, which is being held in Ft. Lauderdale.

Our ongoing collaboration with the Southern Regional Testing Agency (SRTA), our partners in administering the ADEX Dental Examinations, continues to be excellent. The decision by SRTA to become an ADEX testing agency has had great impact on ADEX and thus the NERB's testing process. Over the last year we have added composite restorations with the ability of the candidate to prepare a preparation commensurate with the disease presented in the tooth. In the coming year a candidate who is unsuccessful on the second restorative procedure will only be required to challenge that restoration. The foundation and suggestion for both of these significant improvements came from SRTA. In addition, we have jointly completed a total overhaul of the computerized examinations to align them with the new Occupational Analysis as well as to improve their discrimination and psychometric foundations. As a result the DSE Examination has been reduced to 60% of its original length. Truly, this partnership of ADEX with SRTA and the NERB is greater than the sum of the parts.

*Continued on page 2*

## Pathways to Dental Licensure

*David Perkins, DMD*

Presently, there are many alternative pathways for dental licensure. The pathway chosen by a candidate can have lifetime consequences. Not only do the candidates need to have an awareness of all of the options but every NERB member should have an equal understanding to ensure that everyone understands the ramifications of choosing one pathway over the other.

*Continued on page 4*



# NERB

## NERB VISION

Adopted by NERB BOD - January 9, 2013

It is the **VISION of NERB** to be a preeminent resource in the development, innovation and administration of competency assessments for the oral health professions.

## NERB MISSION

Adopted by NERB BOD - January 9, 2013

*The NERB is:*

- Committed to serving boards of dentistry by **designing and administering assessments** that are based on sound principles of testing and measurement.
- Pledged to **excellence, integrity and fairness.**
- Committed to a national uniform examination process **dedicated to the protection of the public** through cooperation with state dental boards, testing agencies, organized dental and dental hygiene, and educational institutions.

Another regional testing agency, **The Council of Interstate Testing Agencies, CITA, has just joined ADEX!** There are now three of the five regional testing agencies collaborating with ADEX to deliver a national licensure examination series for dentistry. ADEX will now test over 60% of the dental graduates in the United States and is accepted in 44 jurisdictions, 42 states, plus the District of Columbia and Puerto Rico.

The Board of Directors has also looked closely at the challenges we face in placing the dental hygiene performance examination on a digital platform. **Our Director of IT, Michael Zeder, has presented a process of procuring the extensive equipment required as well as working on the logistics.** As a result, the Board has voted to budget the funds required to computerize and automate the dental hygiene examinations for 2015.

All of you should have received your "**Call for Examiners**". I know that you were surprised and excited to see two new dental schools on the list. We were invited back to examine *once again* at the **University of Illinois-Chicago School of Dentistry, and we are looking forward to an excellent examination series in a completely renovated, beautiful clinic in the school.** In addition, the A.T. Still Arizona School of Dental Oral Health, ASDOH, is now our newest dental-school testing site. The school site visit has been completed and they offer an outstanding facility and we have scheduled the CIF Examination Series. I know we will perform with excellence as well as have a rewarding relationship with ASDOH.

As I mentioned earlier, **ADEX continues to grow with new member states and potential new interest** by other regional testing agencies — *so stay tuned for updates.*

The NERB candidate registration for both dental and dental hygiene examinations continue to grow to record levels. This year we have enjoyed tremendous growth in large part due to the acceptance of the ADEX Examination, as well as the administrative changes that we have proposed. These initiatives continue to improve our examinations. But it is your performance as examiners and your professional conduct that continue to present the NERB in a fashion that encourages candidates to register for our exams. This is the essence of our success. Recently, **the NERB was privileged to welcome Dr. Robert Faiella, President of the American Dental Association, as a Consultant Examiner.** Bob examined with the NERB and SRTA at the August NYU examination. He is an excellent addition to the NERB examiner cadre, and it is very significant to have the ADA President participate in our examination process.

*Continued on page 3*

Finally, those of you who were at last years General Assembly heard me describe the NERB and the revolutionary changes that have occurred over the previous two years. A large part of the success of our organization is our new member states and the enhancements, diversity, and the innovative and dynamic ideas they bring to the NERB.

The entire Board of Directors is excited about our future and we look forward to seeing you at an exam and in Ft. Lauderdale at our 2014 Annual Meeting!

Sincerely,

*Guy Champagne*

CHAIR



*See you in*  
**FORT LAUDERDALE**  
**FOR THE 2014**  
**NERB**  
**ANNUAL MEETING**



**44 JURISDICTIONS**

*Announcement*

- |             |                |                |
|-------------|----------------|----------------|
| Alabama     | Maryland       | Ohio           |
| Arizona     | Massachusetts  | Oregon         |
| Arkansas    | Michigan       | Pennsylvania   |
| Colorado    | Minnesota      | Rhode Island   |
| Connecticut | Mississippi    | South Carolina |
| Florida     | Missouri       | Tennessee      |
| Hawaii      | Montana        | Texas          |
| Idaho       | Nebraska       | Utah           |
| Illinois    | Nevada         | Vermont        |
| Indiana     | New Hampshire  | Virginia       |
| Iowa        | New Jersey     | Washington     |
| Kansas      | New Mexico     | West Virginia  |
| Kentucky    | North Carolina | Wisconsin      |
| Maine       | North Dakota   | Wyoming        |

*District of Columbia*  
*Territory of Puerto Rico*



Presently there are four alternative pathways for licensure; Postgraduate Year 1 (PGY-1), Objective Structured Clinical Examination (OSCE), Hybrid Portfolio and traditional clinical board examinations. The acceptance and transferability of each of these options vary greatly.

*A brief description of each of these options follows.*

**PGY-1** is the term given to the pathway of granting a license to an applicant who has completed at least a one-year postgraduate residency program in lieu of taking a traditional clinical board examination. Currently, this is the only option for initial licensure in the State of New York. This is an alternative pathway in Washington, Minnesota, California, and Connecticut.

**OSCE** is currently only offered to graduates of the University Of Minnesota School of Dental Medicine and is only accepted by the State of Minnesota. This pathway is based on the Canadian model for licensure.

The **Hybrid Portfolio** is being developed in California for initial licensure for fourth year dental students prior to graduation. The portfolio will consist of clinical procedures performed independently on the student patients of record during the sequential treatment of their patients. The clinical procedures completed will be Operative, Endodontics, Periodontics, Surgery, and possibly other clinical procedures. The successfully completed portfolio would replace passing the Western Regional Examination Board (WREB) examination for initial licensure. The American Dental Association has endorsed the use of the hybrid portfolio as the model for a universally accepted process for initial licensure if California's experiment is successful.

**Traditional patient based clinical licensure examinations** are by far the most prevalent pathway for initial licensure. Most states accept for initial licensure a candidate who successfully passes all parts of a board examination administered by one of the regional testing agencies. The regional testing agencies are CITA (Council of Interstate Testing Agencies), CRDTS (Central Regional Testing Service), NERB (North East Regional Board of Dental Examiners), SRTA (Southern Regional Testing Agency) and WREB (Western Regional Examining Board). Many states will accept for initial licensure one or more regional board. The NERB and SRTA both administer the examination developed by ADEX (American Dental Examiners). ADEX is a test development agency made up of representatives from member state Boards and does not administer any examinations.

While many states accept multiple Regional Boards for initial licensure, some states may require qualifiers for licensure if a candidate has taken certain Board examinations. For example, a candidate who has successfully passed the WREB examination and has applied for initial licensure in Michigan would be asked to take the ADEX manikin portion because there is no clinical prosthetic section on the WREB clinical examination. Similarly, a candidate taking the WREB examination would be asked to take the ADEX Dental Simulated Examination (DSE) computer based examination because there is no didactic section of the WREB examination. Likewise, a candidate who successfully passed the ADEX examination but did not take the optional periodontal scaling exercise would not be granted a license in Florida because Florida requires all parts of the ADEX examination in order to be granted an initial license. It is also possible that a longtime practicing dentist who wishes to move and be relicensed in a new state may find it necessary to take a portion or all of a clinical licensure examination before being granted a license. The point is that it is incumbent for all candidates for initial licensure to check with whichever state that they would like to get a license from for their specific requirements for initial licensure.

Because the Regional Board examinations are administered in the dental schools many students have the misconception that the Board examination is a continuation of the dental school curriculum. In fact, the Board examination has nothing to do with the school and is administered by an independent agency for the state licensing authority. A dental license is granted by a jurisdiction to a candidate who has demonstrated clinical competency by successfully passing a Board examination. The licensing jurisdiction has the responsibility to the citizens of their jurisdiction to only license clinically competent individuals to protect the public from potential harm from incompetent individuals.

*Continued on page 6*



## ADEX DENTAL HYGIENE EXAMINATION COMMITTEE (ADEX DHEC) REPORT *November 2013*

The ADEX Dental Hygiene Committee has been busy working towards a truly national dental hygiene exam that is fair, defensible, candidate-friendly and electronically efficient. Our goal for hygienists to enjoy national portability upon graduation remains paramount. Having had multiple conference calls in preparation for our Annual ADEX meeting we are creating a manual template that can be used by any testing agency. This is blending talents from SRTA and ADEX, and is chaired by Irene Stavros (FL). The 2015 commitment to create the ADEX dental hygiene examination in an electronic platform is a key guiding principle to every discussion.

As Chair of ADEX DHEC, I was honored to be invited to the SRTA Annual Meeting in August.

ADEX, SRTA and NERB hygienists attended a meeting at the NERB central office to review CSCE questions this past October. Gaining clarity around this part of the ADEX DH exam has become very important as we collaborate with other testing agencies.

Most recently, at the November ADEX Annual Meeting, with no changes in the current ADEX DH exam for 2014, we accepted multiple format changes that will make the examination formatted electronically in 2015. Guests at this meeting included SRTA leadership and CITA hygienists with presentations by Dina Vaughn (WV-SRTA) and Dr. Guy Champaine.

Lynda Sabat (OH), Jill Mason (OR), Dina Vaughn (WV), and Judith Neely (DC) terms expired at this meeting and we expressed great appreciation for their efforts.

**“Even if you are on the right track, you will get run over if you just sit there.”**

*~Will Rogers*

*Submitted 11/17/13 by Nan Kosydar Dreves, RDH, MBA, Chairperson, ADEX DHEC*

## Letter to American Student Dental Association (ASDA)

*Stan Kanna, DDS*

Currently there are three major clinical dental licensure examinations that are administered in the United States; the ADEX examination, the Western Regional Examination Board (WREB) examination and the Central Regional Dental Testing Service (CRDTS) examination.

Dental licensure is the sole purview of each States' Boards of Dentistry. Some states accept multiple exams and some states only accept one. Dental licensure candidates must contact each state to determine which exam or exams they accept. **Which dental licensure examination is the most widely accepted licensure examination in the country?**

This is a very important question to a dental candidate. By taking and successfully completing the most widely accepted dental licensure exam,

he/she will have the most choices of states to be licensed in and greater portability. If a candidate chooses an examination that they believe is the most widely accepted and it is not, not only is it frustrating but costly in time and money. Finding the answer to this question can be confusing and cumbersome. A candidate must access web sites of every State Board of Dentistry or access web sites of all the Regional Dental Testing Agencies (NERB, SRTA, WREB, CRDTS, CITA) which can be confusing. For example, what are member states vs. states that accept a particular exam, because some states are members of multiple testing agencies but only accept the results of one examination - e.g. Hawaii is a member of CRDTS and the NERB testing agencies but only accepts the results of the ADEX dental examination for licensure. Let us try to clarify some of the confusion for member ASDA dental students who are accessing this information, and promote the concept of a Uniform National Dental Licensure examination.

*Continued on page 6*

The Board examinations are administered in the dental school setting for a variety of reasons. Firstly, from a logistical point of view, using the multiple operatories of a dental school can accommodate many candidates quickly and efficiently. Second, there is a comfort level for the candidates to take the examination in an environment in which they are familiar and comfortable.

If asked by a potential candidate seeking dental licensure, NERB members should encourage them to take the time to carefully research the licensure requirements of the state in which they plan to practice. Highlight the fact that they should also consider possible future ramifications of that decision. While a PGY-1 or OSCE license may be expedient for the short term, it may limit one's future options. An OSCE granted license in Minnesota would limit the candidate to practicing in only Minnesota. Presently, the licensure pathway with the most options is the ADEX examination. Upon successful completion of the entire five part (DSE, manikin endodontic and prosthetics, periodontal scaling exercise, restorative dental exercise) ADEX examination a candidate is eligible for initial licensure in 44 jurisdictions. This number will probably increase as more jurisdictions recognize the ADEX examination. The bottom line is by taking the ADEX examination it would leave the candidate with the most options for his/her future dental career.

*David Perkins*, VICE CHAIR



There are five major dental testing agencies in the United States, NERB, WREB, CRDTS, SRTA, and CITA who administer dental exams, but **only** three clinical dental exams, ADEX, WREB, and CRDTS. We must also understand that dental licensure acceptance is the sole purview of each States' Boards of Dentistry.

ADEX is the only dental examination that is not developed by a Dental Testing Agency. ADEX is **NOT** a Testing Agency. ADEX is an independent exam development corporation whose members are States Dental Boards. ADEX was designed and incorporated as a dental and dental hygiene licensure development corporation whose sole purpose was to develop a uniform national dental and dental hygiene licensure examination that would be administered by Regional Dental Testing agencies and accepted in all 50 states and districts. Achieving this goal would result in creating one standard in dentistry and allow 100% portability of licensure throughout the United States. It is important to note that dentistry is the only high stakes profession that still maintains regional licensure examinations.

Currently, the Northeast Regional Board Testing Agency (NERB), the Council of Independent Testing Agencies (CITA) and the Southern Regional Testing Agency (SRTA) administer the ADEX dental licensure exam. **The ADEX dental licensure exam is accepted in 44 jurisdictions (42 states,**

### **the District of Columbia and Puerto Rico).**

ADEX is seven states short of a national dental licensure examination. According to the most current web site information; the WREB dental exam is accepted in 33 states, the CRDTS dental exam is accepted in 38 states (Fig. 1). ADEX has been the leader in the push for a uniform national dental and dental hygiene licensure examination. **The ADEX dental examination is the most widely accepted dental licensure examination in the country and is administered in Canada by the NERB (fig. 2). ADEX has more member states (33) than any other dental exam development entity in the United States.** The ADEX organization is a non-profit corporation which does not benefit financially by the number of states that accept the exam for licensure or the quantity of exams given.

ADEX would like to ask ASDA and its members to advocate for a uniform national dental and dental hygiene licensure examination and to understand ADEX is the most widely accepted dental licensure exam in the country and very close to realizing a universal national acceptance concept that will truly benefit the members of ASDA and our country. If any ASDA member has questions please do not hesitate to call or e-mail ADEX. We will be more than happy to answer any question. We know that ASDA and its members are our profession's future and we are working together to make the dental and dental hygiene licensure process uniform, accessible, portable, and current.



# The Gies Report & Its Impact on Dental Licensure

*David Perkins, DMD*

Whenever a patient walks in to their dentist's office they are confident that their dentist is competent to diagnose and competently treat any dental problems that they may have. The reason patients can go to their dentist with confidence is one of the benefits of states requiring professionals to be licensed in order to deliver dental treatment to patients. While we accept licensing professionals as the final step to begin treating patients, this hasn't always been the case.

The benchmark that we can look to as the turning point in insuring that only well educated, competent individuals should be allowed to treat dental patients is the Gies report of 1926. Dr. William Gies was a professor at Columbia University and was funded by the Carnegie Foundation to study the current status of dental education. It took Dr. Gies 5 years to research and write his report. His report found that there was a wide disparity in dental education. While there were dental schools that provided an excellent dental education, there were some schools that were analogous to trade schools. As a result of Dr. Gies report many of these schools were closed and the standards for dental education were improved. Dental school accreditation through the ADA Council on Dental Education (CODA) now establishes the standards that all dental schools must follow.

The improved standardization of dental education was one important step in giving patients confidence in their dentist's competence. Licensure was the next step. The sole purpose of licensure is to protect the public from incompetent dentists. Licensing jurisdictions established the standards that individuals must meet to be granted a license. While this further ensures the safety of the public, it makes it difficult for a professional to move from state to state. A move from one state to another may have required a dentist to have to take another licensing examination. About 40 years ago the North East Regional Board (NERB) was founded so that any of those 16 member states would grant an initial license to anyone who had passed the NERB examination. After the NERB the other regional testing agencies were founded (i.e. CRDTS, SRTA, CITA and WREB). However, mobility from state to state is still limited. Most individuals in the dental profession desire a single, universally accepted examination for initial licensure.

About a decade ago, the American Board of Dental Examiners (ADEX) was founded with the vision that it would become the universally accepted national examination for initial licensure. ADEX is a test development entity that develops the examination for initial licensure in dentistry and dental hygiene. This concept would allow the individual regional testing agencies to administer the ADEX examination, while maintaining their autonomy to give candidates a credential that would be recognized by all states. Presently, SRTA and the NERB both administer the ADEX examinations. Presently, the ADEX examination is recognized for licensure in 44 jurisdictions. ADEX will continue to work to have every licensing jurisdiction recognize the ADEX examination for initial licensure.

*David Perkins*

VICE CHAIR



## Communications Committee

Mary Johnston, RDH, Chair  
Lisa Deem, DMD  
Nanette Dreves, RDH  
Stephen DuLong, DMD

Stanwood Kanna, DDS  
Clance LaTurner, Public Member  
Lynda Sabat, RDH  
Cynthia Fong, RDH, Board Liaison



Design and Layout  
**OUTER GRAPHICS**

**AGENDA**  
**Health Professionals' Services Program Meeting**  
**Date / Time: October 22, 2013 - 9:00 – 11:00**  
**Location: Oregon Board of Nursing**  
**17938 SW Upper Boones Ferry Rd., Portland 97201**

**Dial-in#: 877-810-9415**

**Participant Code: 361576**

**Advisory Committee**

Christopher Hamilton	Gary Schnabel	Kathleen Haley	Patrick Braatz
Chris O'Neill	Harvey Wayson	Traci Coleman	Perla Sloane
Dale Kaplan	Jeff McVay	Margaret Semple	Shannon O'Fallon
Eric Brown	Jessica Gregg	Nita Goss	Shrestha Sangit
Gary Miner		Patricia Alderson	Vickie Wilson

**Guests: John Wakefield, OHA-AMH budget**

1. Welcome and Introductions ( <b>Christopher</b> )	<b>5 min</b>
2. Approve July 23, 2013 Minutes ( <b>Handout # 1</b> )	<b>5 min</b>
3. HPSP Budget Overview ( <b>John Wakefield</b> )	<b>10 min</b>
4. HB 2124 Update ( <b>Christopher</b> )	<b>10 min</b>
5. Memo of Concern ( <b>Dale &amp; Christopher</b> )	<b>15 min</b>
6. Review guideline for suspensions (see attachment) Specifically, the OSBN would like to review if a L. is out for medical or military, should the time in the program be extended? Currently, the guideline states it should be extended. ( <b>Handout #2</b> ) ( <b>Dale &amp; Margaret</b> )	<b>10 min</b>
7. <b>BREAK</b>	<b>10 min</b>
8. Alternative testing/Saturday collection. Methods (Hair, PEth (nail), and Soberlink, ETG Hair testing) ( <b>Decision Needed</b> ) ( <b>Dale and Jessica</b> )	<b>10 min</b>
9. Testing Levels ( <b>Dale</b> )	<b>10 min</b>
10. Face to Face license meeting requests (Dale)	<b>10 min</b>
11. Third year Satisfaction Survey ( <b>Handout #3-Dale</b> )	<b>10 min</b>
12. Annual Report Year 3 <b>Review</b> ( <b>Handout #4-Dale</b> )	<b>10 min</b>
13. HPSP Metric discussion ( <b>C. O'Neill</b> )	<b>5 min</b>
14. 2014 HPSP Advisory Committee Meeting Schedule (quarterly: Jan, Apr, Jul, Oct) ( <b>Christopher</b> )	<b>5 min</b>
15. Incident Reports ( <b>Dale</b> )	<b>5 min</b>

**Addictions and Mental Health Division (AMH)**

**Health Professionals' Services Program  
Advisory Committee Meeting  
Minutes for July 23, 2013 – Draft until approved**

- |   |  |  |  |
|---|--|--|--|
| <input checked="" type="checkbox"/> Christopher Hamilton, AMH | <input checked="" type="checkbox"/> Gary Miner, Brd of Pharmacy        | <input type="checkbox"/> Kathleen Haley, Medical Brd       | <input type="checkbox"/> Shannon O'Fallon, DOJ (phone)         |
| <input checked="" type="checkbox"/> Chris O'Neill, ONF        | <input checked="" type="checkbox"/> Gary Schnabel, Brd of Pharmacy     | <input checked="" type="checkbox"/> Nita Goss, Medical Brd | <input checked="" type="checkbox"/> Traci Coleman              |
| <input checked="" type="checkbox"/> Dale Kaplan, RBH          | <input checked="" type="checkbox"/> Harvey Wayson, Brd of Dentistry    | <input checked="" type="checkbox"/> Patricia Alderson, AMH | <input checked="" type="checkbox"/> Vickie Wilson, Medical Brd |
| <input type="checkbox"/> Eric Brown, Medical Brd              | <input checked="" type="checkbox"/> Jeff McVay, OSBN Lead Investigator | <input type="checkbox"/> Patrick Braatz, Brd of Dentistry  | <input type="checkbox"/>                                       |
| <input type="checkbox"/>                                      | <input checked="" type="checkbox"/> Jessica Gregg, Med Dir, RBH        | <input checked="" type="checkbox"/> Perla Estrada, RBH     | <input type="checkbox"/>                                       |

**Guests:** David Cadiz, O.F.N., Nicole Collier, R.B.H.

**Conference Callers:** Shannon O'Fallon

<b>Agenda Topic</b>	<b>Key Discussion</b>	<b>Action/Task/Decision Log</b>	<b>Responsible Persons</b>	<b>Due Date</b>
1. Introductions/Welcome/Announcements	All introduced.			
2. Review & Approval of <u>April 23, 2013</u> Minutes	<ul style="list-style-type: none"> <li>Minutes approved with minor changes.</li> </ul>	<ul style="list-style-type: none"> <li>Send final out to group</li> </ul>	Patricia	<b>ASAP</b>
3. 20ng/ml THC Screening level update	<ul style="list-style-type: none"> <li>Change to previous decision in April</li> <li>Last meeting lowered level from 50ng/ml to 20 ng/ml. Dale Kaplan explained that there was a cost and administrative effort to change it. Consensus around the table was that the DOT level of 50 ng/ml will be maintained.</li> </ul>		Patricia	
4. Substantial non-compliance	<ul style="list-style-type: none"> <li>Margaret Semple described a</li> </ul>	It was discussed and agreed that if		

**Health Professionals' Services Program  
Advisory Committee Meeting  
Minutes for March 27, 2012 – Draft until Approved**

Agenda Topic	Key Discussion	Action/Task/Decision Log	Responsible Persons	Due Date
	<p>situation where a licensee was expelled from a group because of his inappropriate behavior. He was required to get an independent clinical evaluation before returning to the group. At what point should the board be notified if the licensee ignores or resists the requirement for the evaluation? Christopher explained that the recent changes (HB 2124) changes the role of the board and will have implications for a decision. He explained that he will attain legal consult to determine the focus and scope of “concerning behavior” communications.</p> <ul style="list-style-type: none"> <li>• OSBN: Compliance Summary information provided (15022186). Follow-up from last meeting (Perla). A new compliance summary was completed and sent in to the Board.</li> </ul>	<p>there are program concerns identified (i.e., poor employer reviews, issues of absenteeism, treatment concerns, etc.) and these issues would significantly impact a licensee’s ability to complete their contract, communication via a memo should be sent and will be kept in licensee’s file. This process will keep the Board informed of any issues going on with a licensee that are not considered “non-compliance”.</p>		
5. Monitoring Definition	Monitoring occurs for both compliance with the licensee agreement and warning signs in the workplace. In the case of titration from an addictive Rx	Dale is going to reach out to the federation of allied health professionals for feedback and direction on this.		

**Health Professionals' Services Program  
 Advisory Committee Meeting  
 Minutes for March 27, 2012 – Draft until Approved**

<b>Agenda Topic</b>	<b>Key Discussion</b>	<b>Action/Task/Decision Log</b>	<b>Responsible Persons</b>	<b>Due Date</b>
	<p>medication, Suboxone is a case in point. Often, a licensee wants to be free of medication as part of their recovery. Does the program have a role when the licensee is titrating and about to successfully complete the program? Would a “memo of concern” from HPSP to the relevant board be appropriate as they consider a decision on completion? Margaret indicated that the OSBN would want to know whenever HPSP believes that a monitoring agreement be extended for a period of time based on specific concerns. Chris indicated that the issue is more complex than a single meeting can effectively handle, and recommended a more detailed review of the focus and scope of monitoring in the Oregon context. Dale indicated that she will put a question to the National Federation of Physician Health Programs, and meantime send a “letter of concern” when pattern of behavior warning signs would possibly extend monitoring to the relevant board when information indicates.</p>			

**Health Professionals' Services Program  
Advisory Committee Meeting  
Minutes for March 27, 2012 – Draft until Approved**

Agenda Topic	Key Discussion	Action/Task/Decision Log	Responsible Persons	Due Date
6. Self-referral missed tests excuses	Dale explained that Reliant understands that there are circumstances when a board will excuse a missed test. (for example: medical, inclement weather, or technical difficulties) and when there is no pattern of other concerning circumstances. It was requested that HPSP be permitted to “excuse” a missed toxicology test when documentation is provided because of an extraordinary circumstance as described above.	The Advisory Committee agreed that HPSP may excuse a missed test with appropriate documentation of the event.		
7. Missed Calls to Agreement Monitor	Perla requested that the Advisory committee determine a standard for compliance to the requirement regarding checking in weekly with the licensee’s agreement monitor. The concern is that the Program has not been consistent and a standard needs to be developed. It was proposed that following the 6 <sup>th</sup> missed call in a six month period would result in a non-compliance report. It was further determined that a warning letter prior to the missed 6 call would be sent to the licensee with a cc to the appropriate board. RBH will communicate the new	The Advisory Committee agreed that a non-compliance report would be completed following any missed call after the 6 <sup>th</sup> missed call in a 6 month period. A warning letter will be sent to the licensee after several missed calls with a cc to the appropriate board for board referrals.		

**Health Professionals' Services Program  
Advisory Committee Meeting  
Minutes for March 27, 2012 – Draft until Approved**

Agenda Topic	Key Discussion	Action/Task/Decision Log	Responsible Persons	Due Date
	<p>requirement to the licensees through the HPSP newsletter and the individual agreement monitors will inform their licensees that have been having problems with the weekly check in. The weekly requirement is in the statute, and the monitoring agreement, and will be enforced starting <b>October 01, 2013</b>.</p>			
8. BREAK				
9. Alternative testing/Saturday collection. Methods (Hair, PEth (nail), and Soberlink, ETG Hair testing)	<ul style="list-style-type: none"> <li>• Tabled to the next meeting</li> </ul>			ASAP
10. Online Supervisor Skill training outcomes	<ul style="list-style-type: none"> <li>• David Cadiz provided a handout and explained the recent completion of the study of ORCAS online training (supported by NIDA funding) and also reviewed the previous results of the classroom version conducted two years earlier. He explained that Oregon has two evidence-based supervisor skill training formats that are accessible and affordable.</li> </ul>			
11. 2013 Legislative Update (HB 2124)	<p>Christopher Hamilton provided details about changes in the statute that will apply into the future. Christopher will follow up with boards to determine how they would like to implement the</p>			

**Health Professionals' Services Program  
Advisory Committee Meeting  
Minutes for March 27, 2012 – Draft until Approved**

Agenda Topic	Key Discussion	Action/Task/Decision Log	Responsible Persons	Due Date
	changes.			
12. Unusual Incidents	Dale provided information regarding two unusual incidents- re: failure to report a failed test during a period of relapse as other positive tests had been reported and failure to report a positive PEth test timely due to misreading the report on the test result.			
13. Next meeting	<b>Oct 22, 2013, (9:00-11:00) – Oregon Board of Nursing – 17938 SW Upper Boones Ferry Rd, Portland</b>			

**Summary Annual Report  
Health Professionals' Services Program  
Highlights of Year Three 7/1/12-6/30/13**

The purpose of this report is to provide the Oregon Health Authority and the representatives of the participating health licensing boards with a summary of the highlights of year three of the Health Professionals' Services Program (HPSP). HPSP began provision of monitoring services to the Oregon Board of Dentistry, Oregon Board of Nursing, Oregon Medical Board, and the Oregon Board of Pharmacy on July 1, 2010. The following data tables were developed to give an overview of the HPSP program during the period from July 1, 2012 through June 30, 2013.

**Table 1: Enrollment Overview: Year 3**

<b>Enrollment Overview: Year 3 (7/1/12 - 6/30/13)</b>	<b>Board of Dentistry</b>	<b>Board of Nursing</b>	<b>Board of Pharmacy</b>	<b>Medical Board</b>	<b>TOTAL</b>
<b>Total Enrolled End of Year 2 (6/30/12)</b>	19	182	20	98	<b>319</b>
<b>Enrolled: Board Referral</b>	2	29	3	20	<b>54</b>
<b>Enrolled: Self-Referral</b>	1	3	0	11	<b>15</b>
<b>Successfully Completed</b>	4	34	2	17	<b>57</b>
<b>Terminations</b>	1	31	4	6	<b>42</b>
<b>Total Enrolled End of Year 3 (6/30/13)</b>	<b>17</b>	<b>149</b>	<b>17</b>	<b>106</b>	<b>289</b>
<b>Referred but Not Enrolled/Inquiry Only</b>	0	9	1	8	<b>18</b>

Table 1 provides a summary of year three, beginning with the number of licensees enrolled at the end of year two and reviewing the changes in enrollment during the year. In particular, it displays: the number of licensees referred by board to the program, the number of self-referrals to the program, the number of licensees who successfully completed the program and the number of licensees who were terminated from the program by the licensing boards. The total enrollees at the end of year three follows from this data. Table 1 also displays the number of licensees who were referred but never enrolled or those who called about the program but did not enroll. As should be anticipated, the Oregon Board of Nursing had the largest number of licensees referred to the program, as well as the largest number of successful completions and terminations. At the end of year three, the program had 289 participants with growth only in the Medical Board's participants. Compared to year two (see Table 2), there were a similar number of self-referrals with fifteen during year three and fourteen during year two. There were far fewer Board Referrals made by each Board except the Medical Board. The number of terminations was similar except for the Board of Nursing which had less during year three than year two (43 in year two compared to 31 in year three).

**Table 2: Enrollment Overview: Year 2**

<b>Enrollment Overview: Year 2 (7/1/11 - 6/30/12)</b>	<b>Board of Dentistry</b>	<b>Board of Nursing</b>	<b>Board of Pharmacy</b>	<b>Medical Board</b>	<b>TOTAL</b>
<b>Total Enrolled End of Year 1 (6/30/11)</b>	15	236	17	92	<b>360</b>
<b>Enrolled: Board Referrals</b>	5	36	7	20	<b>68</b>
<b>Enrolled: Self-Referrals</b>	0	4	0	10	<b>14</b>
<b>Successfully Completed</b>	0	51	1	19	<b>71</b>
<b>Terminations</b>	1	43	3	5	<b>52</b>
<b>Total Enrollees End of Year 2 (6/30/12)</b>	<b>19</b>	<b>182</b>	<b>20</b>	<b>98</b>	<b>319</b>
<b>Referred but Not Enrolled/Inquiry Only</b>	1	6	0	16	<b>23</b>

**Table 3 Program Termination Reasons\***

Termination Reasons: Year 3	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Deceased	0	0	0	0	0
Inappropriate Referral (Determined after Enrollment)	0	2	0	1	3
License Inactivated	0	3	0	4	7
License Retired	0	1	0	1	2
License Revoked	0	7	3	0	10
License Surrendered	0	14	1	0	15
License Suspended	1	1	0	0	2
Probation	0	3	0	0	3
<b>TOTAL</b>	<b>1</b>	<b>31</b>	<b>4</b>	<b>6</b>	<b>42</b>

Table 3 reviews the reasons for terminations from the HPSP program this year. Please note that a licensee has to be enrolled in order to be terminated from the program. The primary reason for program termination was the licensee surrendered his/ her license; this is consistent with the last two years of the program. The second most common reason this year was that the participant's license was revoked, however the Board of Nursing and the Board of Pharmacy are the only contributors to these categories: The Board of Dentistry only had one termination this year and that was due to a suspended license. The Medical Board's participants were terminated due to an inactivated license (4) or a retired license (1) or an inappropriate referral that was identified after the licensee was already enrolled (1).

There have been a total of 158 terminations of enrolled licensees since the date of program inception. Of these, 110 were licensees transferred into the program. Of the 158 licensees terminated from the program, 62 or 39.2% were terminated during the first year of their participation in the program. This figure is 44% (4) for the Board of Pharmacy, 47% (9) for the Medical Board, 37% (46) for the Board of Nursing and 75% (3) for the Board of Dentistry.

**Table 4 Suspensions During Year 3**

Suspensions (At Any Time During Year 3)	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Non-Compliance: Financial	1	1	0	0	2
Expired License	0	2	0	0	2
Health: Severe Issues	1	1	1	1	4
<b>TOTAL</b>	<b>2</b>	<b>4</b>	<b>1</b>	<b>1</b>	<b>8</b>

Table 4 details the number of licensees who were suspended at any time during year three. A total of eight licensees were suspended from the program during year three: four from the Board of Nursing, two from the Board of Dentistry and one each from the Board of Pharmacy and the Medical Board. The most common reason for suspension was due to severe health issues. Financial non-compliance and expired licenses also were reasons for suspension. By the close of the third program year, there were only five licensees suspended (see Table 5, next page). Two of these licensees are from the Board of Nursing and one is from each of the other boards.

**Table 5: Suspensions at the End of Year 3**

Suspensions (At End of Year 3)	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Non-Compliance: Financial	1	0	0	0	1
Expired License	0	1	0	0	1
Health: Severe Issues	0	1	1	1	3
<b>TOTAL</b>	<b>1</b>	<b>2</b>	<b>1</b>	<b>1</b>	<b>5</b>

**Table 6 Non-Compliance Reports by Licensee**

Non-Compliance Reports by Licensee: Year 3	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Total Non-Compliance Reports	6	236	22	31	295
Total Non-Compliance Reports as a Percentage of Average # of Licensees Enrolled in Year 3	33.3%	142.6%	118.9%	30.4%	97.0%
# of Licensees with NC Reports	5	88	7	19	119
# of Licensees with >1 NC report	1	48	2	6	57
# of Licensees with >3 NC report	0	17	2	2	21

Table 3 gives the total number of non-compliance reports by Board and then a specific break-down giving the number of licensees who received more than one non-compliance report throughout the year. The table also shows the total number of non-compliance reports submitted as a percentage of the average number of licensees enrolled during year three (304). The Board of Nursing had the highest percentage at 142.6%, followed by the Board of Pharmacy at 118.9%. This is compared to 33.3% for the Board of Dentistry and 30.4% for the Medical Board. With the exception of the Board of Pharmacy, these figures improved from year two.

	Year Two	Year Three
Board of Dentistry	218%	33.3%
Board of Nursing	211%	142.6%
Board of Pharmacy	76%	118.9%
Medical Board	36%	30.4%

The Board of Nursing had the most repeat offenders (with at least two non-compliance reports) at 48, followed by the Medical Board at six, the Board of Pharmacy at two and the Board of Dentistry at one. Typically the licensees with more than three non-compliant reports had either stopped participating in the HPSP program and/or the Boards were in the process of investigation and determination of a final decision regarding licensee's status.

**Table 8: Self-Referrals Known to Board After Report of Non-Compliance**

Self-Referrals Known to Board After Report of Non-Compliance	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Year 1 (7/1/10 - 6/30/11)	0	0	0	11	11
Year 2 (7/1/11 - 6/30/12)	0	1	0	8	9
Year 3 (7/1/12 - 6/30/13)	1	0	0	5	6
<b>TOTAL</b>	<b>1</b>	<b>1</b>	<b>0</b>	<b>24</b>	<b>26</b>

Table 7 shows the number of Self-Referrals licensees who were reported non-compliant and are thus now known to the board. This year, the Medical Board had five self-referrals who are now board known and the Board of Dentistry had one. This is a decrease from prior years.

**Table 9 Non-Compliance Reasons**

Non-Compliance Reasons: Year 3*	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Failure to Enroll	0	1	0	1	2
Failure to Participate: Missed IVR Call	1	23	12	1	37
Failure to Participate: Missed Test (includes failure to provide specimen)	6	160	20	13	199
Failure to Participate: Non-Payment	0	3	0	0	3
Failure to Participate: Other	0	43	2	4	49
Hospitalization	0	0	0	1	1
Violated Restriction on Practice	0	1	0	0	1
Positive Non-RBH Test**	0	0	0	1	1
Positive Toxicology Test	0	36	1	9	46
Impaired in a Health Care Setting in the Course of Employment (including admitted substance use & diversion of medications)	0	0	0	0	0
Impaired Outside of Employment (including admitted substance use & diversion of medications)	0	5	0	2	7
Public Endangerment	0	0	0	0	0
Criminal Behavior (including DUI)	0	4	0	1	5
Use of Prescription Medication – Not Approved**	0	2	0	0	2
<b>TOTAL</b>	<b>7</b>	<b>278</b>	<b>35</b>	<b>33</b>	<b>353</b>

\* May have more than 1 reason per report

\*\*New categories added end of year 3

Table 9 shows the reasons why a non-compliance report was submitted to the appropriate board. The most common reason for non-compliance was the licensee failing to test as scheduled with 199 reports. Last year there were 212 reports for this reason. “Failure to participate: other” and a positive toxicology test were the next most common reasons but with far fewer reports at 49 and 46 respectively.

**Table 10: Non-Negative Tests**

Non-Negative Tests: Year 3	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Positive Tests (non-negative results)	0	37	1	10	48
Positive Tests as a Percentage of Average # of Licensees Enrolled in Year 3	0.0%	22.4%	5.4%	9.8%	15.8%
Invalid Tests	2	10	1	4	17
<b>TOTAL</b>	<b>2</b>	<b>47</b>	<b>2</b>	<b>14</b>	<b>65</b>

Table 10 shows the number of non-negative tests and invalid test results per board. Examples of problems that would cause an invalid test result include a specimen bottle leaking, a broken seal, the panel not being identified (we now have a fall back panel identified when this happens), identification numbers of the specimen and chain of custody form do not match and insufficient volume of specimen (this should have been caught at the collection site). The positive tests (non-negative results) re-test results. During year three, there were a total of 3 positive retests. One of these tests was also

positive on the original toxicology panel. This test and re-test are counted as two non-negative test results under the Medical Board.

The number of non-negative results is also reflected as a percentage of the average number of licensees enrolled in the program during year three (304). This was the highest for the Board of Nursing at 22%. This is down, however, from 31% last year. Overall the non-negative tests represented 15.8% of the average number of enrolled licensees (304). Again, this is down from last year's 23%.

The total number of positive (non-negative) tests can be compared to the number of Non-Compliance reports submitted due to a positive toxicology test result. These numbers match with the following exceptions:

1. The Board of Nursing has one less non-compliance reports submitted with the reason "positive toxicology test." The licensee tested negative, but the specimen was dilute. It was retested to the lowest level of detection (LLD) and was found to have a low ETG without ETS. By policy, a non-compliance report was not provided.
2. The Medical Board has one less non-compliance reports submitted with the reason "positive toxicology test." As explained previously, there was one test that was positive on the original panel and on the re-test. Although this was counted as two non-negative test results, there was only one non-compliance report submitted to address the original and the re-test result.

**Table 11: Positive Tests - Drugs Found**

Positive Tests - Drugs Found: Year 3	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
amphetamines / methamphetamines	0	1	0	0	1
anti-depressants	0	0	0	0	0
Barbiturates	0	1	0	0	1
Benzodiazepines	0	0	0	0	0
ethyl glucuronide (ETG)	0	23	1	8	32
ethyl glucuronide (ETG) – PETH	0	0	0	2	2
marijuana metabolite (THC)	0	4	0	0	4
Methadone	0	0	0	0	0
muscle relaxants	0	0	0	0	0
opiates (narcotics/opiates)	0	4	0	0	4
Oxycodone	0	6	0	0	6
Propoxyphene	0	0	0	0	0
Tramadol	0	4	0	0	4
<b>TOTAL</b>	<b>0</b>	<b>43</b>	<b>1</b>	<b>10</b>	<b>54</b>

\*May have more than one drug per test

Table 11 shows the various drugs that resulted in a positive test result. Similar to last year, the largest number of positive tests was for alcohol. This means that the licensee had an ETG test of 500mg/dl or higher as the result and there was also an ETS result.

**Table 12: Missed Test Details – Breakdown by Reason**

<b>Missed Test Breakdown by Reason: Year 3</b>	<b>Board of Dentistry</b>	<b>Board of Nursing</b>	<b>Board of Pharmacy</b>	<b>Medical Board</b>	<b>TOTAL</b>
<b>No Call/No Show</b>	2	108	14	5	<b>129</b>
<b>No Show</b>	4	66	5	3	<b>78</b>
<b>Refused</b>	0	3	0	0	<b>3</b>
<b>TOTAL</b>	<b>6</b>	<b>177</b>	<b>19</b>	<b>8</b>	<b>210</b>

Table 12 gives detail on licensees who failed to take a scheduled toxicology test. No call/no show refers to licensees who failed to call the IVR and did not test as scheduled. No Show refers to situations when the licensee did not go to the collection site to give a specimen but did check to see if a test was required by either calling the IVR or looking at the website. Refused refers to licensees who went to the collection site but did not provide an adequate specimen. This is considered a refusal to test which is treated like a positive test unless the licensee can provide a medical explanation from a physician, verifying that the licensee has a medical condition which prevents the licensee from providing an adequate sample. Notably, within the Oregon Board of Nursing a significant number of licensees checked the system to see if a test was required, learned that they were scheduled to test but still failed to go to the collection site. This was also noted for the last two years. The Oregon Board of Nursing had three licensees who reported to the collection site but refused to provide a specimen this year.

**Table 12: Missed Test Details – By Licensees**

<b>Missed Test Details: Year 3</b>	<b>Board of Dentistry</b>	<b>Board of Nursing</b>	<b>Board of Pharmacy</b>	<b>Medical Board</b>	<b>TOTAL</b>
<b>Total Number of Missed Tests</b>	6	177	19	8	<b>210</b>
<b>Number of Licensees with a Missed Test</b>	5	65	5	8	<b>83</b>
<b>Missed Tests as a Percentage of Average # of Licensees Enrolled in Year 3</b>	27.8%	39.3%	27.0%	7.8%	<b>27.3%</b>

Table 12 shows the number of licensees who missed a scheduled toxicology test as compared to the total number of missed tests (also reported in Table 11). For the Board of Nursing and the Board of Pharmacy these two numbers are very different showing that a smaller number of licensees were responsible for a larger number of missed tests. In other words, there was a pattern of licensees repeatedly missing tests. Conversely, these numbers are similar for the Board of Dentistry and the same for the Medical Board, meaning that almost every missed test was by a unique individual licensee. Table 12 also shows the number of missed tests as a percentage of the average number of licensees enrolled in year three (304). On average, this percentage was 27.3% but was highest for the Board of Nursing at 39.3% and lowest for the Medical Board at 7.8%.

**Table 13: Workplace Safe Practice Reports**

<b>Workplace Safe Practice Reports: Year 3</b>	<b>Board of Dentistry</b>	<b>Board of Nursing</b>	<b>Board of Pharmacy</b>	<b>Medical Board</b>	<b>TOTAL</b>
<b>Number of Licensees who had Reports Submitted</b>	11	156	14	94	275
<b>Number of Reports Received / Reviewed</b>	96	1256	109	756	2217
<b>Percentage of Required Reports Received</b>	95.0%	95.5%	97.3%	95.3%	95.5%
<b>Number of Reports Received with Concerns Noted</b>	0	53	2	23	78
<b>Percentage of Reports with Concerns Noted</b>	0.0%	4.2%	1.8%	3.0%	3.5%
<b>Number of Licensees with a Report with Concerns Noted</b>	0	30	2	9	41
<b>Number of Licensees with Concerns Reported who also had a NC report</b>	0	15	1	3	19
<b>Above as a Percentage of the Total Licensees with NC Reports</b>	0.0%	17.0%	14.3%	15.8%	16.0%

Table 13 displays details on the workplace safe practice reports received from workplace monitors during the year, including the number of licensees who had reports submitted, the total number of reports received and reviewed and the percentage of the required reports that were actually received. It is important to note that this number was a minimum of 95%. A goal for year there will be to increase this percentage even further. The table then displays the number and percentage of reports in which the workplace monitor noted concerns about the licensee in the workplace. Note that the Board of Nursing had the most such reports at 53, which was 4.2% of all the reports received for the Board of Nursing licensees. This percentage may be higher than the other boards because the Board of Nursing workplace monitors participated in the Fit to Perform supervisor training. Table 13 further displays the number of licensees with a report indicating concerns, and of these, how many had a non-compliance report. Finally, the number of licensees with a workplace safe practice report noting concerns is reflected as a percentage of the number of licensees with a non-compliance report.

**Year Four**

One goal for year four is to increase the percentage of workplace safe practice reports to 98%. There is an extensive effort put forth by the HPSP staff to obtain these reports. Due to program enhancements during the last quarter of year three, the agreement monitors are now much more easily able to identify missing workplace safe practice reports.

For those boards that are opting to allow self-referrals, we would like to increase self-referrals by working with the professional associations. Developing relationships with the professional associations is a goal which will also help with increasing responses to the satisfaction survey.

I would also recommend as a group we look to see how we can better support licensees during their first year in the program.

Dale Kaplan, MSW, LCSW-C (Maryland), MSWAC  
 HPSP Program Manager  
 August 13, 2013



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

**Year 3: July 1, 2012 – June 30, 2013**

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

## Executive Summary

### Health Professionals' Services Program Satisfaction Survey: Year Three

**Overview:** This Health Professionals' Services Program report reviews the survey results from the third year of the program, covering July 1, 2012 through June 30, 2013. It also details the survey results of the July 1, 2013 survey. Surveys were sent to the following groups of stakeholders both in July and at other times throughout the year: Licensees, Employers (Workplace Monitors), Treatment Providers, Health Associations and the Boards. Each of these groups of stakeholders will be surveyed again in January 2014.

An overview of the number of surveys sent, number of responses received, and the response rate for each group of stakeholders in July is displayed below:

Table 1: Response Rate - July 2013	Licensees	Employers (Workplace Monitors)	Treatment Providers	Health Associations	Boards
# Sent	292	192	187	5	8
# of Responses	69	41	18	0	4
Response Rate	23.6%	21.4%	9.6%	0.0%	50.0%

**Highlights:** Surveys during the third year of the program showed consistent or improved satisfaction compared to prior years along with response rates that were also either consistent or improved. Overall, the results of this survey indicate continued improvement in the stakeholders' perception of the Health Professionals' Services Program (HPSP).

For the first time, the largest group of licensee respondents' rated Reliant Behavioral Health's (RBH's) customer service as "above average." Agreement Monitors received strong ratings again this year. Overall, 50% of respondents rated the services as "Excellent" or "Above Average" for the year. Although there were fewer comments than we have seen previously, they are overall more positive and less negative than in prior reports. Comment areas were more widely dispersed this period.

This year saw a significant improvement in the response rate from the treatment facilities due to increased efforts by RBH to track and communicate with these providers. The responses from this larger pool however mirrored those from last year: Responses were positive although not outstanding. RBH will plan to continue relationship building with this group in an effort to further support the licensees.

RBH's efforts to improve communication with and enhance the partnership with the Workplace Monitors were visible in the results. On each item, the response by the largest group of respondents was the most positive response possible. Of significant importance for the program, 67.2% of the Workplace Monitors rated RBH's ability to monitor the licensee to ensure safety in the workplace as "Excellent" or "Above Average." RBH will continue to increase contact with the Workplace Monitors based on the feedback received.

There continues to be a lack of response from the Associations which is a continuing problem. Outreach efforts are planned for Year 4.

Responses from the Boards were positive with mode responses of "excellent" or "above average."

This report indicates that progress continues to be made in terms of program staff being responsive to the needs of its stakeholders.

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

## Purpose

The purpose of assessing participants (Licensees) of the Health Professionals' Services Program (HPSP) is to obtain constructive feedback that can be used to improve and maintain the quality, effectiveness, and efficiency of the HPSP Program. In order to provide continuous quality services, RBH evaluates Licensees' satisfaction with the HPSP Program on a twice yearly basis. (This was changed from Quarterly after January 2013).

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

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

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

## Data Results

### Response Rate

Table 1: Response Rate	This Period	Year 3	Year 2
# Sent	292	915	1330
# of Responses	69	246	367
Response Rate	23.6%	26.9%	27.6%

The HPSP Licensee Satisfaction Survey was issued to 100% of the Licensees enrolled in the HPSP Program at the end of June 2013. The survey was emailed to 258 licensees and mailed to 34. A total of 69 responses were received, representing a response rate of 23.6%. For Year 3, which includes surveys sent in October, January and July, the average response rate was 26.9%. This is comparable to Year 2's rate of 27.6%.

## Respondents

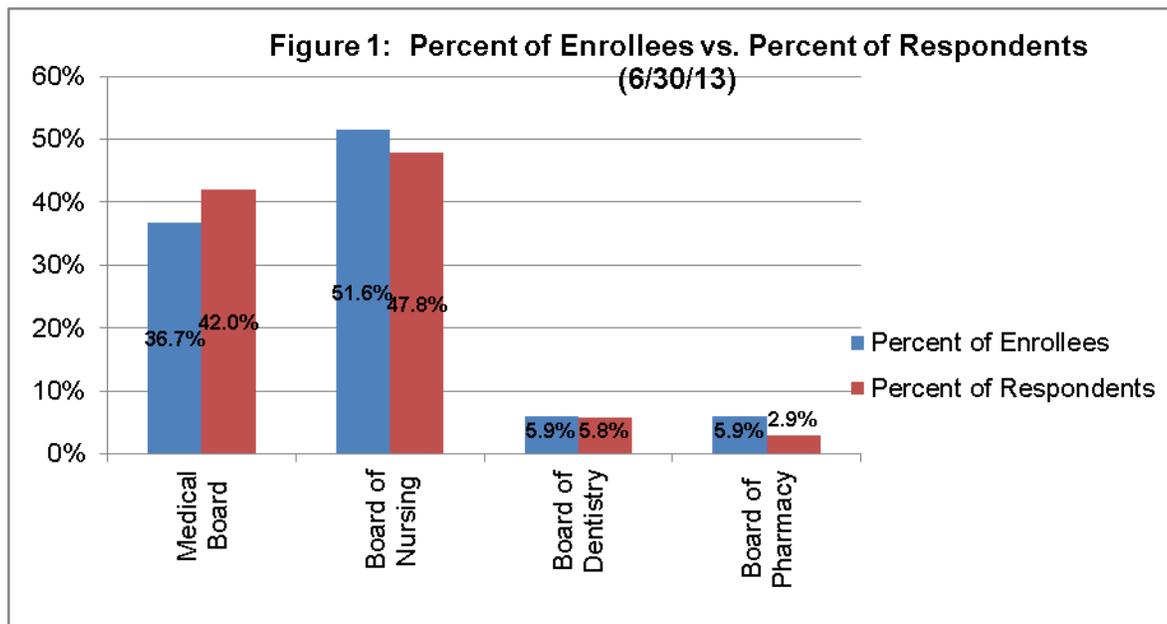
47.8% of respondents this period were representatives of the Board of Nursing, bringing the average for the year to 47.3%. The Medical Board follows with 42% for the period, and 42.8% for the year. The Board of Dentistry was represented by 5.8% of the respondents this period, and 6.2% for the year. The Board of Pharmacy was represented by 2.9% for the period and 3.7% for the year. (See Table 2)

**Data Table 2:**

Table 2: Respondents by Board	This Period (n=69)		Year 3 (n=246)		Year 2 (n=367)	
	#	%	#	%	#	%
Medical Board	29	42.0%	104	42.8%	105	28.6%
Board of Nursing	33	47.8%	115	47.3%	222	60.5%
Board of Dentistry	4	5.8%	15	6.2%	16	4.4%
Board of Pharmacy	2	2.9%	9	3.7%	17	4.6%
No Response	1	1.4%	3	1.2%	7	1.9%

Comparing the response data to the enrollment data shows if the breakdown of respondents by board mirrors that of the enrolled licensees. The July breakdown is displayed in Table 3 and Figure 1, showing a skew towards the Medical Board.

Table 3: Comparison of Enrollees to Respondents	Percent of Enrollees (6/30/13)	Percent of Respondents (This Period)
Medical Board	36.7%	42.0%
Board of Nursing	51.6%	47.8%
Board of Dentistry	5.9%	5.8%
Board of Pharmacy	5.9%	2.9%



## Customer Service

This question asks respondents to “Think about [their] most recent call to RBH.....” and evaluate 2 statements, one regarding responsiveness and the other regarding clarity and professionalism of the communication. Both for the period and the year, the mode response to both items was “strongly agree,” an improvement from Year 2’s mode of “agree.” (See Data Tables 4a – 4c).

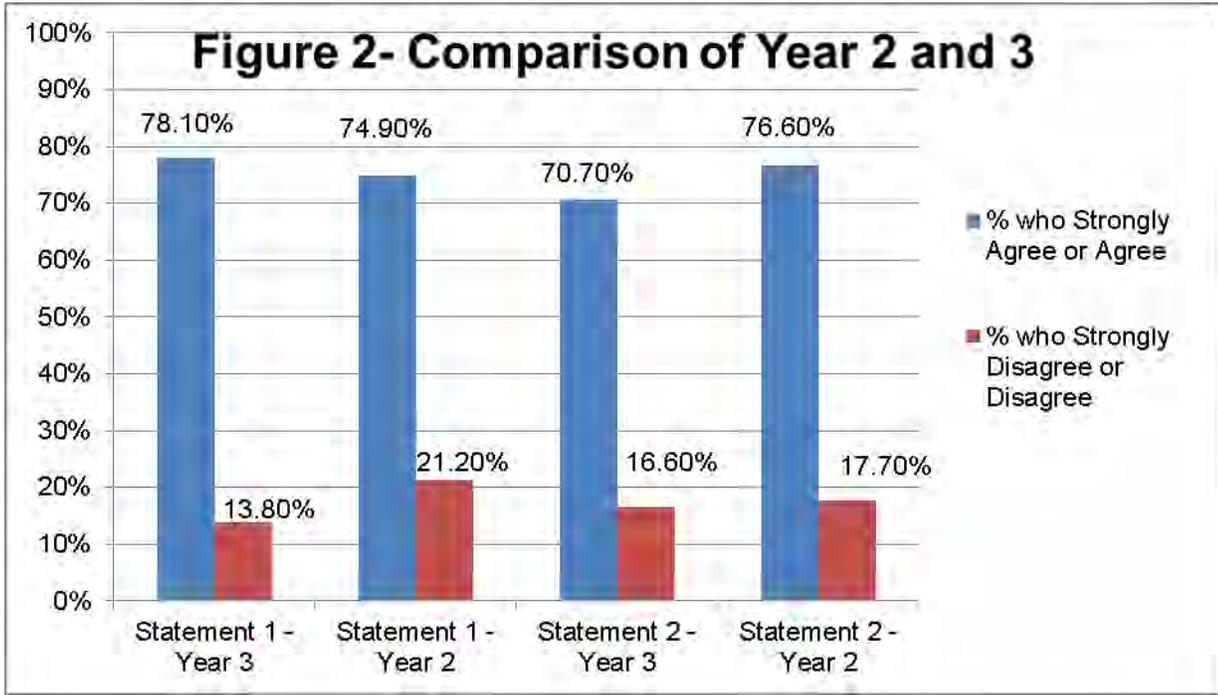
Only 13.8% of respondents in Year 3 “disagree” or “strongly disagree” that their questions/concerns were responded to promptly. Comparatively, 78.1% of respondents indicated that they “agree” or “strongly agree” with this statement. This is an improvement from 74.9% in Year 2. Similarly, only 16.6% of respondents in Year 3 “disagree” or “strongly disagree” that information was communicated clearly and professionally. This is an improvement from the 17.7% who responded in this way in Year 2. On the other hand, 70.7% indicated that they “agree” or “strongly agree” with this statement in Year 3 which is a decrease from the 76.6% in Year 2. This is illustrated on Figure 2 on the next page.

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

Table 4a: This Period (n=69)	Strongly Agree		Agree		Disagree		Strongly Disagree		N/A		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
Questions and/or Concerns Were Responded to within one business day	27	39.1%	19	27.5%	2	2.9%	7	10.1%	6	8.7%	8	11.6%
Information was Communicated Clearly and Professionally	23	33.3%	20	29.0%	7	10.1%	5	7.2%	5	7.2%	9	13.0%

Table 4b: Year 3 (n=246)	Strongly Agree		Agree		Disagree		Strongly Disagree		N/A		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
Questions and/or Concerns Were Responded to within one business day	104	42.3%	88	35.8%	11	4.5%	23	9.3%	12	4.9%	8	3.3%
Information was Communicated Clearly and Professionally	93	37.8%	81	32.9%	23	9.3%	18	7.3%	10	4.1%	21	8.5%

Table 4c: Year 2 (n=367)	Strongly Agree		Agree		Disagree		Strongly Disagree		N/A		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
Questions and/or Concerns Were Responded to within one business day	119	32.4%	156	42.5%	39	10.6%	39	10.6%	12	3.3%	2	0.5%
Information was Communicated Clearly and Professionally	116	31.6%	165	45.0%	30	8.2%	35	9.5%	12	3.3%	9	2.5%



*(Report continues on next page.)*

## Agreement Monitors

The next item asked respondents to react to the following: “Regarding our Agreement Monitors, to what extent do you agree that...” The first item indicates that the Agreement Monitor is knowledgeable about the respondent’s case and the second indicates that the respondent’s needs and concerns are understood. For both items this year the mode response was “strongly agree.” This is an improvement over Year 2 when the mode response was “agree.” Combining both positive responses (“agree” and “strongly agree”) we find that there was not much change from year 2 to year 3:

	Year 3 (Agree/Strongly Agree)	Year 2 (Agree/Strongly Agree)
• Statement 1	78.9%	78.5%
• Statement 2	70.3%	73.6%

These findings indicate that although there is not a greater percentage of respondents providing positive feedback on their agreement monitors, those who DO provide positive responses are providing even more favorable responses (moving from “agree” to “strongly agree.”)

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

Table 5a: This Period (n=69)	Strongly Agree		Agree		Disagree		Strongly Disagree		N/A		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
My Agreement Monitor is knowledgeable about my case	25	36.2%	22	31.9%	8	11.6%	6	8.7%	1	1.4%	7	10.1%
My needs and concerns are understood	21	30.4%	21	30.4%	10	14.5%	9	13.0%	1	1.4%	7	10.1%

Table 5b: Year 3 (n=246)	Strongly Agree		Agree		Disagree		Strongly Disagree		N/A		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
My Agreement Monitor is knowledgeable about my case	103	41.9%	91	37.0%	23	9.3%	19	7.7%	4	1.6%	6	2.4%
My needs and concerns are understood	91	37.0%	82	33.3%	30	12.2%	30	12.2%	3	1.2%	10	4.1%

Table 5c: Year 2 (n=367)	Strongly Agree		Agree		Disagree		Strongly Disagree		N/A		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
My Agreement Monitor is knowledgeable about my case	123	33.5%	165	45.0%	40	10.9%	26	7.1%	9	2.5%	4	1.1%
My needs and concerns are understood	127	34.6%	143	39.0%	42	11.4%	38	10.4%	6	1.6%	11	3.0%

## Service Components

This item asked respondents to “Please rate the following services as they contribute to your successful completion of the program.” Agreement Monitor contacts, newsletters, toxicology testing and the website are all listed for rating. This year, Individual Monitoring Consultants and Group Monitoring were also included for Medical Board (OMB) participants only. The majority of respondents rated each service element as “helpful” this period, this year and last year (Year 2).

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

Table 6a: This Period (n=69) (*OMB only– n=29)	Extremely Helpful		Helpful		Unhelpful		Extremely Unhelpful		N/A		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
Agreement Monitor contacts	14	20.3%	<b>27</b>	<b>39.1%</b>	13	18.8%	7	10.1%	2	2.9%	6	8.7%
Newsletter	4	5.8%	<b>38</b>	<b>55.1%</b>	16	23.2%	3	4.3%	2	2.9%	6	8.7%
Toxicology testing	11	15.9%	<b>24</b>	<b>34.8%</b>	17	24.6%	6	8.7%	4	5.8%	7	10.1%
Website	6	8.7%	<b>29</b>	<b>42.0%</b>	16	23.2%	3	4.3%	8	11.6%	7	10.1%
Individual Monitoring Consultants*	4	13.8%	<b>7</b>	<b>24.1%</b>	6	20.7%	2	6.9%	5	17.2%	5	17.2%
Group Monitoring*	4	13.8%	<b>8</b>	<b>27.6%</b>	3	10.3%	1	3.4%	10	34.5%	3	10.3%

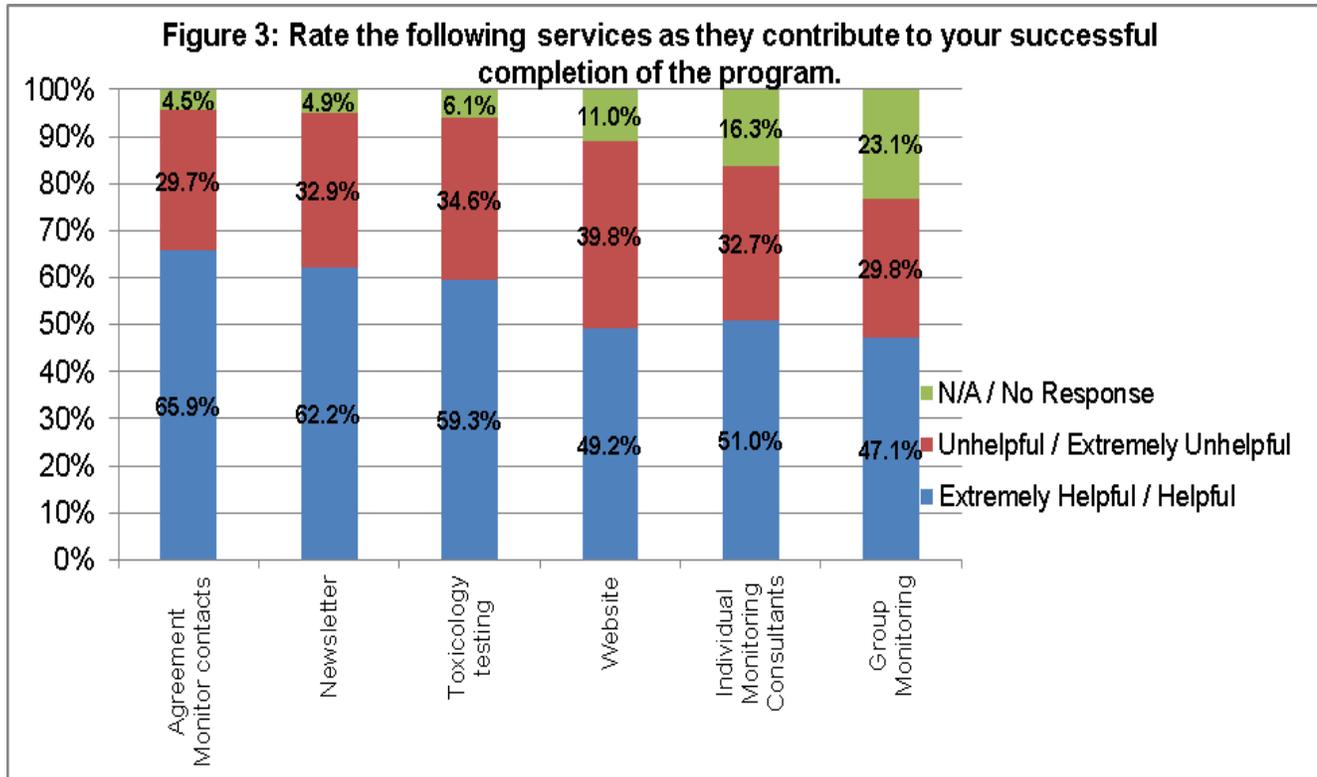
Table 6b: Year 3 (n=246) (*OMB only– n=104)	Extremely Helpful		Helpful		Unhelpful		Extremely Unhelpful		N/A		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
Agreement Monitor contacts	54	22.0%	<b>108</b>	<b>43.9%</b>	54	22.0%	19	7.7%	2	0.8%	9	3.7%
Newsletter	19	7.7%	<b>134</b>	<b>54.5%</b>	65	26.4%	16	6.5%	2	0.8%	10	4.1%
Toxicology testing	37	15.0%	<b>109</b>	<b>44.3%</b>	61	24.8%	24	9.8%	4	1.6%	11	4.5%
Website	18	7.3%	<b>103</b>	<b>41.9%</b>	76	30.9%	22	8.9%	8	3.3%	19	7.7%
Individual Monitoring Consultants*	17	16.3%	<b>36</b>	<b>34.6%</b>	21	20.2%	13	12.5%	5	4.8%	12	11.5%
Group Monitoring*	16	15.4%	<b>33</b>	<b>31.7%</b>	19	18.3%	12	11.5%	10	9.6%	14	13.5%

Table 6c: Year 2 (n=367)	Extremely Helpful		Helpful		Unhelpful		Extremely Unhelpful		No Response	
	#	%	#	%	#	%	#	%	#	%
Agreement Monitor contacts	78	21.3%	<b>178</b>	<b>48.5%</b>	78	21.3%	30	8.2%	3	0.8%
Newsletter	26	7.1%	<b>204</b>	<b>55.6%</b>	101	27.5%	26	7.1%	10	2.7%
Toxicology testing	58	15.8%	<b>192</b>	<b>52.3%</b>	61	16.6%	51	13.9%	5	1.4%
Website	9	2.5%	<b>153</b>	<b>41.7%</b>	141	38.4%	39	10.6%	25	6.8%

For the year in descending order, the following percentage of respondents rated the components “helpful” or “extremely helpful:”

- Agreement Monitor contacts - 65.9%
- Newsletters - 62.2%
- Toxicology Testing – 59.3%
- Individual Monitoring Consultants – 51.0%
- Website - 49.2%
- Group Monitoring – 47.1%

Year 3’s data is displayed in Figure 3.



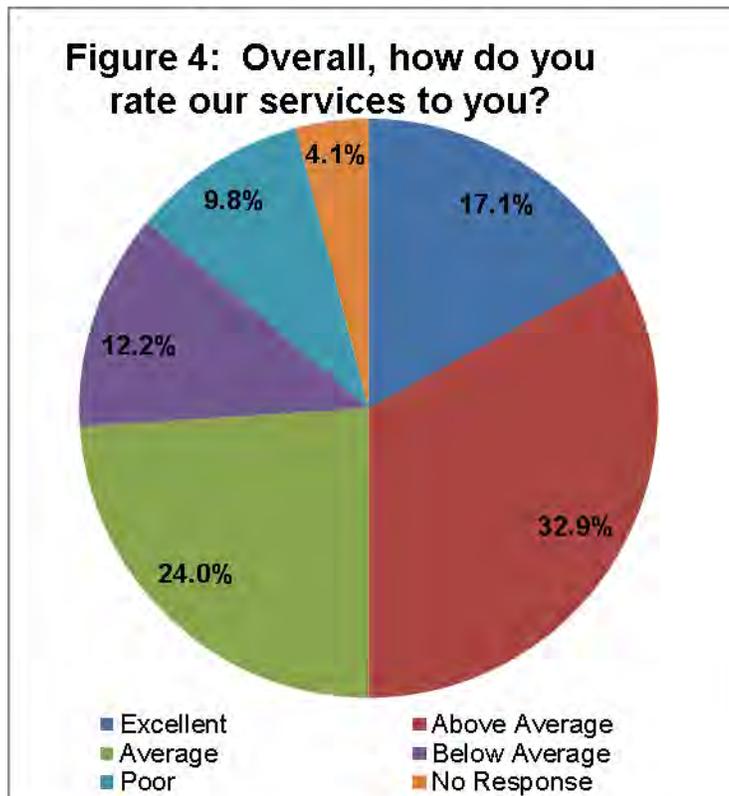
## Overall Rating of Services

Respondents were asked to rate the overall services. The mode response this year was “above average” for the first time this year. It did slide back to “average” for this period, however. For the year, 50.0% of respondents rated the program “excellent” or “above average” compared to 42.0% last year.

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

Table 7: Overall Rating	This Period (n=69)		Year 3 (n =246)		Year 2 (n=367)	
	#	%	#	%	#	%
Excellent	14	20.3%	42	17.1%	52	14.2%
Above Average	19	27.5%	<b>81</b>	<b>32.9%</b>	102	27.8%
Average	<b>20</b>	<b>29.0%</b>	59	24.0%	<b>125</b>	<b>34.1%</b>
Below Average	6	8.7%	30	12.2%	44	12.0%
Poor	3	4.3%	24	9.8%	40	10.9%
No Response	7	10.1%	10	4.1%	4	1.1%

Figure 4 displays the Year 3 responses.

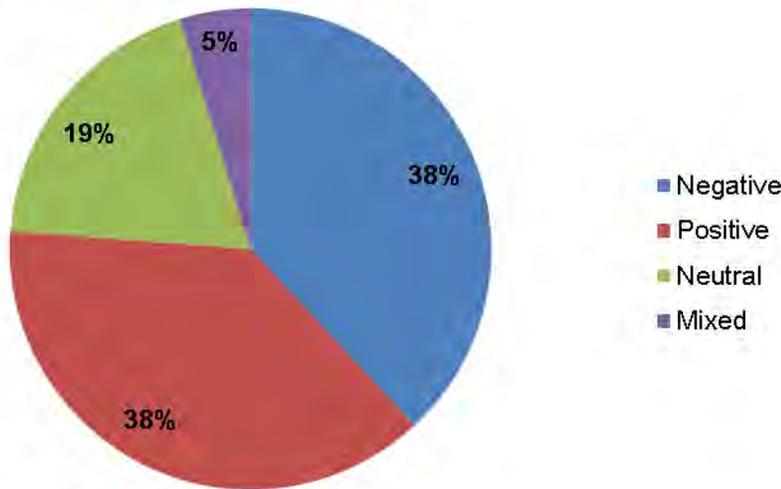


## Additional Comments

At the conclusion of the survey, respondents are asked for any additional comments. Twenty-one (21) comments were received, reviewed, and categorized in July. Comments were received from 30.4% of respondents compared to 35.4% in January and 40.7% in October. Comments were first categorized with an overall type: positive, negative, neutral or mixed (containing both positive and negative). In summary, 38% of the comments were positive, 38% were negative, 19% were neutral and 5% were mixed (both positive and negative). This data is displayed in Figure 5. There are significantly more positive comments than in the July and October surveys and significantly less negative comments than in those surveys. (See Figure 6) Overall, although there were fewer comments than we have seen previously, they are more positive and less negative than in prior reports.

Comments were then categorized by area (see Data Table 8, next page). Each issue within a comment was categorized to maximize the ability to capture all feedback. Comments areas were more widely disbursed this period. There were 3 each in the positive/general category and the positive/program structure category. It is important to note that the percentage of negative program structure and negative toxicology comments dropped substantially from the prior to reports.

**Figure 5: Comment Type**



**Figure 6: Comment Type by Survey**

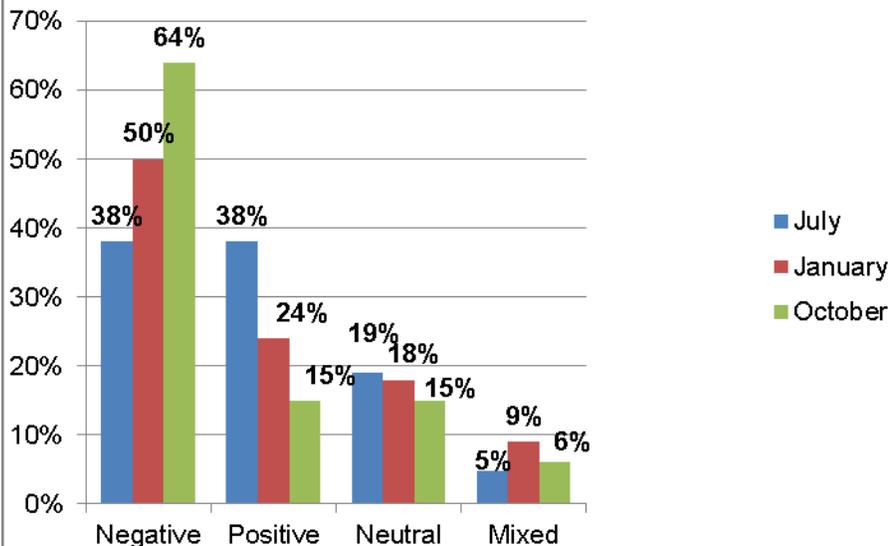


Table 8: Categories of Comments Received		July		January		October	
		#	%	#	%	#	%
Communication	Positive						
	Negative	1	3.7%	2	4.5%	2	4.4%
Financial Comp	Positive						
	Negative	1	3.7%	1	2.3%	2	4.4%
General	Positive	<b>3</b>	<b>11.1%</b>	5	11.4%	3	6.7%
	Negative	2	7.4%	3	6.8%	4	8.9%
	Neutral			2	4.5%	1	2.2%
Mental Health Component	Positive						
	Negative	1	3.7%	1	2.3%	1	2.2%
Program Structure	Positive	<b>3</b>	<b>11.1%</b>	3	6.8%		
	Negative	2	7.4%	<b>11</b>	<b>25.0%</b>	<b>12</b>	<b>26.7%</b>
	Neutral	2	7.4%	3	6.8%	1	2.2%
Staff – Account Manager	Positive	2	7.4%	2	4.5%	4	8.9%
	Negative	2	7.4%	4	9.1%	1	2.2%
	Neutral	1	3.7%	1	2.3%	1	2.2%
Staff - General	Positive	2	7.4%	1	2.3%		
	Negative	1	3.7%			1	2.2%
Staff Availability & Responsiveness	Positive					1	2.2%
	Negative					1	2.2%
Toxicology / Lab Locations	Positive						
	Negative	1	3.7%	5	11.4%	7	15.6%
	Neutral	2	7.4%			2	4.4%
Website / IVR	Positive						
	Negative	1	3.7%			1	2.2%

## Actual Comments Received – July 2013

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

1. I was reported as non-compliant because my monitor did not understand one of the HPSP policies. When I attempted to discuss it with her prior to reporting me, she refused and reported me anyway. Then when she did finally understand it, she forwarded situation to her supervisor. Now they refuse to reverse the decision unless my board on their own decides that it was reported in error, which of course will not happen because they do not investigate, just record what decisions are given to them by HPSP. This whole situation was handled VERY unprofessionally, and demonstrated a complete lack of insight and integrity on the part of HPSP.
2. Keep up the good work-constant improvement has produced good results.
3. Agreement monitor frequently has no idea what is going on. Loses paper work and doesn't recording interactions. She is talks down to myself as well as my employer. I have had many complaints from my employer regarding unprofessional attitude of my monitor.
4. My agreement monitor is the BEST!! [Name], I couldn't do it without you.
5. System for call ins doesn't work all the time. Frustrating
6. The team is always friendly and helpful
7. Thank you for addressing all my previous questions. Here are some more:
  1. My monitoring agreement and addendum don't make any reference to having a sponsor. Why do I have to report the frequency of contacts with my sponsor?
  2. Does the Advisory Committee have any current or former monitorees on it? Shouldn't there be a consumer advisory committee comprised of monitorees as well?
8. I find it very odd that my agreement monitor is located on the east coast while I am participating in the HPSP in Portland Oregon. I think it would be better to have an agreement monitor who is local and in the same time zone. It would be great to be able to meet the agreement monitor in person also. To be able to attach the voice on the phone to a face. Much like meeting with a behavioral health counselor or a 12-step program sponsor.
9. I'm grateful to be a participant in this Helath Professional's Program which is rigorous but with outstanding evidence-based outcome statistics. An excellent program which is complementary to my 12 step recovery work in my local community
10. Consider changing UA requirements and increasing vacation days as the years go by. It would be nice to be rewarded for sustained recovery.
11. Too restrictive for nurses who are completely voluntary, nurses who sign up to do the right thing, not nurses who sign up because they are afraid their employer will turn them in.
12. This service does not help the participant
13. Let's face it: you are a monitoring agency. I resent the little "tips" to stay sober which seem condescending. Monitoring is your task; leave the sobriety to our learned mechanisms.
14. The program is very helpful and I understand the need to keep the community safe but the number of toxicology test and cost are quite detrimental to someone trying to get back on their feet and the length of the program. All programs are 2 years, yet we are required to call daily for 4 years. Seems random test after two years would suffice if given 1-2 days to complete. Thank you.
15. Its not difficult to stay in compliance. The rules of the contract provide necessary structure.
16. My monitor- [Name] is incredible and takes the time to be sure I am ok in my program. Kudos to her!!
17. Not set up for mental illness which is not active or ever a problem for medical practice.
18. I have seen more of an individualized approach lately. All in all very helpful pgm.
19.
  1. Please eliminate the monthly workplace monitor requirement. Quarterly should be adequate after the first 2 years.
  2. Please restore Tier1 testing as an approved site (even if probationary).
  3. Vacation should be vacation, and free of required call-in or testing, since it does not affect the workplace. Increased testing after a prolonged absence would be an appropriate trade-off to help avoid relapse.
  4. A single missed test should not represent "substantial noncompliance" if testing is completed within 24 hours. RBH cannot maintain it's call-in service reliably 100% of the time, why should participants be expect to achieve "perfect" results?
20. I appreciate your genuine kindness, empathy and willingness to listen.
21. I feel it is important that we get a chance to meet face to face with our monitor. It should be voluntary and if an additional cost needs to be assessed I have no problem with that.

## Summary Analysis

The average licensee survey response rate was 26.9% for Year 3, which includes surveys sent in October, January and July. This is comparable to Year 2's rate of 27.6%. The breakdown of respondents by board is skewed by 6 percentage points towards the Medical Board, but is otherwise representative of the licensee population.

For the year, when thinking about their most recent call to RBH, 78.1% of respondents indicate that they "agree" or "strongly agree" that their questions/concerns were responded to promptly. Similarly, 70.7% indicate that they "agree" or "strongly agree" that information was communicated clearly and professionally. The mode response to both items was "strongly agree."

Agreement Monitors received strong ratings again this year: 78.9% of respondents "agree" or "strongly agree" that (his/her) Agreement Monitor is knowledgeable about (his/her) case. Similarly, 70.3% of respondents "agree" or "strongly agree" that (his/her) needs and concerns are understood. For both items this year the mode response was "strongly agree." This is an improvement over Year 2 when the mode response was "agree."

When rating how various components contribute towards the successful completion of the program, Agreement Monitor contacts, Newsletters, Toxicology testing, the Website Individual Monitoring and Group Monitoring were all most frequently rated as "Helpful" both for the period and the year.

Overall, 50% of respondents rated the services as "excellent" or "above average" for the year. This is up from 42% in Year 2 and 26.0% in year 1. The mode response this year was "above average" for the first time, an improvement from "average."

Twenty-one (21) comments were received, reviewed, and categorized in July. Overall, although there were fewer comments than we have seen previously, they are more positive and less negative than in prior reports. Comments areas were more widely dispersed this period. It is important to note that the percentage of negative program structure and negative toxicology comments dropped substantially from the prior to reports.

# Reliant Behavioral Health

## Health Professionals' Services Program (HPSP)

### Satisfaction of EMPLOYERS / WORKPLACE MONITORS

#### Purpose

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

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

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

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

#### Data Results

#### Response Rate

Table 1: Response Rate	This Period	Year 3	Year 2
# Sent	192	389	387
# Responses	41	73	53
Response Rate	21.4%	18.8%	13.7%

The HPSP Employers Satisfaction Survey was distributed to Workplace Monitors through email and mail in both January and July. Out of the total 389 surveys distributed, 73 responses were received for a response rate of 18.8%. This is a significant improvement over Program Year 2's rate of 13.7%. This period's response rate was the strongest to-date at 21.4%, representing 41 responses out of 192 surveys sent.

## Type of Service Provided by Employer

Respondents are first asked the type of services provided by their organization. Although “medical” was the most frequent response for this period as we saw last year, for Year 3 the most frequent response overall was “nursing.” This is consistent with the break-down of the population of enrolled licensees.

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

Table 2: Type of Services Provided	This Period (n=41)		Year 3 (n=73)		Year 2 (n=53)	
	#	%	#	%	#	%
Medical	21	51.2%	33	45.2%	24	45.3%
Nursing	17	41.5%	36	49.3%	19	35.8%
Pharmacy	1	2.4%	1	1.4%		
Dental	1	2.4%	2	2.7%	2	3.8%
Other	1	2.4%	1	1.4%	7	13.2%
No Response					1	1.9%

## Services

Respondents are then asked to rate HPSP's services, including timeliness and knowledge of licensee when there is a concern in the workplace. This year, the 3<sup>rd</sup> item was modified from "Our ability to respond to concerns regarding program administration" to "Our ability to respond to questions regarding program administration." An additional item was added this year, "Frequency of feedback from RBH regarding Licensee's compliance." Finally, an overall rating is requested. For this period and year, the mode response to all items was clearly "excellent." This is a noticeable improvement from Year 2 when the mode for all items was "above average."

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

Table 3a This Period (n=41)	Excellent		Above Average		Average		Below Average		Poor		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
	Response timeframe when I request information	17	41.5%	5	12.2%	2	4.9%	1	2.4%	1	2.4%	15
Staff knowledge of a licensee when there is concern in the workplace	13	31.7%	4	9.8%	4	9.8%					20	48.8%
Our ability to respond to questions regarding program administration	20	48.8%	7	17.1%	2	4.9%	1	2.4%			11	26.8%
Frequency of feedback from RBH regarding Licensee's compliance	13	31.7%	8	19.5%	7	17.1%	1	2.4%	4	9.8%	8	19.5%
Overall rating of our services	19	46.3%	8	19.5%	8	19.5%	1	2.4%			5	12.2%

Table 3b Year 3 (n=73)	Excellent		Above Average		Average		Below Average		Poor		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
	Response timeframe when I request information	30	41.1%	14	19.2%	5	6.8%	2	2.7%	2	2.7%	20
Staff knowledge of a licensee when there is concern in the workplace	22	30.1%	16	21.9%	6	8.2%					29	39.7%
Our ability to respond to questions regarding program administration	31	42.5%	18	24.7%	7	9.6%	1	1.4%			16	21.9%
Frequency of feedback from RBH regarding Licensee's compliance	23	31.5%	15	20.5%	11	15.1%	4	5.5%	7	9.6%	13	17.8%
Overall rating of our services	33	45.2%	18	24.7%	14	19.2%	3	4.1%			5	6.8%

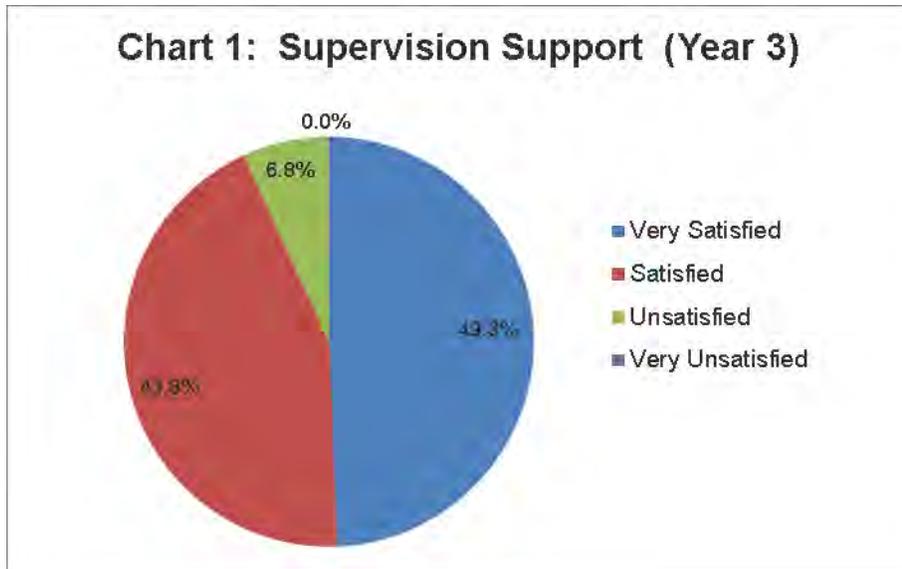
Table 3c Year 2 (n=53)	Excellent		Above Average		Average		Below Average		Poor		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
	Response timeframe when I request information	12	22.6%	15	28.3%	6	11.3%	2	3.8%	2	3.8%	16
Staff knowledge of a licensee when there is concern in the workplace	10	18.9%	13	24.5%	9	17.0%	1	1.9%			20	37.7%
Our ability to respond to concerns regarding program administration	8	15.1%	17	32.1%	7	13.2%	2	3.8%			19	35.8%
Overall rating of our services	13	24.5%	23	43.4%	11	20.8%	3	5.7%			3	5.7%

## Supervision Support

The next item reads: “RBH supports your supervision of licensees. How satisfied are you with our support?” For the period and the year, the mode response was “very satisfied” which was an improvement from Year 2. This period, 51.2% indicated they were “very satisfied” and 41.5% indicated that they were “satisfied.” For all of Year 3, 49.3% of respondents indicated they were “very satisfied,” followed by 43.8% who indicated they were “satisfied.”

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

Table 4: Supervision Support	This Period (n=41)		Year 3 (n=73)		Year 2 (n=53)	
	#	%	#	%	#	%
Very Satisfied	21	51.2%	36	49.3%	21	39.6%
Satisfied	17	41.5%	32	43.8%	26	49.1%
Unsatisfied	3	7.3%	5	6.8%	3	5.7%
Very Unsatisfied						
No Response					3	5.7%



## Workplace Safety

A new item was added to the survey this year: “How would you rate RBH's ability to monitor the licensee to ensure safety in the workplace?” The mode response was “excellent” both for the period and the year, with between 42% and 44% of responses. The second most common response was “average.”

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

Table 5: Workplace Safety	This Period (n=41)		Year 3 (n=73)		Year 2 N/A – Not Asked	
	#	%	#	%	#	%
Excellent	18	43.9%	31	42.5%		
Above Average	9	22.0%	18	24.7%		
Average	14	34.1%	21	28.8%		
Below Average			2	2.7%		
Poor						
No Response			1	1.3%		

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

### Actual Comments – July:

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

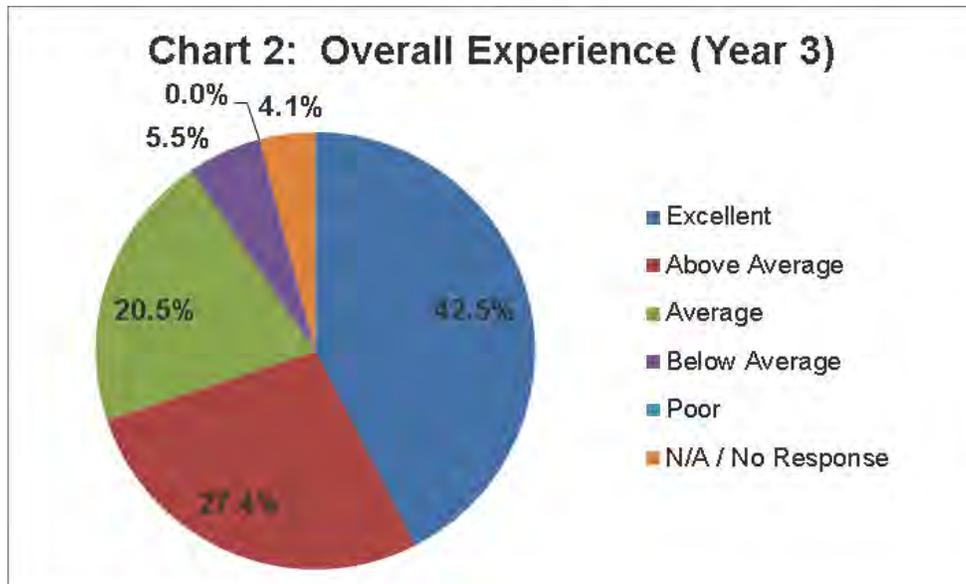
1. Taking into consideration sleep patterns for night shift RNs who have to test when travel is involved can potentially have a negative safety impact. (i.e. RN works on Thursday and Friday nights, has to drive over an hour to test during business hours, can impact sleep patterns.)
2. I like that I get an email monthly now to remind me to send in my monitor report
3. I have not ever gotten any feedback - I am hoping that no news is good news.
4. In the last year I started receiving emails to remind me to send in the monthly workplace agreement. That is very helpful. However, if there is a problem with the worker and they need to refrain from patient care for a period of time, I don't get a lot of follow up feedback once the issue is resolved. Maybe that is because of confidentiality.
5. You do not communicate to me what you are doing outside of having me fill out monthly reports.
6. The program seems pretty one sided. I provide information but never get any information back as to the staff members compliance or progress from RBH's standpoint.
7. The link to learn more information about didn't work so I really don't know who you are, what you are monitoring the licensee for, or why. I am the second monitor for this licensee so my predecessor may have gotten this information and I take some responsibility since I didn't ask before now, but since RBH was aware of the change in monitor it would have been nice if there could have been some kind of overview of the program.
8. I oversee two individuals. For one of the individuals I often (but not always) receive a monthly form to complete in a PDF. However, the form is not labeled regarding who it is for, so I am never sure which one to use it for. So, please use the electronic form consistently, with all individuals, and complete the information regarding who it is for, before distributing.

## Overall Experience

Respondents are then asked to rate their overall experience working with RBH. The mode response was “excellent” at 46.3% for the period and 42.5% for the year. Although “excellent” was also the mode in Year 2, it increased from 35.8% that year. There continue to be no “poor” responses.

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

Table 6: Overall Experience	This Period (n=41)		Year 3 (n=73)		Year 2 (n=53)	
	#	%	#	%	#	%
Excellent	19	46.3%	31	42.5%	19	35.8%
Above Average	9	22.0%	20	27.4%	17	32.1%
Average	10	24.4%	15	20.5%	12	22.6%
Below Average	2	4.9%	4	5.5%	3	5.7%
Poor						
N/A or No Response	1	2.4%	3	4.1%	2	3.8%



## Additional Comments

### Actual Comments – July:

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

1. Would be nice to email workplace monitor report instead of faxing each month. Could be checkboxes and then send form.
2. I didn't have any issues raised with this employee, and therefore didn't have much contact with RBH beyond routine monthly reports.
3. I am new as supervising clinician for employee engaged. He reports good experiences to date.
4. I have an employee who during the first year of being monitored response time was good from your company. Now that we are in the second year of monitoring, i still have emails out that have not been responded to.
5. Have not had any issues with RN that is being monitored, Appreciate reminders to get reports in via email. I do feel that if I had issues or concerns, I would be able to readily reach someone to discuss those concerns.
6. With any problems they notify me right away so I can make necessary arrangements with Providers schedule. However I don't get follow up feedback after a situation is resolved.
7. I've had no contact from RBH for at least a year. I fill out forms monthly, but receive no information from RBH. If this is integral to the process (as your questions above seem to imply) then you should be in better communication with your monitors. I've had no specific issues with the person I monitor, so have not needed to contact RBH this year.
8. I appreciate your email reminders for timeliness
9. I am a new workplace monitor and can only speak to the initial discussion I had with your agency which was very helpful. Also, I have recently started receiving email reminders for the monthly forms and that has been very helpful to make sure its not forgotten or overlooked.
10. I only put average on a lot of my answers, because I don't have anything to compare it to.

## Summary Analysis

The HPSP Employers Satisfaction Survey had a response rate of 18.8% for Year 3, a significant improvement from the prior year (13.7% response rate.). Respondents indicated that their organizations primarily provide Nursing services (49.3%) or Medical services (45.2%) which is consistent with the licensee population.

HPSP's customer service, particularly in this case timeliness of responses, knowledge of licensees when there is a concern in the workplace, ability to respond to questions regarding program administration and frequency of feedback regarding licensee's compliance, were all rated as "excellent" by the largest group of respondents. This is an improvement from Year 2 when the mode responses were "above average."

49.3% of all respondents this year are "very satisfied" with the support they receive when supervising licensees. This is followed by 43.8% who indicate they are "satisfied." Further, 42.5% of all respondents indicate they rate RBH's ability to monitor the licensee to ensure safety in the workplace as "excellent." Again this is followed by an additional 24.7% who provide a rating of "above average."

Further, 42.5% rate their overall experience working with RBH HPSP as "excellent" and an additional 27.4% rate it as "above average" for a total of 69.9%.

RBH will continue to increase contact with the Workplace Monitors based on the feedback, particularly the comments, received.

# **Reliant Behavioral Health Health Professionals' Services Program (HPSP) Satisfaction of PROFESSIONAL ASSOCIATIONS**

## **Purpose**

The purpose of assessing representatives from the Oregon Medical Association, Oregon Nursing Association, Oregon Pharmacy Association, and the Oregon Dental Association is to obtain constructive feedback that can be used to improve and maintain the quality, effectiveness, and efficiency of the HPSP Program. In order to provide continuous quality services, RBH evaluates this stakeholder group's satisfaction with the HPSP Program on a twice yearly basis.

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

Feedback includes information about the timeliness of response, knowledge level of staff, ability to enroll licensees, and an overall rating of RBH services. Also, the survey asks about the value of the HPSP Program to their membership, and asks for any additional comments.

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

## **Data Results**

### **Response Rate**

The HPSP Satisfaction survey was distributed to 1 representative of each Professional Association, plus a second representative from the Oregon Nursing Association. A total of 5 surveys were emailed both in January and July. Unfortunately, no responses were received to either survey. This was also true in year two. During year one, this survey had an average response rate of 12% although the response rate ranged from 0% to 20% throughout the year.

### **Summary Analysis**

There were not any responses to this survey. It is recommended that RBH provide outreach to the Professional Associations.

# Reliant Behavioral Health

## Health Professionals' Services Program (HPSP)

### Satisfaction of TREATMENT PROVIDERS

#### Purpose

The purpose of assessing representatives from Treatment Providers is to solicit feedback that can be used to improve the services provided through the HPSP Program. RBH strives to maintain the quality, effectiveness, and efficiency of the program, and evaluates the Treatment Providers' satisfaction with the HPSP Program on a twice yearly basis.

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

Feedback includes information about RBH's communication, responsiveness of staff, overall rating of experience, and any additional comments.

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

#### Data Results

#### Response Rate

Table 1: Response Rate	This Period	Year 3	Year 2
# Sent	187	294	62
# Responses	18	27	5
Response Rate	9.6%	9.2%	8.1%

The HPSP Treatment Program Satisfaction Survey was distributed to representatives at various treatment programs that provide services to Licensees enrolled in HPSP. A total of 294 surveys were sent by mail or email between January and July; 187 of these were sent in July. The population that received surveys has dramatically increased from Year 2 when only 62 surveys were distributed. The response rate is not increasing as dramatically, but is improving: 9.6% for the period, 9.2% for Year 3 and 8.1% for Year 2.

## Role of Respondent

The survey was modified this year to include an additional open-ended question which asked “In what capacity were you working with the licensee?” For Year 4, the open-ended question will be converted to a multi-select question. The following responses were received this year:

Table 2: Role of Respondent	July	January
Counselor / Therapist	5	1
Independent Psychiatrist		1
EAP Counselor	1	
Therapist / PMC	6	1
Group Monitor (GMC)	1	2
Monitor (type unspecified)	2	
Consultant, Therapist		1
Treating physician		1
Treating physician / Evaluator	1	
Outpatient substance abuse counseling		1
Chemical Dependency Treatment		1

## Customer Service and Communication

Survey respondents are asked to rate three different statements relating to customer service, particularly communication between HPSP and the provider. Although there were a wide-variety of responses, the majority of respondents “Agreed” that their concerns were responded to promptly and that information was communicated clearly and professionally. This mirrors the results seen in Year 2. Responses were more split to the statement “I had all the information I needed when I saw the licensee.” Seven respondents for the period indicated they “agreed” while seven also “disagreed;” For the year, 10 “agreed” and 11 “disagreed.”

Data Tables 3 a, b, and c: The mode (most frequent) response is highlighted in red. Not all responses have a mode.

Table 3a: This Period (n=18)	Strongly Agree		Agree		Disagree		Strongly Disagree		N/A		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
My questions and/or concerns were responded to promptly	4	22.2%	<b>11</b>	<b>61.1%</b>	1	5.6%			2	11.1%		
Information was communicated clearly and professionally	4	22.2%	<b>11</b>	<b>61.1%</b>			1	5.6%	2	11.1%		
I had all the information I needed when I saw the licensee	2	11.1%	7	38.9%	7	38.9%	1	5.6%	1	5.6%		

Table 3b: Year 3 (n=27)	Strongly Agree		Agree		Disagree		Strongly Disagree		N/A		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
My questions and/or concerns were responded to promptly	7	25.9%	<b>16</b>	<b>59.3%</b>	1	3.7%			3	11.1%		
Information was communicated clearly and professionally	6	22.2%	<b>15</b>	<b>55.6%</b>	3	11.1%	1	3.7%	2	7.4%		
I had all the information I needed when I saw the licensee	4	14.8%	10	37.0%	<b>11</b>	<b>40.7%</b>	1	3.7%	1	3.7%		

Table 3c: Year 2 (n=5)	Strongly Agree		Agree		Disagree		Strongly Disagree		N/A		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
My questions and/or concerns were responded to promptly			<b>4</b>	<b>80%</b>					1	20%		
Information was communicated clearly and professionally			<b>5</b>	<b>100%</b>								
I had all the information I needed when I saw the licensee			<b>4</b>	<b>80%</b>	1	20%						

## Overall Experience

Respondents are next asked “Overall, how would you rate your experience working with RBH staff of the HPSP program?” The majority of respondents this period, this year and last year all responded “average.”

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

Table 4: Overall Rating	This Period (n=18)		Year 3 (n=27)		Year 2 (n=5)	
	#	%	#	%	#	%
Excellent	3	16.7%	5	19.2%		
Above Average	3	16.7%	4	15.4%	2	40%
Average	<b>9</b>	<b>50.0%</b>	<b>12</b>	<b>46.2%</b>	<b>3</b>	<b>60%</b>
Below Average	2	11.1%	4	15.4%		
Poor	1	5.6%	1	3.8%		
No Response			1	3.8%		

## Additional Comments

### Actual Comments – July:

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

1. Communication and expectations have become clearer over time, to your credit. Thank you.
2. Staff was very responsive
3. There have been times in the past year or so when the participant informed me at a quarterly meeting of situations that arose that I should have had better communication with agreement monitors about.
4. it would be helpful if more information were provided regarding return to work process, without having to be asked for it. More collaboration between HPSP and us.
5. unreasonable, unwilling to change their stance even with overwhelming evidence to the contrary. Seems like all you are/were concerned with is the money and not taking into consideration the actual facts and consequences of your demands on the health professional and her career. When you have 4 other professionals countering a diagnoses and one that you stand with and contract with it would see logical that you might question the validity of your contracted agency and the qualifications of the person(s) handing out a diagnosis that will severely and permanently impact a young professional in the field.
6. the agreement monitors and support staff are very helpful and pleasant
7. One planning meeting with all parties involved seems minimum for a successful program. This would need to be paid for me to participate.
8. I marked all of the first questions as N/A as I have not seen a new pt recently which presumably would result in some form of communication from RBH? Nor have I made an inquiry of RBH. I don't think I have ever been contacted by RBH. As a treating clinician I am expected to send in a form summarizing status periodically but I am not sure what to expect from RBH in the form of communication or collaboration.
9. Patient has had several occurrences where she could not reach her monitor and miscommunication around a travel day resulted in a missed UA. Despite travel clearance, she was expected to test on her travel day. I have concerns of patient needs being reasonably met.
10. I do not receive any feedback on my evaluations, and I do not receive results of UAs and evaluations my patients have gotten through RBH. As a medical director of a rehab unit as well as an addiction treatment physician I think open communication is the best pathway to consistent and professional treatment of people with addiction issues.
11. I'm very pleased with the program and the responsiveness the staff have to it's affiliates and their clients.

## Summary Analysis

The response rate to the HPSP Treatment Program Satisfaction Survey for Year 3 was 9.2%, an improvement from last year's 8.1%. Respondents varied in their relationship to the licensee, however "consultant" (GMC or PMC) was the most common relationship identified.

The majority of respondents "agreed" that their concerns were responded to promptly and that information was communicated clearly and professionally. This mirrors the results seen in Year 2. Responses were more split to the statement "I had all the information I needed when I saw the licensee." Seven respondents for the period indicated they "agreed" while seven also "disagreed;" For the year, 10 "agreed" and 11 "disagreed."

The mode response for overall rating was "Average."

It is recommended that RBH change the relationship item to a multi-select question. Further, RBH should continue to work to strengthen the relationship with the various Treatment Providers based on the feedback provided. This should not only create a better partnership with which to serve the licensee, but also a stronger response rate from which to obtain more feedback next year.

# Reliant Behavioral Health

## Health Professionals' Services Program (HPSP)

### Satisfaction of BOARDS

#### Purpose

The purpose of assessing representatives from the Medical Board, Board of Nursing, Board of Dentistry, and the Board of Pharmacy, is to obtain constructive feedback that can be used to improve and maintain the quality, effectiveness, and efficiency of the HPSP Program. In order to provide continuous quality services, RBH evaluates satisfaction with the HPSP Program on a quarterly basis.

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

Feedback includes information about the overall program and staff, timeliness of our responses to inquiries, knowledge level of our staff, our ability to enroll referred licensees, and our ability to administer the program.

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

#### Data Results

##### Response Rate

Table 1: Response Rate	This Period	Year 3	Year 2
# Sent	8	17	16
# Returned	4	8	8
Response Rate	50.0%	47.1%	50.0%

The HPSP Boards Satisfaction Survey was emailed to representatives at 100% of the participating Boards both in January and July. The response rate for July was 50.0%, representing four responses to eight surveys sent. For the year, a total of eight responses were received out of 17 possible, resulting in a 47.1% response rate. Last year's response rate was similar at 50.0%

##### Respondents

This period, surveys were sent to three representatives each from the Medical Board and Board of Pharmacy and one each from the other two boards. Respondents this period were from the Medical Board (3) and the Board of Pharmacy (1). For the year, the Board of Nursing is also represented. Year 2's survey had better representation from each board.

Table 2: Respondents by Board	This Period (n=4)		Year 3 (n=8)		Year 2 (n=8)	
	#	%	#	%	#	%
Medical Board	3	75%	5	62.5%	3	37.5%
Board of Nursing			1	12.5%	2	25%
Board of Dentistry					1	12.5%
Board of Pharmacy	1	25%	2	25%	2	25%

## Services

Respondents were asked to rate four different service components based on their experience. All responses to the July survey were “Excellent” or “Above Average.” In all but one question, there was not a mode because the responses were evenly split. For the year, results are more varied but the mode response was “Excellent” or “Above Average” for each question. Results from Year 2 are also displayed for comparison purposes.

**Data Table 3a, b and c:** The mode (most frequent) response is highlighted in red. Not all responses have a mode:

Table 3a – This Period (n=4)	Excellent		Above Average		Average		Below Average		Poor		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
Staff knowledge of the case when I need to discuss a board referred licensee	2	50%	2	50%								
Response timeframe when I request information	2	50%	2	50%								
Our ability to respond to Board concerns regarding program administration	1	25%	<b>3</b>	<b>75%</b>								
Overall, how do you rate our services	2	50%	2	50%								

Table 3b – Year 3 (n=8)	Excellent		Above Average		Average		Below Average		Poor		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
Staff knowledge of the case when I need to discuss a board referred licensee	<b>4</b>	<b>50.0%</b>	3	37.5%	1	12.5%						
Response timeframe when I request information	<b>4</b>	<b>50.0%</b>	3	37.5%			1	12.5%				
Our ability to respond to Board concerns regarding program administration	2	25.0%	<b>4</b>	<b>50.0%</b>	1	12.5%					1	12.5%
Overall, how do you rate our services	<b>4</b>	<b>50.0%</b>	3	37.5%			1	12.5%				

Table 3c – Year 2 (n=8)	Excellent		Above Average		Average		Below Average		Poor		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
Staff knowledge of the case when I need to discuss a board referred licensee	<b>5</b>	<b>62.5%</b>	2	25.0%	1	12.5%						
Response timeframe when I request information	2	25.0%	<b>4</b>	<b>50.0%</b>	2	25.0%						
Our ability to respond to Board concerns regarding program administration	3	37.5%	3	37.5%	2	25.0%						
Overall, how do you rate our services	3	37.5%	3	37.5%	2	25.0%						

## What Should We Improve?

### Actual Comments – July:

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

1. Understanding each of the Boards' processes and how they interact or might interact with HPSP.
2. There are occasions when response time is slow, but since we experience heavy volume periods as well, I try to be understanding.

## Additional Comments

### Actual Comments – July:

No comments received

## Summary Analysis

The Medical Board was most heavily represented in this year's survey response set with six responses. The Board of Nursing and Board of Pharmacy each had one response. The Board of Dentistry did not respond. The overall response rate for the period was 50% and for the year was 47.1%

The following four statements were rated:

1. Staff knowledge of the case when I need to discuss a board referred licensee
2. Response timeframe when I request information
3. Our ability to respond to Board concerns regarding program administration
4. Overall, how do you rate our services

Except for item three, these responses had a mode response of "excellent" for the year. Item three had a mode response of "above average." Four recommendations for improvement were provided and three general comments were provided.

## **Health Professionals' Services Program Program Guidelines**

**Title: Suspension from HPSP**

**Pages: 2**

**Revision Date: 8/12/13; 5/15/2013; 2/15/2013**

### **Guideline:**

1 Licensing boards participating in the Health Professionals Services' Program (HPSP) are the only entities  
2 empowered to terminate board referred licensees from the monitoring program. There may be  
3 situations when licensees are not in compliance with HPSP requirements and it is necessary to cease  
4 monitoring before the licensing board is able to terminate the licensee. Prior to board action, the HPSP  
5 program will place these licensees in a suspended status. This status means that the licensee is no  
6 longer being monitored by the program; licensees are not required to remain in weekly contact with  
7 their agreement monitor or continue in the toxicology program. The appropriate board will be notified  
8 prior to any action being taken and when possible will be notified as soon as the agreement monitor has  
9 indicators that licensee may meet the criteria for suspended status. If employed, the licensee's  
10 employer will be informed that licensee has been suspended from the program and the licensee will be  
11 requested to step-down from practice. The agreement monitor will request that the employer send a  
12 statement indicating that the licensee is not working. The licensee will be required to sign the Refrain  
13 from Practice agreement.

14 Circumstances which can result in a licensee being suspended from the program include but are not  
15 limited to:

- 16 1. Licensee is unable to maintain a current financial balance, including the agreed upon deposit.
- 17 2. Licensee is on active military duty outside of the United States.
- 18 3. Licensee has an illness that prevents licensee from participating in the program.
- 19 4. Licensee has an expired license.

20 When the Program receives a letter from a physician stating that the licensee should be suspended from  
21 monitoring, the Program may immediately suspend the licensee from toxicology testing. The Program  
22 needs to immediately notify the licensee's licensing board. The appropriate board will respond as soon  
23 as possible indicating what other monitoring requirements should also be suspended. The decision to  
24 suspend more than toxicology testing for a medical suspension is a licensing board decision.

25 Licensees may request reinstatement prior to termination from program. Licensees must show that the  
26 behavior(s) that resulted in suspension has been ameliorated. The Board will be informed when  
27 licensee is removed from suspended status. The licensee will be sent a new addendum to the

28 monitoring agreement to reflect a new estimated completion date to account for days out of the  
29 program.

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# 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**

H6639	J. MICHAEL CORTEZ, R.D.H.	10/10/2013
H6640	JENNIFER J HASENYAGER, R.D.H.	10/10/2013
H6641	SIMRANPREET K GREWAL, R.D.H.	10/10/2013
H6642	RANDILYN D ARMSTRONG, R.D.H.	10/10/2013
H6643	HILARY G LUHN, R.D.H.	10/10/2013
H6644	LYNN G BOUCHARD, R.D.H.	10/18/2013
H6645	ANGELA M SUMNER, R.D.H.	10/18/2013
H6646	MCKENZIE R BEHR, R.D.H.	10/18/2013
H6647	SARA M NEWCOMER, R.D.H.	10/18/2013
H6648	DIANE M CASE, R.D.H.	10/22/2013
H6649	MORGAN E JENKINS, R.D.H.	10/25/2013
H6650	EMILY T PHAM, R.D.H.	10/25/2013
H6651	RACHEL E RANZ, R.D.H.	10/25/2013
H6652	JOHN J PETERSEN, R.D.H.	11/5/2013
H6653	ANDREW D JOHNSTON, R.D.H.	11/6/2013
H6654	SELINA R NAVA, R.D.H.	11/6/2013
H6655	ROSALYN E LAMB, R.D.H.	11/6/2013
H6656	MARK W LOUEY, R.D.H.	11/8/2013
H6657	KELLY H POLLETTE, R.D.H.	11/12/2013
H6658	MISTY D CAMACHO, R.D.H.	11/12/2013
H6659	RANDI E JOHNSON, R.D.H.	11/15/2013
H6660	ANNA E ATKINSON, R.D.H.	11/20/2013
H6661	TESSA R SIMPSON, R.D.H.	11/20/2013
H6662	TYLER DANIEL MOLINE, R.D.H.	11/20/2013
H6663	LILYANN M COLE, R.D.H.	11/20/2013
H6664	ELIZABETH N WILLIAMS, R.D.H.	11/20/2013
H6665	KIRSTIE J LERUM, R.D.H.	11/21/2013
H6666	DAIONNA G MC GRAW, R.D.H.	12/5/2013

### **DENTISTS**

D9967	ERIC D BERKNER, D.M.D.	10/10/2013
D9968	BHARAT RAM CHOWDRY GUTTIKONDA, D.D.S.	10/10/2013
D9969	CORY M JOHNSTON, D.M.D.	10/18/2013
D9970	CAROLYN M ASH, D.D.S.	10/18/2013
D9971	DONALD W SCHIESS, D.D.S.	10/18/2013
D9972	CAROLYN C BROOKES, D.M.D.	10/22/2013
D9973	L. THOMAS MILLER, D.D.S.	10/25/2013
D9974	GEORGINA O JAMISON, D.D.S.	11/6/2013
D9975	KENDRA R.C. FLANN, D.M.D.	11/8/2013
D9976	JARID A BURLEY, D.M.D.	11/15/2013
D9977	R. JOSEPH TEMPLE, D.D.S.	11/15/2013
D9978	BHARATHI CHARUGUNDLA, D.M.D.	11/15/2013
D9979	SYLVIA G JIMENEZ, D.D.S.	11/20/2013

D9980	SIMON A YAKLIGIAN, D.D.S.	11/20/2013
D9981	AARON BENJAMIN CHRISTOPHER, D.M.D.	11/20/2013
D9982	STEVEN M MORALES, D.D.S.	11/20/2013
D9983	KULBIR SINGH GORAYA, D.D.S.	12/5/2013
D9984	LEN BAROZZINI, D.D.S.	12/5/2013