PUBLIC PACKET

OREGON BOARD OF DENTISTRY

BOARD MEETING
APRIL 16, 2021

Oregon
Kate Brown, Governor

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

NOTICE OF REGULAR MEETING

PLACE: **VIRTUAL VIA ZOOM**

DATE: **April 16, 2021**

TIME: **8:00 a.m. – 2:00 p.m.**

Call to Order – Yadira Martinez, R.D.H., President **8:00 a.m.**

OPEN SESSION (Via Zoom)

*** This is when the public may connect to the Board Meeting, please see page three for meeting details**

Review Agenda

1. Approval of Minutes
   - February 19, 2021 - Board Meeting
   - OLD BUSINESS

NEW BUSINESS

2. Association Reports
   - Oregon Dental Association
   - Oregon Dental Hygienists' Association
   - Oregon Dental Assistants Association

3. Committee and Liaison Reports
   - WREB Liaison Report – Yadira Martinez, R.D.H.
   - AADB Liaison Report – Yadira Martinez, R.D.H.
   - ADEX Liaison Report – Vacant
   - CDCA Liaison Report – Amy B. Fine, D.M.D.
   - Committees needing to convene later in year after legislative session
     - Dental Hygiene Committee
     - Rules Oversight Committee
     - Other Committees needing to meet, open discussion

4. Executive Director's Report
   - Board Member & Staff Updates
   - OBD Budget Status Report
   - Accounts Receivable Honor Roll FY 2020
   - Customer Service Survey
   - 2021 Dental License Renewal
   - Board and Staff Speaking Engagements
   - 2021 Legislative Session
   - AADA & AADB Mid-Year Meetings
   - Memo - Strategic Planning
   - 2022 Proposed Board Meeting Dates

5. Unfinished Business and Rules

6. Correspondence
   - Letter regarding sponsorships of meetings addressed to AADB sent to Dental Boards
   - Dental Scope of Practice Concerns – American Academy of Sleep Medicine
   - AADSM Response to AADM Letter re: Home Sleep Apnea Testing
   - ODS Teledentistry Services-Fluoride Application
   - Request regarding Kybella – scope of practice

7. Other
   - CODA - Call for Nominations to Review Committee Positions
   - Proposal from Pacific University Dental Hygiene Students
   - Election of Officers (President & Vice-President)

8. Articles & Newsletters (No Action Necessary)
   - FDA – Dental Amalgam Recommendations
   - HPSP Feb 2021 Newsletter
   - HPSP March 2021 Newsletter
   - SRTA Expands to New States with Live & Manikin Based Testing
   - Recognition of Yadira Martinez as OBD President
   - CDCA Spring 2021 Newsletter

EXECUTIVE SESSION **10:30 a.m.**

The Board will meet in Executive Session pursuant to ORS 192.660(2)(f)(h) and (l); ORS 676.165, ORS 676.175(1) and ORS 679.320 to review records exempt from public disclosure, to review confidential materials and investigatory information, and to consult with counsel. No final action will be taken in Executive Session.

9. Review New Cases Placed on Consent Agenda
10. Review New Case Summary Reports
11. Review Completed Investigative Reports
12. Previous Cases Requiring Further Board Consideration
13. Personal Appearances and Compliance Issues
14. Licensing and Examination Issues
15. Consult with Counsel

LUNCH **12:00 p.m.**

OPEN SESSION **1:00 p.m.**

Enforcement Actions (vote on cases reviewed in Executive Session)

LICENSURE AND EXAMINATION

16. Ratification of Licenses Issued
17. License and Examination Issues
    - Request for approval of local anesthesia course – University of Florida

OTHER BUSINESS

ADJOURN **2:00 p.m.**

Board Meeting - Public Session

Time: April 16, 2021 08:00 AM Pacific Time (US and Canada)

Register in advance for this meeting:
https://us02web.zoom.us/meeting/register/tZctce2hqzsjHN1oAuNqVRwJXVfHr0TtYEC1

After registering, you will receive a confirmation email containing information about joining the meeting.

You will use the same Zoom Meeting information to log back in for Open Session at 1:00 p.m.

*Public Comments: If you wish to speak to an issue on the agenda, please use the “raise hand” function of Zoom.

Staff will turn on your microphone and call on you at the direction of the OBD President. When you speak, please state your name, and indicate the agenda item or other topic you wish to communicate about.

The OBD President may set specific time constraints for each attendee’s comments.

Notes:
(1) A working lunch will be served for Board members at approximately 12:00 p.m.
(2) The meeting location is accessible to persons with disabilities. A request for an interpreter for the hearing impaired or for other accommodations for persons with disabilities should be made at least 48 hours before the meeting to Haley Robinson at (971) 673-3200.
(3) The Board may from time to time throughout the meeting enter into Executive Session to discuss matters on the agenda for any of the reasons specified in ORS 192.660. Prior to entering into Executive Session, the Board President will announce the nature of and authority for holding the Executive Session. No final action will be taken in Executive Session.

APPROVAL OF MINUTES

DRAFT 1

OREGON BOARD OF DENTISTRY
MINUTES
FEBRUARY 19, 2021

MEMBERS PRESENT:	Yadira Martinez, R.D.H., President
MEMBERS PRESENT VIA TELECONFERENCE:	Alicia Riedman, R.D.H., Vice-President Gary Underhill, D.M.D Jose Javier, D.D.S. Reza Sharifi, D.M.D. Chip Dunn Hai Pham, D.M.D.
STAFF PRESENT:	Stephen Prisby, Executive Director Daniel Blickenstaff, D.D.S., Dental Director/ Chief Investigator (portion of meeting) Winthrop "Bernie" Carter, D.D.S., Dental Investigator Haley Robinson, Office Manager (portion of meeting) Shane Rubio, Investigator (portion of meeting) Samantha VandeBerg, Office Specialist (portion of meeting) Ingrid Nye, Examination and Licensing Manager (portion of the meeting)
ALSO PRESENT:	Lori Lindley, Sr. Assistant Attorney General
VISITORS PRESENT VIA TELECONFERENCE*:	Jen Lewis-Goff, Oregon Dental Association; Phillip Marucha, D.M.D.; Lisa Rowley, R.D.H., ODHA; Mary Harrison, Oregon Dental Assistants Association (ODAA)

*This list is not exhaustive, as it was not possible to verify all participants on the teleconference.

Call to Order: The meeting was called to order by the President at 8:01 a.m. at the Board office; 1500 SW 1st Ave., Suite 770, Portland, Oregon.

Board Members Jennifer Brixey and Dr. Amy B. Fine did not attend the meeting.

EXECUTIVE SESSION: The Board entered into Executive Session pursuant to ORS 192.606 (1)(2)(f), (h) and (L); ORS 676.165; ORS 676.175 (1), and ORS 679.320 to review records exempt from public disclosure, to review confidential investigatory materials and investigatory information, and to consult with counsel

OPEN SESSION: The Board returned to Open Session at 12:30 p.m.

President Yadira Martinez, RDH welcome everyone to the meeting and had the Board Members,

Lori Lindley and Stephen Prisby introduce themselves.

NEW BUSINESS

Approval of Minutes

Dr. Pham moved and Dr. Javier seconded that the Board approve the minutes from the December 18, 2020 Board Meeting as presented. The motion passed unanimously.

EXECUTIVE DIRECTOR'S REPORT

Board Member & Staff Updates

Mr. Prisby reported on a number of Board updates. Dr. Hai Pham has indicated he will not seek a second term on the OBD, and his term is set to expire on April 2, 2021. We appreciate and thank Dr. Pham for his service and support over the last four years. His experience and clinical knowledge has been very valuable in OBD discussions and decisions.

Alicia Riedman's term is set to expire on April 30, 2021 and she has applied to serve another term. Chip Dunn's term is set to expire on April 2, 2021, and Mr. Dunn has indicated he will apply to serve another term as well. We appreciate their willingness to volunteer for four more years with the OBD.

Dr. Aarati Kalluri is on the Governor's list of board member appointments to go forward on Feb 23rd to a Senate committee, one step closer to joining the Board. She will need to be confirmed by the full Senate after the committee meeting. Her term is tentatively scheduled to begin on March 1 (if confirmed by then), and we will work out the details of her new board member orientation in the next few weeks. Dr. Kalluri is joining the Board due to the board opening created when Dr. Todd Beck resigned in August 2020.

Dr. Daniel Blickenstaff, Dental Director & Chief Investigator will be retiring from the OBD this spring with his last day on April 1, 2021.We previously recognized Dr. Blickenstaff for his service and will send him off appropriately on his last day.

All Board openings have been publicized through our email blasts, in our newsletter, on state employment website (for staff position) and on our website. The OBD thanks all interested candidates that have applied for these openings. The dental investigator candidate interview process is moving along and I will have an update at this meeting.

OBD Budget Status Report

Mr. Prisby presented the budget report for the 2019 - 2021 Biennium. This report, which is from July 1, 2019 through December 31, 2020, shows revenue of $2,776,851.24 and expenditures of $2,449,877.96.

Customer Service Survey

Mr. Prisby presented the legislatively mandated survey results from July 1, 2020 – January 31, 2021. The results of the survey show that the OBD continues to receive positive ratings from the majority of those that submit a survey.

Board Member and Staff Speaking Engagements
Ingrid Nye gave a virtual License Application Presentation to the graduating Dental Hygiene Students at OIT in Klamath Falls on Wednesday, February 3, 2021.

2021 Dental License Renewal
Mr. Prisby provided an update to the Board that the new database and interface to renew licenses was being tested and finalized at the time of this report.

OBD SB 5511 Presentation and Documentation
Mr. Prisby presented the materials from the Joint Committee On Ways and Means Subcommittee On Education from his presentation on February 3, 2021.

2021 Legislation being tracked
Mr. Prisby presented some reference materials on legislation and a report of 2021 legislation he is tracking for the OBD.

OBD Strategic Planning Preparation
Mr. Prisby discussed strategic planning survey results for Board Members to review. The Board discussed next steps to advance work on the Board's next strategic plan to replace the 2017-2020 edition.

AADA & AADB 2021 Mid - Year Meetings
The American Association of Dental Administrators (AADA) and the American Association of Dental Boards (AADB) 2021 Mid-Year Meetings will both be held virtually this year. Mr. Prisby presented the meeting agendas and there will be a report back to the Board in April on them.

Statewide Diversity, Equity & Inclusion Conference Summary
This past October, the 2020 Statewide Diversity, Equity, & Inclusion Conference was held virtually, and welcomed a record number of state employees to the annual professional development event with all OBD staff members participating. Mr. Prisby presented the Conference Planning Committee post-event executive report. This report was developed to provide department leadership a snapshot of our planning efforts, successes and lessons learned, attendee feedback, and a breakdown of conference expenses.

Workday Payroll Project
The Payroll and Time Tracking replacement project officially kicked off on January 13, 2021. In 2019 Oregon state government made a leap forward in modernizing legacy IT systems with the rollout of Workday – our HR information system. The next major step is to replace the over 30-year old payroll system (Oregon Statewide Payroll Application--OSPA) by moving to Workday payroll and time tracking. Workday will replace our time tracking system (ePayroll) and leave accrual system, and everyone in state government will begin using Workday for time tracking and payroll starting July 1, 2022.

ASSOCIATION REPORTS

Oregon Dental Association (ODA)
Jen Lewis-Goff reported that the ODA is working hard to ensure that every dental provider in the state has access to the covid-19 vaccine. The ODA partnered with OHSU to provide a dental

vaccination clinic to 1,100 metro-area professionals. They are also working with local health departments all over the state to ensure that all providers have access. She reported that the ODA has a great deal of information and resources on their website for any providers seeking information on getting access to the vaccine. The 2021 Oregon Dental Conference will be held in a virtual format this year, with live events happening April 8-10, and on-demand offerings through April 15. She reported that over 700 dental professionals have already registered for this year's conference.

Oregon Dental Hygienists' Association

Lisa Rowley reported the ODHA partnered with the ODA & other stakeholders to send a letter to Governor Kate Brown urging her to increase access to the COVID-19 vaccine for dental providers. The ODHA appreciates the work that the ODA has done to advocate for dental providers to have access to the COVID-19 vaccine.

In their February 2021 newsletter, the ODHA clarified that the Oregon Board of Dentistry does not have the legal authority to allow dental hygienists in Oregon to administer the COVID-19 vaccine, and that this would need to be done as an executive order from the Governor. The American Dental Hygienists' Association (ADHA) has launched an Advocacy Alert asking dental hygienists across the country to contact their state governors and urge them to grant dental hygienists the authority to administer the COVID-19 vaccines.

The ODHA is supporting House Bill 2528, House Bill 2627 and House Bill 2969 during the 2021 Oregon Legislative Session.

Oregon Dental Assistants Association

Mary Harrison reported that the ODAA is happy with the OBD and does not feel at this time that it is necessary for them to add anything to their rules regarding the proposed ADAA mandatory infection control CE requirement.

COMMITTEE AND LIAISON REPORTS

WREB Liaison Report

Nothing to report at this time.

AADB Liaison Report

Ms. Martinez reported that the mid-year meeting will take place on February 26-28, 2021.

ADEX Liaison Report

Nothing to report at this time.

CDCA Liaison Report

Nothing to report at this time.

UNFINISHED BUSINESS & RULES

Request for revision of vaccine course

OHSU School of Dentistry CE department would like to request the board's consideration for a slight revision of the currently approved Dental Based Immunization Training program. They have received feedback from great deal of dentists who are only looking to administer vaccine in a volunteering manner, and not seeking to go through the full immunization training program. With the evolution of the COVID-19 vaccine availability, along with an increase of dentists inquiring about the current training, they have an updated process we are seeking approval for.

Dr. Underhill moved and Dr. Javier seconded that the Board approve the requested revisions to OHSU's vaccination course as presented. The motion passed unanimously.

CORRESPONDENCE

Requests for Dental Hygienists to administer vaccines – Melissa Turner, R.D.H.; Pamela Lynch, R.D.H.; Laura Crosby, R.D.H.

Lori Lindley reported on behalf of the OBD that the Board does not have statutory authority to grant permission for dental hygienists to administer vaccines under their dental hygiene license, however, a dental hygienist working under the supervision of a medical doctor could administer vaccines.

American Dental Assistants' Association (ADAA) mandatory infection control education

The OBD received notification from the ADAA that they intend to implement mandatory infection control education for the oral healthcare team, to include a requirement that ALL dental assistants have a minimum of 12 hours of CODA, ADA CERP, or AGD PACE-approved didactic and four hours of clinical education in infection control, including performance evaluation. The Board does not have jurisdiction over dental assistants and did not make a motion.

OTHER ISSUES

Strategic Planning Survey Responses

Mr. Prisby provided a summary of the responses the OBD received from the strategic planning survey. Since two new Board members will join the OBD in the spring, Mr. Prisby suggested that the Board wait until June to start the work when a committee meeting could potentially take place in-person. There was general discussion and this was agreed to by the Board.

OSHA – Question to the Board regarding medical history evaluation

The Board received correspondence from OSHA asking for clarification on whether or not a dentist is able to interpret a medical history evaluation to determine if someone can safely be fit-tested to wear an N95 respirator mask.

The Board discussed the matter, and determined that dentists are able to review these types of medical evaluations. No motion was made.

ARTICLES AND NEWS (Informational Only)

- January 2021 HPSP Newsletter
- OHA Dental Director Recruitment

President Martinez recognized and thanked Dr. Hai Pham for his four years of service on the Board as his term is ending in early April and this is his last OBD Board meeting. She virtually presented a certificate to him, which Board staff will mail to Dr. Pham.

CONSENT AGENDA

2021-0083, 2021-0079, 2021-0091, 2021-0057, 2021-0085, 2021-0089, 2021-0084, 2021-0096
Ms. Riedman moved and Dr. Sharifi seconded that the Board close the matters with a finding of No Violation or No Further Action. The motion passed unanimously.

COMPLETED CASES

2021-0072, 2021-0055, 2021-0040, 2021-0041, 2021-0063, 2021-0077, 2021-0011, 2021-0082, 2021-0060
Ms. Riedman moved and Mr. Dunn seconded that the Board close the matters with a finding of No Violation or No Further Action. The motion passed unanimously.

2021-0061
Ms. Riedman moved and Mr. Dunn seconded that the Board close the matter with a finding of No Violation or No Further Action. The motion passed unanimously. The motion passed with Ms. Martinez, Ms. Riedman, Mr. Dunn, Dr. Sharifi, Dr. Pham, and Dr. Underhill voting aye. Dr. Javier recused.

2021-0065
Dr. Underhill moved and Mr. Dunn seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that biological monitoring is completed on a weekly basis. The motion passed with Ms. Martinez, Ms. Riedman, Mr. Dunn, Dr. Sharifi, Dr. Pham, and Dr. Underhill voting aye. Dr. Javier recused.

2021-0058
Dr. Sharifi moved and Ms. Riedman seconded that the Board close the matter with a Letter of Concern reminding Licensee to test his autoclave with a biological monitoring system on a weekly basis. The motion passed unanimously.

2021-0094
Mr. Dunn moved and Dr. Underhill seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that all CE is completed within the required time frame. The motion passed unanimously.

2021-0036
Dr. Pham moved and Mr. Dunn seconded that the Board close the matter with a Letter of Concern reminding Licensee to take a radiographic image when there is as question as to how much, or if any, tooth structure remains after performing a tooth extraction, to assure that he follows up on referrals of his patients to specialists, and assure that the instruments he uses have been sterilized in an autoclave that is tested with a biologic monitoring system on a weekly basis. The motion passed unanimously.

2020-0196
Dr. Sharifi moved and Mr. Dunn seconded that the Board close the matter with a Letter of Concern reminding Licensee it is not recommended to use 4% local anesthetic when administering inferior alveolar blocks. In regards to nerve deficits, paresthesia and hypoesthesias, it is recommended to refer patients to a nerve specialist and/or neurologist in a timely manner. The motion passed unanimously.

2021-0064
Dr. Underhill moved and Dr. Javier seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that all of his autoclaves are tested with a biological monitoring system on a weekly basis. The motion passed unanimously.

FELLER, JONATHAN M., D.D.S.; 2021-0071
Dr. Javier moved and Mr. Dunn 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 to be paid within 60 days, complete six hours of Board approved continuing education in infection control within 60 days, complete three hours of Board approved continuing education in record keeping within 30 days, complete 56 hours of Board approved continuing education in the placement of endossious implants within one year, pass the Oregon Board of Dentistry Jurisprudence Exam within 30 days, and for a period of one year from the effective date of the Order, submit results of weekly testing of his heat sterilizing devices with a biologic monitoring system on a weekly basis, and to direct staff to open a complaint against the dentist who placed the implant in the area of tooth #19. The motion passed unanimously.

2021-0066
Dr. Sharifi moved and Dr. Javier seconded that the Board close the matter in regards to Respondent #1 with a finding of No Further Action, and in regards to Respondent #2, move to close the matter with a finding of No Violation. The motion passed unanimously.

2021-0080
Mr. Dunn moved and Dr. Pham seconded that the Board close this matter with a STRONGLY WORDED Letter of Concern reminding Licensee to assure that all CDC and OHA guidelines are followed regarding COVID-19. The motion passed unanimously.

2015-0084
Dr. Pham moved and Dr. Javier seconded that the Board close the matter with No Further Action. The motion passed unanimously.

2015-0097
Dr. Underhill moved and Mr. Dunn seconded that the Board close the matter with No Further Action. The motion passed unanimously.

2015-0150
Dr. Sharifi moved and Dr. Javier seconded that the Board close the matter with No Further Action. The motion passed unanimously.

2020-0118

Mr. Dunn moved and Dr. Javier seconded that the Board close the matter with No Further Action. The motion passed unanimously.

2018-0228
Dr. Pham moved and Ms. Riedman seconded that the Board write a letter to the Executive Director of the Geriatric Dental Group; stating that we notified them in October 2018 they were not in compliance regarding non-profit ownership. Since that time, they attempted in the Fall of 2019 to get a legislative fix through the 2020 session with the prior Representative, however it never went forward. The prior House Representative has since been replaced by a newly elected Representative. They are currently still out of compliance. The Board requests in writing within 30 days some type of documentation as to who their dental director is, listing them by name, and require that they outline their plan for following ORS 679.020(4) (A) – (I) with as much detail as possible. In addition, the Board has set a deadline for Geriatric Dental Clinic to propose legislative change to the Oregon State legislature within the next 180 days **or** sign a consent order whereby they agree to reorganize the non-profit to a dental owned clinic in compliance with ORS 679, so that it comports with the requirements of the law. The motion passed unanimously.

2020-0102
Dr. Underhill moved and Dr. Javier seconded that the Board close the matter with a STRONGLY WORDED Letter of Concern reminding Licensee to assure that he documents in the patient records any radiographic images taken, a diagnosis for removing and replacing endossious implants, and the strength of all local anesthetics administered, to assure that his Healthcare Provider level BLS/CPR certificate does not lapse, and to assure that he does not allow his dental assistants to work on patients without at least indirect supervision.

2021-0059
Dr. Javier moved and Dr. Sharifi seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that she conducts biological monitor testing on a weekly basis. The motion passed unanimously.

2021-0047
Dr. Sharifi moved and Dr. Javier seconded that the Board close the matter with a STRONGLY WORDED Letter of Concern reminding Licensee to document in the patient records all medications prescribed, a diagnosis or dental justification for prescribing the medications, and to insure that all dental equipment is functioning properly before starting a dental procedure. The motion passed unanimously.

2021-0070
Mr. Dunn moved and Dr. Javier seconded that the Board close the matter with a Letter of Concern reminding Licensee to document the diagnosis of periapical pathologies in the patient treatment records. The motion passed unanimously.

TRIEU, ANITA, D.M.D., 2021-0035
Dr. Pham moved and Dr. Underhill seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand, and to pass the Oregon Board of Dentistry Jurisprudence Exam within 30 days. The motion passed unanimously.

2021-0075
Dr. Underhill moved and Dr. Javier seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that all instruments that she uses have been sterilized in an autoclave that has been tested with a biologic monitoring system on a weekly basis. The motion passed unanimously.

2021-0074
Dr. Javier moved and Mr. Dunn seconded that the Board close the matter with a Letter of Concern reminding Licensee to test all of his autoclaves with a biological monitoring system on a weekly basis. The motion passed unanimously.

PREVIOUS CASES REQUIRING BOARD ACTION

ANDERSON, JAMES R., D.M.D.; 2021-0005
Dr. Sharifi moved and Dr. Javier seconded that the Board grant Licensee's late hearing request and deny Respondent #1's request and affirm the Board's December 18, 2020 decision, and refer the case to OAH for a hearing. The motion passed unanimously.

2020-0008
Dr. Pham moved and Dr. Javier seconded that the Board issue an Order of Dismissal dismissing the Second Amended Notice of Proposed Disciplinary Action dated August 26, 2020 and close the matter with No Further Action. The motion passed unanimously.

CAUBLE, DAVID A., D.M.D., 2021-0016
Mr. Dunn moved and Ms. Riedman seconded that the Board offer Licensee a Consent Order incorporating a reprimand, a $9,000.00 civil penalty to be paid within 120 days, complete six hours of Board approved continuing education in infection control within 60 days, complete three hours of Board approved continuing education in record keeping within 30 days, pass the Oregon Board of Dentistry Jurisprudence Exam within 30 days, and for a period of one year from the effective date of the Order, submit results of weekly testing of his heat sterilizing devices with a biologic monitoring system on a weekly basis. The motion passed unanimously.

2020-0171
Dr. Javier moved and Mr. Dunn seconded that the Board issue a Notice of Dismissal, dismissing the Notice of Proposed Disciplinary action and close the matter with a Letter of Concern reminding Licensee to assure that biological monitoring devices are tested on a weekly basis. The motion passed unanimously.

HIGBEE, T.J., D.D.S., 2006-0086 & 2012-0073
Dr. Underhill moved and Dr. Javier seconded that the Board deny Licensees request to end the Interim Consent Order and issue Licensee a Notice if Proposed License Revocation. The motion passed unanimously.

2020-0014

Dr. Sharifi moved and Mr. Dunn seconded that the Board affirm their June 19, 2020 decision. The motion passed unanimously.

SWEETEN, J. COLT, D.D.S., 2021-0023
Mr. Dunn moved and Ms. Riedman seconded that the Board accept Licensee's offer, and offer Licensee a Consent Order incorporating a reprimand, a $6,000.00 civil penalty to be paid within 360 days, complete three hours of Board approved continuing education in record keeping within 30 days, complete six hours of Board approved continuing education in infection control within 60 days, pass the Oregon Board of Dentistry Jurisprudence Exam within 30 days, and submit monthly results of the biological monitoring of his autoclave for a period of one year, of the effective date of the Order. The motion passed unanimously.

WOLFE, BENJAMIN J., D.M.D., 2021-0022
Dr. Underhill moved and Mr. Dunn seconded that the Board offer Licensee a Consent Order incorporating a reprimand, take a three hour board approved continuing education course on Record Keeping within 30 days, and pass the Oregon Board of Dentistry Jurisprudence Exam within 30 days of the effective date of the Order. The motion passed with Ms. Martinez, Ms. Riedman, Mr. Dunn, Dr. Sharifi, Dr. Javier, and Dr. Underhill voting aye. Dr. Pham recused.

LICENSE & EXAMINATION ISSUES

Request for Approval of Soft Relines Course – Paul Wayne Lamoreau, D.M.D.
Dr. Javier moved and Dr. Pham seconded that the Board approve the course as presented. The motion passed unanimously.

Request for Non-Resident Permit – Sara Jamima Park, D.D.S.
Dr. Pham moved and Mr. Dunn seconded that the Board deny the non-resident permit as requested. The motion passed unanimously.

Reinstatement of Expired Dental License – Michael James Purcell, D.D.S.
Dr. Javier moved and Ms. Riedman seconded that the Board approve the reinstatement of dental license as requested. The motion passed unanimously.

Reinstatement of Expired Dental Hygiene License – Jacque'line Marie Palmer, R.D.H.
Dr. Pham moved and Ms. Riedman seconded that the Board approve the reinstatement of dental hygiene license as requested. The motion passed unanimously.

RDH Scope of Practice – myofunctional therapy and orofacial therapy
Dr. Javier moved and Ms. Riedman seconded that the Board recognize that myofunctional therapy and orofacial therapy are within a dental hygienists' scope of practice provided they have the training and education to do so safely. The motion passed unanimously.

Extension for Volunteer Licenses to renew in 2021
Dr. Sharifi moved and Dr. Javier seconded that the Board grant an extension for those who hold volunteer licenses, and give them until December 31, 2021 to make up any missed volunteer hours. The will still need to meet their 80 hours requirement in their subsequent renewal. The motion passed unanimously.

Request for Approval of Soft Reline Course- Alyssa Kobylinsky
Dr. Javier moved and Mr. Dunn seconded that the Board approve the soft relines course as presented. The motion passed unanimously.

Request for Approval of a Local Anesthesia Course – University of New Mexico
Dr. Javier moved and Ms. Riedman seconded that the Board approve the local anesthesia course as presented. The motion passed unanimously.

Request for Board Recognition as Dental Study Group – Dental Hero
Dr. Javier moved and Ms. Riedman seconded that the Board approve the dental study group as presented. The motion passed unanimously.

RATIFICATION OF LICENSES

Dr. Javier moved and Mr. Dunn seconded that the Board ratify the licenses presented. The motion passed unanimously.

ADJOURNMENT

The meeting was adjourned at 1:50 p.m. Ms. Martinez stated that the next Board Meeting would take place on April 16, 2021.

_____
Yadira Martinez, R.D.H.
President

ASSOCIATION REPORTS

Nothing to report under this tab

COMMITTEE REPORTS

Nothing to report under this tab

EXECUTIVE DIRECTOR'S REPORT

EXECUTIVE DIRECTOR'S REPORT
April 16, 2021

Board Member & Staff Updates

The Governor appointed and the Senate confirmed Dr. Aarati Kalluri as our newest Board Member on March 4, 2021. She is joining the Board due to the opening created when Dr. Todd Beck resigned from the Board in August 2020.

Her first term began March 15, 2021 and ended March 31, 2021. This partial term was to fulfill the remaining term of Dr. Beck. Her first full term began April 1, 2021 and ends March 31, 2025. She is eligible to serve another full term.

Dr. Aarati Kalluri is a General Dentist and owner of Infinity Dental Care based in Hillsboro. She completed her Bachelors in Dentistry (BDS) and Masters in Prosthodontics and Dental Materials (MDS) in India and served as faculty in Graduate Prosthodontics in India, before moving to the United States. She completed her DDS from University of California at San Francisco in 2008 with honors and was inducted into the Omicron Kappa Upsilon (OKU) Society for Academic Excellence. She opened her practice Infinity Dental Care in 2013 and ever since has been serving communities in Hillsboro and surrounding areas.

OBD Staff welcomed her with new Board Member orientation on March 19, 2021 with our assigned attorney Lori Lindley participating as well.

At the time of this report there was not enough information to share about other Board Member appointments and reappointments, but I should have an update at this meeting.

Dr. Winthrop "Bernie" Carter is now the OBD's Dental Director/Chief Investigator as of April 1st as Dr. Daniel Blickenstaff's retirement was effective March 31, 2021.

OBD Budget Status Report

Attached is the budget report for the 2019 - 2021 Biennium. This report, which is from July 1, 2019 through February 28, 2021, shows revenue of $2,857,143.50 and expenditures of $2,705,126.44. **Attachment #1**

Accounts Receivable Honor Roll FY 2020

The OBD was awarded honor roll status for commitment to excellence in the management and reporting of accounts receivable in FY 2020. **Attachment #2**

Customer Service Survey

Attached are the most recent customer service survey results for the current Fiscal Year, from July 1, 2020 through March 31, 2021. The results of the survey show that the OBD continues to receive positive feedback from those that choose to submit a survey. **Attachment #3**

2021 Dental License Renewal

OBD Staff have completed the OBD's first dental license renewals through our new InLumon database and interface which began on February 20, 2021. It was very challenging not only for staff but for Licensees.

As of April 2, 2021 here is the data on the March 2021 Dental License renewal period: Renewed 1,622; Expired 236; Retired 29; Revoked 0; Resigned 0 and Deceased 6.

Overall we saw a decrease of approximately 10% from one year ago when 1803 Dentists renewed their dental licenses in March 2020.

Board and Staff Speaking Engagements
Ingrid Nye gave a License Application virtual presentation to the graduating Dental Hygiene Students at OIT in Salem on Wednesday, February 10, 2021.

OBD Staff recorded virtual presentations for the Oregon Dental Conference on Tuesday, March 2, 2021. Dr. Bernie Carter, Shane Rubio, Haley Robinson, Ingrid Nye and I recorded presentations covering an overview of the Board, expanded practice permits, FAQs, the HPSP, enforcement issues and record keeping. The presentations would be made available between April 8 – May 15 to ODC participants. We thank the Oregon Dental Association for inviting us to present again at their well respected conference.

Dr. Reza Sharifi gave a Board Updates virtual presentation to his colleagues at the Oregon Society of Oral and Maxillofacial Surgeons (OSOMS) on Saturday, March 6, 2021.

Alicia Riedman, RDH, and I co-presented a Board Updates virtual presentation to the BDP Dental Hygiene Study Club & the Gum Gardeners Dental Hygiene Study Club on Monday, March 15, 2021.

Ingrid Nye gave a License Application virtual presentation to the graduating Dental Students at the OHSU School of Dentistry on Tuesday, April 6, 2021.

2021 Legislative Session
I attached a report of legislation I am tracking on behalf of the OBD as the 2021 Legislative Session continues on under challenging conditions. Since this report is compiled almost ten days before this meeting, I will have an oral report on bills that could impact the work of the OBD or Licensees. **Attachment #4**

AADA & AADB Mid-Year Meetings
The American Association of Dental Boards (AADB) 2021 Mid-Year Meeting was held February 26 - 28, 2021 as a virtual presentation. Lori Lindley participated and led the Board Attorneys' Roundtable and Yadira Martinez, RDH, attended portions of the meeting.

The American Association of Dental Administrators (AADA) 2021 Mid-Year Meeting was held on Tuesday, March 2, 2021. I attended both the AADA and AADB Meetings and they were well run and informative. **Attachment #5**

Strategic Planning Memo
A memo is attached seeking guidance from the Board regarding next steps and preparation for strategic planning. **Attachment #6 ACTION REQUESTED**

2022 Proposed Board Meeting Dates
Attached is a draft of the proposed meeting dates for 2022. I ask that the Board consider adopting these dates for next year's meetings. **Attachment #7 ACTION REQUESTED**

Appn Year 2021

BOARD OF DENTISTRY
Fund 3400 BOARD OF DENTISTRY
For the Month of FEBRUARY 2021

REVENUES

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
0505	FINES AND FORFEITS	390,212.52	9,000.00	399,212.52	200,000.00	-199,212.52
0205	OTHER BUSINESS LICENSES	2,323,636.00	43,064.00	2,366,700.00	3,270,001.00	903,301.00
0975	OTHER REVENUE	12,858.82	329.24	13,188.06	49,999.00	36,810.94
0410	CHARGES FOR SERVICES	19,376.00	196.00	19,572.00	20,000.00	428.00
0210	OTHER NONBUSINESS LICENSES AND FEES	11,500.00	1,250.00	12,750.00	10,000.00	-2,750.00
0605	INTEREST AND INVESTMENTS	44,926.23	794.69	45,720.92	20,000.00	-25,720.92
		2,802,509.57	**54,633.93**	**2,857,143.50**	**3,570,000.00**	**712,856.50**

TRANSFER OUT

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
2443	TRANSFER OUT TO OREGON HEALTH AUTHORIT'	108,157.00	16,408.00	124,565.00	226,800.00	102,235.00
		108,157.00	**16,408.00**	**124,565.00**	**226,800.00**	**102,235.00**

PERSONAL SERVICES

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
3220	PUBLIC EMPLOYES' RETIREMENT SYSTEM	152,870.09	8,611.48	161,481.57	207,191.00	45,709.43
3160	TEMPORARY APPOINTMENTS	0.00	0.00	0.00	4,219.00	4,219.00
3110	CLASS/UNCLASS SALARY & PER DIEM	1,034,232.76	58,552.28	1,092,785.04	1,312,557.00	219,771.96
3260	MASS TRANSIT	6,050.62	341.84	6,392.46	8,250.00	1,857.54
3190	ALL OTHER DIFFERENTIAL	13,459.20	767.70	14,226.90	38,194.00	23,967.10
3170	OVERTIME PAYMENTS	1,185.57	74.92	1,260.49	6,136.00	4,875.51
3230	SOCIAL SECURITY TAX	79,448.09	4,535.15	83,983.24	105,198.00	21,214.76
3270	FLEXIBLE BENEFITS	161,670.70	8,516.41	170,187.11	281,472.00	111,284.89
3221	PENSION BOND CONTRIBUTION	53,698.94	2,981.22	56,680.16	73,260.00	16,579.84
3250	WORKERS' COMPENSATION ASSESSMENT	252.89	10.86	263.75	464.00	200.25
3210	ERB ASSESSMENT	290.16	14.04	304.20	427.00	122.80
3180	SHIFT DIFFERENTIAL	8.00	0.00	8.00	0.00	-8.00
3240	UNEMPLOYMENT ASSESSMENT	16.24	0.00	16.24	0.00	-16.24
		1,503,183.26	**84,405.90**	**1,587,589.16**	**2,037,368.00**	**449,778.84**

SERVICES and SUPPLIES

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
4225	STATE GOVERNMENT SERVICE CHARGES	158,764.11	1,968.96	160,733.07	161,339.00	605.93
4315	IT PROFESSIONAL SERVICES	10,500.00	0.00	10,500.00	140,031.00	129,531.00
4650	OTHER SERVICES AND SUPPLIES	70,581.97	2,774.75	73,356.72	97,999.00	24,642.28

Attachment #1

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
4100	INSTATE TRAVEL	17,641.88	22.40	17,664.28	50,784.00	33,119.72
4175	OFFICE EXPENSES	37,481.63	451.74	37,933.37	91,230.00	53,296.63
4400	DUES AND SUBSCRIPTIONS	9,933.60	0.00	9,933.60	7,126.00	-2,807.60
4200	TELECOMM/TECH SVC AND SUPPLIES	21,035.71	752.42	21,788.13	24,925.00	3,136.87
4125	OUT-OF-STATE TRAVEL	0.00	0.00	0.00	7,563.00	7,563.00
4150	EMPLOYEE TRAINING	19,934.79	0.00	19,934.79	54,223.00	34,288.21
4715	IT EXPENDABLE PROPERTY	12,754.70	0.00	12,754.70	23,482.00	10,727.30
4300	PROFESSIONAL SERVICES	239,835.35	9,125.27	248,960.62	255,911.00	6,950.38
4700	EXPENDABLE PROPERTY $250-$5000	0.00	0.00	0.00	5,836.00	5,836.00
4250	DATA PROCESSING	69,133.16	3,329.18	72,462.34	68,458.00	-4,004.34
4575	AGENCY PROGRAM RELATED SVCS & SUPP	30,064.24	523.00	30,587.24	134,566.00	103,978.76
4275	PUBLICITY & PUBLICATIONS	4,018.48	25.00	4,043.48	14,855.00	10,811.52
4325	ATTORNEY GENERAL LEGAL FEES	182,145.41	7,896.60	190,042.01	271,973.00	81,930.99
4425	FACILITIES RENT & TAXES	139,376.77	7,496.16	146,872.93	179,097.00	32,224.07
4375	EMPLOYEE RECRUITMENT AND DEVELOPMENT	0.00	0.00	0.00	705.00	705.00
4475	FACILITIES MAINTENANCE	0.00	0.00	0.00	583.00	583.00
		1,023,201.80	**34,365.48**	**1,057,567.28**	**1,590,686.00**	**533,118.72**

CAPITAL OUTLAY

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
5550	DATA PROCESSING SOFTWARE	59,970.00	0.00	59,970.00	0.00	-59,970.00
		59,970.00	**0.00**	**59,970.00**	**0.00**	**-59,970.00**

		3400		
		Monthly Activity	Biennium Activity	Financial Plan
REVENUES	REVENUE	54,633.93	2,857,143.5	3,570,000.00
	Total	54,633.93	2,857,143.5	3,570,000.00
EXPENDITURES	PERSONAL SERVICES	84,405.9	1,587,589.16	2,037,368.00
	SERVICES AND SUPPLIES	34,365.48	1,057,567.28	1,590,686.00
	CAPITAL OUTLAY	0	59,970	0.00
	Total	118,771.38	2,705,126.44	3,628,054.00
TRANSFER OUT	TRANSFER OUT	16,408	124,565	226,800.00
	Total	16,408	124,565	226,800.00

Attachment #1

Oregon
Kate Brown, Governor

Department of Administrative Services
Chief Financial Office
155 Cottage Street NE
Salem, OR 97301
PHONE: 503-378-3106
FAX: 503-373-7643

March 16, 2021

Stephen Prisby, Executive Director
Oregon Board of Dentistry
1500 SW 1st Ave, Suite 770
Portland, OR 97201

Re: FY 2020 ACCOUNTS RECEIVABLE HONOR ROLL CERTIFICATE

It is a great pleasure to inform you that your agency has earned the Chief Financial Office's Accounts Receivable (A/R) Honor Roll Certificate for fiscal year 2020.

The Chief Financial Office's Accounts Receivable Honor Roll Certificate is awarded to state agencies that submit timely and accurate A/R reports. Achievement of this recognition is due primarily to your agency's diligent efforts to track and report A/R activities.

By meeting the requirements of the Honor Roll Certificate program your agency is an important part of meeting statewide efforts to improve accounts receivable management. Your agency's success in A/R reporting is critical to the Legislative Fiscal Office publication of the *Report on Liquidated and Delinquent Accounts Receivable* and to the Chief Financial Office *Accounts Receivable Management Report*, and the *Statewide Write-off, Abated and Canceled Certification Report,* which are all submitted to the Legislative Assembly each year.

The Honor Roll Certificate will be delivered to the staff that submitted or signed the A/R reports during fiscal year 2020, which included Teresa Haynes, Haley Robinson and Olga Fokina. Congratulations to your agency and your fiscal team for this outstanding work!

Sincerely,

George Naughton, Chief Financial Officer
Chief Financial Office

Robert W. Hamilton, Manager
Statewide Accounting and Reporting Services

Chief Financial Office's Accounts Receivable Honor Roll Certificate

Awarded to

Oregon Board of Dentistry

For Commitment to Excellence
in the Management and Reporting
of Accounts Receivable

Fiscal Year Ended June 30, 2020

George Naughton, Chief Financial Officer

Robert W. Hamilton, SARS Manager

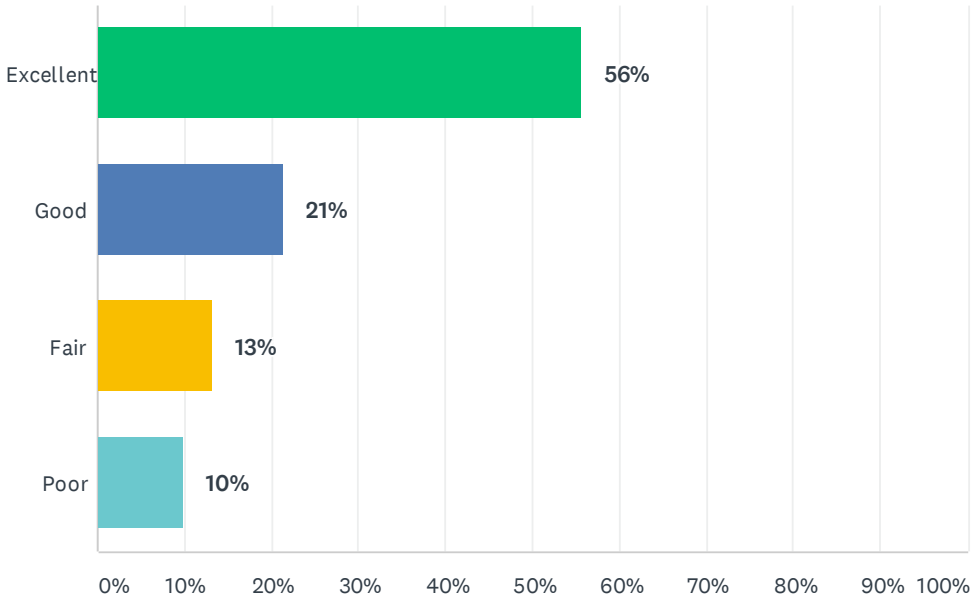
March 8, 2021

Date

State of Oregon
Department of Administrative Services
Chief Financial Office

Q1 How would you rate the timeliness of services provided by the Oregon Board of Dentistry?

Answered: 61 Skipped: 2

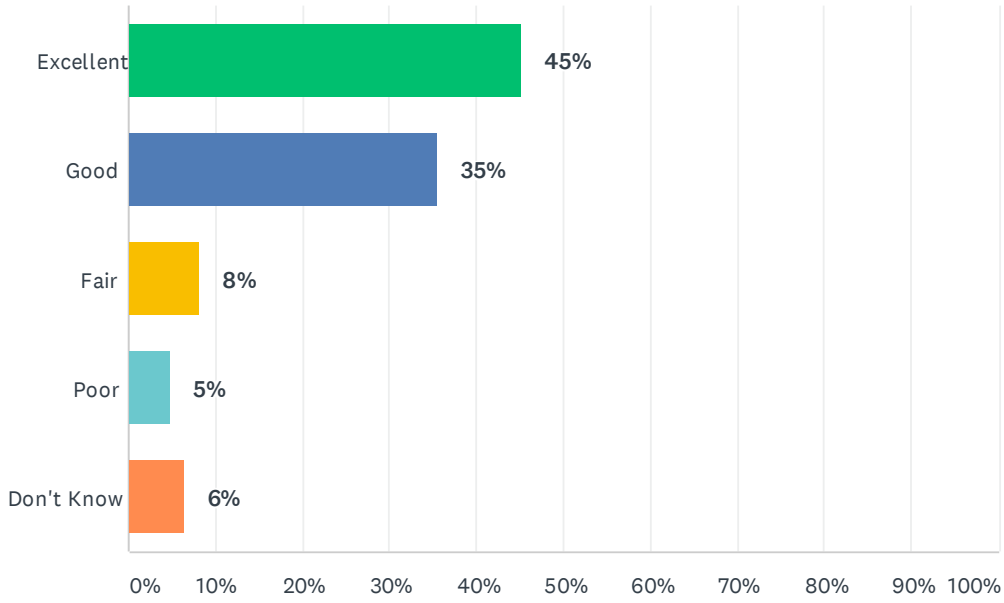


ANSWER CHOICES	RESPONSES	
Excellent	56%	34
Good	21%	13
Fair	13%	8
Poor	10%	6
TOTAL		61

Attachment #3

Q2 How do you rate the ability of the Oregon Board of Dentistry to provide services correctly the first time?

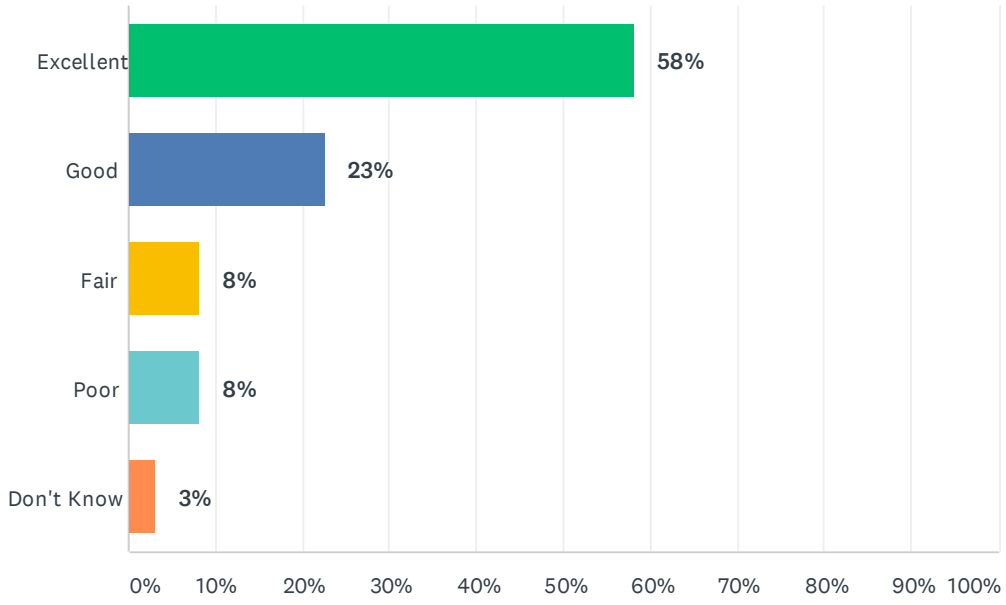
Answered: 62 Skipped: 1



ANSWER CHOICES	RESPONSES	
Excellent	45%	28
Good	35%	22
Fair	8%	5
Poor	5%	3
Don't Know	6%	4
TOTAL		62

Q3 How do you rate the helpfulness of the Oregon Board of Dentistry employees?

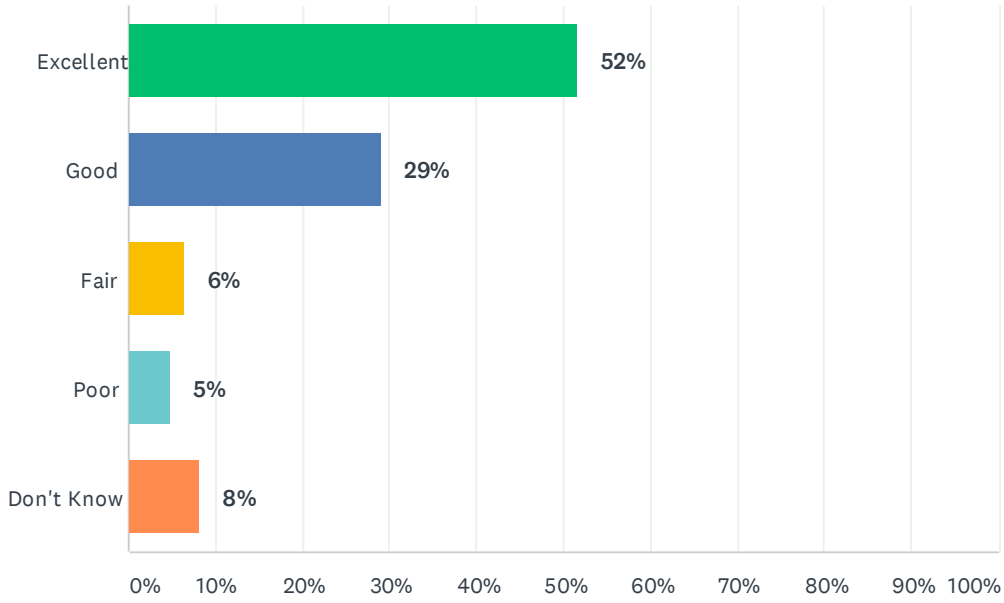
Answered: 62 Skipped: 1



ANSWER CHOICES	RESPONSES	
Excellent	58%	36
Good	23%	14
Fair	8%	5
Poor	8%	5
Don't Know	3%	2
TOTAL		62

Q4 How do you rate the knowledge and expertise of the Oregon Board of Dentistry employees?

Answered: 62 Skipped: 1

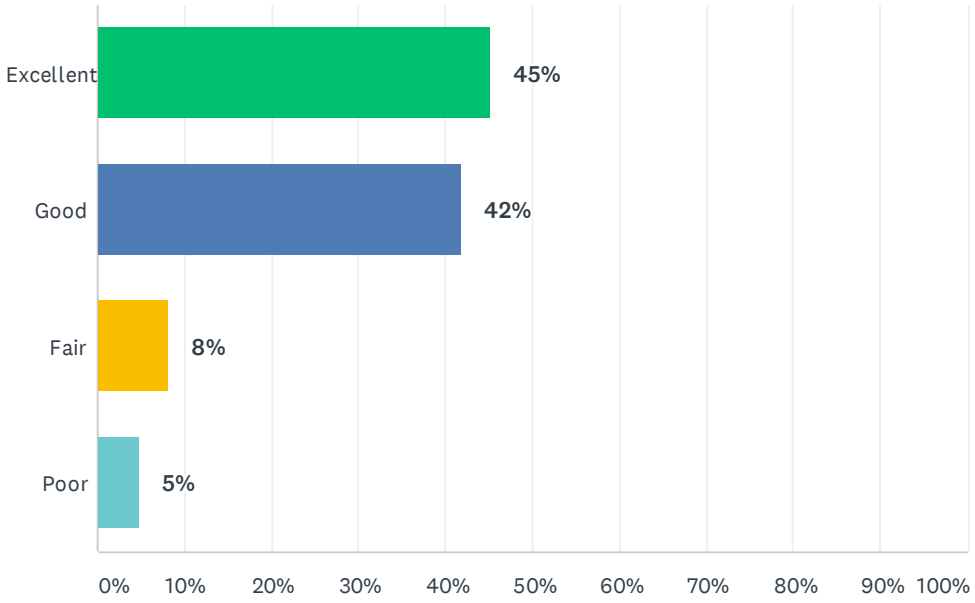


ANSWER CHOICES	RESPONSES	
Excellent	52%	32
Good	29%	18
Fair	6%	4
Poor	5%	3
Don't Know	8%	5
TOTAL		62

Attachment #3

Q5 How do you rate the availability of information at the Oregon Board of Dentistry?

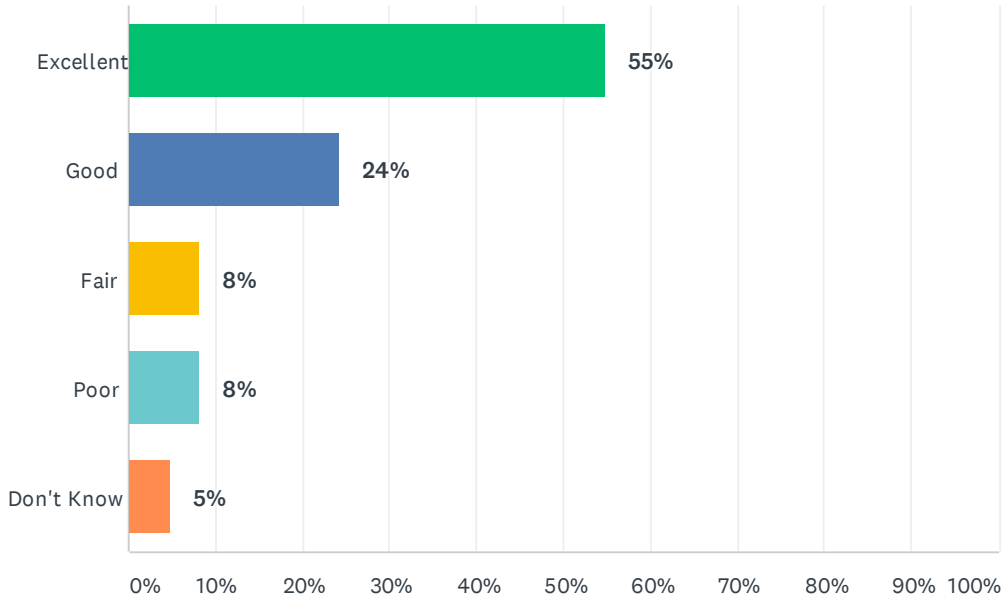
Answered: 62 Skipped: 1



ANSWER CHOICES	RESPONSES	
Excellent	45%	28
Good	42%	26
Fair	8%	5
Poor	5%	3
TOTAL		62

Q6 How do you rate the overall quality of service provided by the Oregon Board of Dentistry?

Answered: 62 Skipped: 1



ANSWER CHOICES	RESPONSES	
Excellent	55%	34
Good	24%	15
Fair	8%	5
Poor	8%	5
Don't Know	5%	3
TOTAL		62

Attachment #3

BillTracker

Custom Report

Report Date: April 5, 2021

Bill Number	Bill Number	Bill Sponsor	Next Hearing
HB 2074	HB 2074 INTRO	Presession filed (at the request of Governor Kate Brown for Oregon Health Authority)	

Relating to prescription monitoring program fees; prescribing an effective date.

Increases prescription monitoring program fees from $25 to $35.
Takes effect on 91st day following adjournment sine die.

Relating to prescription monitoring program fees; creating new provisions; amending ORS 431A.880; and prescribing an effective date.

Bill Number	Bill Number	Bill Sponsor	Next Hearing
HB 2075	HB 2075 INTRO	Presession filed (at the request of Governor Kate Brown for Oregon Health Authority)	

Relating to radiation; declaring an emergency.

Establishes vendor license and annual fee for persons engaging in certain conduct regarding radiation devices and equipment, including X-ray machines and tanning devices. Modifies registration fee for certain radiation devices and equipment from per machine basis to per tube basis. Increases registration fee for tanning devices.
Becomes operative January 1, 2022.
Declares emergency, effective on passage.

Relating to radiation; creating new provisions; amending ORS 453.001, 453.605, 453.729 and 453.757; and declaring an emergency.

Bill Number	Bill Number	Bill Sponsor	Next Hearing
HB 2076	HB 2076 INTRO	Presession filed (at the request of Governor Kate Brown for Oregon Health Authority)	3:15PM 04/06/2021 House Committee Health Care Work Session Remote F

Relating to emergency medical services; prescribing an effective date.

Establishes Emergency Health Care Systems Program and Emergency Health Care System Advisory Board within Oregon Health Authority. Directs authority to designate emergency health care centers for provision of cardiac and pediatric emergency health care. Modifies terminology related to emergency medical services. Authorizes Governor to make available for use emergency medical services personnel and equipment. Creates offense of unlawful operation of unlicensed emergency medical services agency. Punishes by maximum of 364 days' imprisonment, $6,250 fine, or both. Becomes operative January 1, 2022.

Directs authority to designate emergency health care regions within state. Becomes operative January 1, 2023.

Directs authority to designate emergency health care centers for provision of stroke and trauma emergency health care. Directs program to establish emergency health care data systems for collection of information related to emergency health care in this state. Requires licensure for nontransport EMS service. Defines "nontransport EMS service." Becomes operative January 1, 2025.

Takes effect on 91st day following adjournment sine die.

Relating to emergency medical services; creating new provisions; amending ORS 146.015, 181A.375, 353.450, 431A.055, 431A.100, 441.020, 442.507, 442.870, 445.030, 478.260, 682.017, 682.025, 682.031, 682.035, 682.041, 682.045, 682.047, 682.051, 682.056, 682.059, 682.062, 682.063, 682.066, 682.068, 682.075, 682.079, 682.085, 682.089, 682.105, 682.107, 682.204, 682.208, 682.216, 682.218, 682.220, 682.224 and 682.245; repealing ORS 431A.050, 431A.055, 431A.060, 431A.065, 431A.070, 431A.075, 431A.080, 431A.085, 431A.090, 431A.095, 431A.100, 431A.105, 431A.525, 431A.530, 682.027 and 682.039; and prescribing an effective date.

BillTracker

Custom Report

Report Date: April 5, 2021

Bill Number	Bill Number	Bill Sponsor	Next Hearing
HB 2078	HB 2078 A	Presession filed (at the request of Governor Kate Brown)	

Relating to health.

Repeals electronic credentialing information program.
Removes requirement for Pain Management Commission to review pain management curricula of educational institutions. Modifies pain management education requirements for health professionals.
Removes requirement for Oregon Health Authority to annually report to Legislative Assembly on Oregon Health Information Technology program.
Aligns with federal law requirements about eligibility of temporary public employees to qualify for health benefit coverage.

Relating to health; creating new provisions; amending ORS 243.105, 413.310, 413.572, 413.590, 441.223, 459A.200, 675.110, 677.228, 677.510, 678.101, 684.092, 685.102, 685.106 and 689.285; and repealing ORS 441.224, 441.226, 441.228, 441.229, 441.232 and 441.233.

Bill Number	Bill Number	Bill Sponsor	Next Hearing
HB 2079	HB 2079 INTRO	Presession filed (at the request of Governor Kate Brown for Oregon Health Authority)	

Relating to health care providers.

Requires health care entities to obtain approval from Oregon Health Authority before any mergers, acquisitions or affiliations of entities that had $25 million or more in net patient revenue in prior fiscal year or before mergers, acquisitions or affiliations that will result in one entity having increase in net patient revenue of $10 million or more. Specifies procedures.
Requires Oregon Health Policy Board to establish criteria for approval of mergers, acquisitions and affiliations based on specified factors.

Relating to health care providers; creating new provisions; and amending ORS 413.032, 413.037, 413.101, 413.181, 415.013, 415.019 and 415.103.

Bill Number	Bill Number	Bill Sponsor	Next Hearing
HB 2080	HB 2080 INTRO	Presession filed (at the request of Governor Kate Brown for Oregon Health Authority)	

Relating to pharmaceuticals.

Establishes Office of Pharmaceutical Purchasing in Oregon Health Authority and specifies duties. Requires office to administer multistate prescription drug purchasing consortium.
Authorizes Oregon Health Authority to require prior authorization for drugs under specified conditions.

Relating to pharmaceuticals; creating new provisions; and amending ORS 413.032, 414.312, 414.314, 414.318, 414.320, 414.325, 414.326, 414.334, 414.337 and 689.185.

Bill Number	Bill Number	Bill Sponsor	Next Hearing
HB 2081	HB 2081 A	Presession filed (at the request of Governor Kate Brown for Oregon Health Authority)	10:30AM 04/05/2021 Third Reading House Floor

Relating to health care costs.

Modifies Health Care Cost Growth Target program and Health Care Cost Growth Target Implementation Committee.
Directs Oregon Health Authority to adopt schedule of civil penalties for providers or payers that fail to report cost growth data or to develop and implement performance improvement plan if required to do so.

Relating to health care costs; creating new provisions; and amending ORS 442.385, 442.386 and 442.993 and sections 3, 4 and 5, chapter 560, Oregon Laws 2019.

Bill Number	Bill Number	Bill Sponsor	Next Hearing
HB 2084	HB 2084 INTRO	Presession filed (at the request of Governor Kate Brown for Oregon Health Authority)	

Relating to health care.

Requires Oregon Health Authority to report to interim committees of Legislative Assembly related to health on impacts of federal changes arising from executive or legislative branches of federal government on access to health care in this state and to recommend legislation, if any, that is needed to ensure no diminution of access to quality, affordable health care by residents of this state.

Relating to health care.

Bill Number	Bill Number	Bill Sponsor	Next Hearing
HB 2087	HB 2087 INTRO	Presession filed (at the request of Governor Kate Brown for Oregon Health Authority)	

Relating to health care interpreters.

Requires Oregon Health Authority to adopt rules to ensure that health care providers use health care interpreters, reimbursed by state, when interacting with medical assistance recipients who have limited English proficiency or who communicate in sign language.

Relating to health care interpreters; creating new provisions; and amending ORS 413.550 and 413.552.

Bill Number	Bill Number	Bill Sponsor	Next Hearing
HB 2164	HB 2164 INTRO	Presession filed (at the request of Governor Kate Brown for Office of the Governor)	3:15PM 04/06/2021 House Committee Health Care Work Session Remote F

Relating to health; prescribing an effective date.

Directs office of the Governor to study laws related to health and provide results to interim committees of Legislative Assembly no later than September 15, 2022.

Sunsets January 2, 2023.

Takes effect on 91st day following adjournment sine die.

Relating to health; and prescribing an effective date.

Bill Number	Bill Number	Bill Sponsor	Next Hearing
HB 2167	HB 2167 INTRO	Presession filed (at the request of Governor Kate Brown for Office of the Governor)	

Relating to state entities.

Directs Office of Governor to study and make recommendations regarding certain proposals relating to state boards and commissions. Requires office to submit report on findings by January 1, 2023.

Relating to state entities.

Bill Number	Bill Number	Bill Sponsor	Next Hearing
HB 2222	HB 2222 INTRO	Rep Wilde (Presession filed)	

Relating to public meetings.

Modifies definition of "meeting" for purposes of public meetings law to state that meeting may occur without regard to location or stated purpose for which members of governing body convene. Excludes one-on-one meetings of two members of governing body from definition of "meeting," even if serial one-on-one meetings take place between members of governing body.

Establishes affirmative duty of chief administrative officer of public body or employee of public body who routinely and customarily advises governing body on public meetings law requirements to advise governing body on whether meeting content qualifies for executive session. Establishes joint and several liability for specified public body officers and employees who, with willful misconduct, fail or incorrectly advise governing body of meeting content's eligibility for executive session.

Authorizes Oregon Government Ethics Commission to adopt rules establishing criteria for when official or employee of public body has affirmative duty to advise on meeting content qualification for executive session. Authorizes commission to impose civil penalties on members of governing body or specified officers or employees of public body for conducting executive sessions in which meeting content does not meet executive session requirements.

Relating to public meetings; amending ORS 192.610, 192.660, 192.680, 244.290 and 244.350.

BillTracker

Custom Report

Report Date: April 5, 2021

Bill Number	Bill Number	Bill Sponsor	Next Hearing
HB 2315	HB 2315 INTRO	Rep Alonso Leon; Rep Noble; Rep Salinas; Rep Sollman; Rep Williams (Presession filed)	8:00AM 04/05/2021 House Committee Behavioral Health Work Session Remote C

Relating to continuing education for professionals; prescribing an effective date.

Directs Oregon Health Authority and specified professional regulatory boards to require licensees regulated by authority or board to complete six hours of continuing education related to suicide risk assessment, treatment and management every six years and to report completion of continuing education to authority or board. Allows authority and boards to establish minimum requirements that licensee must meet to be exempt from requirement to complete continuing education.

Takes effect on 91st day following adjournment sine die.

Relating to continuing education for professionals; creating new provisions; amending ORS 676.860; and prescribing an effective date.

HB 2321	HB 2321 INTRO	Rep Salinas (Presession filed)	

Relating to health care workers; declaring an emergency.

Requires Oregon Health Authority to convene advisory committee to study adequacy of personal protective equipment provided to health care workers to protect against SARS-CoV-2 and to report findings to interim committee of Legislative Assembly.

Sunsets January 2, 2023.

Declares emergency, effective on passage.

Relating to health care workers; and declaring an emergency.

HB 2335	HB 2335 INTRO	Rep Bonham; Rep Levy; Sen Steiner Hayward (Presession filed)	

Relating to interstate health professional licensure compacts; declaring an emergency.

Enacts interstate Nurse Licensure Compact. Permits Oregon State Board of Nursing to disclose specified information to Interstate Commission of Nurse Licensure Compact Administrators. Exempts individuals practicing nursing in this state under compact from restrictions on use of titles. Allows board to establish account to meet financial obligations imposed on State of Oregon as result of participation in compact. Continuously appropriates moneys from account to board for specified purpose.

Enacts Interstate Medical Licensure Compact. Permits Oregon Medical Board to disclose specified information to Interstate Medical Licensure Compact Commission. Exempts individuals practicing medicine in this state under compact from restrictions on use of titles. Allows board to establish account to meet financial obligations imposed on State of Oregon as result of participation in compact. Continuously appropriates moneys from account to board for specified purpose.

Declares emergency, effective on passage.

Relating to interstate health professional licensure compacts; creating new provisions; amending ORS 676.177, 677.080, 677.290, 678.021, 678.023 and 678.170; and declaring an emergency.

BillTracker

Custom Report

Report Date: April 5, 2021

Bill Number	Bill Number	Bill Sponsor	Next Hearing
HB 2359	HB 2359 INTRO	Rep Alonso Leon; Rep Dexter; Rep Grayber; Rep Nosse; Rep Ruiz; Rep Salinas; Sen Frederick (Presession filed)	3:15PM 04/06/2021 House Committee Health Care Work Session Remote F

Relating to health care interpreters; declaring an emergency.

Requires health care providers to work with health care interpreters from health care interpreter registry operated by Oregon Health Authority to provide interpretation services. Requires authority to adopt rules to enforce requirement. Provides exceptions.

Requires interpretation service companies to register with authority. Requires companies to only employ or contract with health care interpreters listed on health care registry, subject to exceptions. Requires Commissioner of Bureau of Labor and Industries to enforce requirement to only employ or contract with health care interpreters listed on registry.

Requires Oregon Council on Health Care Interpreters to adopt code of ethics for health care interpreters and procedures to evaluation quality of health interpretation services.

Requires authority to train and certify or qualify health care interpreters, maintain central registry of certified or qualified health care interpreters from which patients or health care providers can schedule appointments with health care interpreters and publish specified guidance to health care interpreters.

Requires coordinated care organizations to use health care interpreters listed on health care interpreter registry.

Makes certain health care interpreters subject workers for purposes of workers' compensation benefits.

Declares emergency, effective on passage.

Relating to health care interpreters; creating new provisions; amending ORS 192.630, 413.550, 413.552, 413.556, 413.558, 414.572 and 656.027; repealing ORS 657.048; and declaring an emergency.

Bill Number	Bill Number	Bill Sponsor	Next Hearing
HB 2362	HB 2362 INTRO	Rep Alonso Leon; Rep Campos; Rep Dexter; Rep Grayber; Rep McLain; Rep Meek; Rep Pham; Rep Reynolds; Rep Ruiz; Rep Salinas (Presession filed)	3:15PM 04/06/2021 House Committee Health Care Work Session Remote F

Relating to health care providers; prescribing an effective date.

Requires health care entities to obtain approval from Oregon Health Authority before any mergers, acquisitions or affiliations of entities that had $25 million or more in net patient revenue in preceding three fiscal years or before mergers, acquisitions or affiliations that will result in one entity having increase in net patient revenue of $1 million or more. Specifies procedures.

Requires Oregon Health Policy Board to establish criteria for approval of mergers, acquisitions and affiliations based on specified factors.

Takes effect on 91st day following adjournment sine die.

Relating to health care providers; creating new provisions; amending ORS 413.032, 413.037, 413.101, 413.181, 415.013, 415.019 and 415.103; and prescribing an effective date.

Bill Number	Bill Number	Bill Sponsor	Next Hearing
HB 2376	HB 2376 INTRO	Rep Prusak; Rep Schouten; Rep Smith Warner; Rep Williams (Presession filed)	3:15PM 04/06/2021 House Committee Health Care Work Session Remote F

Relating to naloxone; prescribing an effective date.

Requires health care provider who prescribes opioid to offer prescription for naloxone, or similar drug, and educational material under specified circumstances. Defines "health care provider." Allows health professional regulatory board to impose discipline for violation.

Becomes operative on January 1, 2022.

Takes effect on 91st day following adjournment sine die.

Relating to naloxone; creating new provisions; amending ORS 677.190, 678.111 and 679.140; and prescribing an effective date.

Bill Number	Bill Number	Bill Sponsor	Next Hearing
HB 2401	HB 2401 INTRO	Rep Neron; Sen Frederick; Sen Lieber (Presession filed)	

Relating to employment protections; prescribing an effective date.

Makes certain actions taken by employer because of employee's service as member of board, commission, council or committee created by statute unlawful employment practice. Allows employee to bring civil action or file complaint with Commissioner of Bureau of Labor and Industries for violation.

Takes effect on 91st day following adjournment sine die.

Relating to employment protections; creating new provisions; amending ORS 659A.885; and prescribing an effective date.

Bill Number	Bill Number	Bill Sponsor	Next Hearing
HB 2459	HB 2459 INTRO	Rep Evans; Rep Nathanson; Rep Reardon (Presession filed)	

Relating to video conferencing.

Includes in definition of "conversation" communication occurring through video conferencing program for purposes of statutes regulating recording of communications. Prohibits recording of communication occurring through video conferencing program if participants are not informed of recording. Punishes by maximum of 364 days' imprisonment, $6,250 fine, or both. Specifies exceptions.

Relating to video conferencing; amending ORS 165.535 and 165.540.

Bill Number	Bill Number	Bill Sponsor	Next Hearing
HB 2461	HB 2461 A	Rep Dexter; Rep Evans; Rep Holvey; Rep Nathanson; Rep Neron; Rep Prusak; Rep Reardon; Rep Schouten (Presession filed)	

Relating to critical disaster preparedness; declaring an emergency.

Directs Oregon Business Development Department] Oregon Homeland Security Council to establish program to create Oregon Critical Disaster Preparedness Stockpile to ensure robust stock of emergency supplies and equipment.

Directs Oregon Homeland Security Council] council, in consultation with Oregon Health Authority and relevant state agencies, to develop list of essential equipment, materials, supplies, distribution channels and manufacturing capabilities for stockpile, including personal protective equipment, communicable disease testing equipment and all-hazards emergency surge supplies. Requires council to report to Legislative Assembly.

Directs department] Oregon Business Development Department to establish and administer Oregon Resiliency Partnership in consultation with other entities]. Limits civil liability in certain circumstances.

Declares emergency, effective on passage.

Relating to critical disaster preparedness; and declaring an emergency.

Bill Number	Bill Number	Bill Sponsor	Next Hearing
HB 2494	HB 2494 INTRO	Rep Salinas (Presession filed)	

Relating to health care; prescribing an effective date.

Establishes legislative Task Force on the Impacts of COVID-19 on Health Care Delivery Systems to evaluate impacts of COVID-19 on health care delivery systems in this state.

Sunsets December 31, 2022.

Takes effect on 91st day following adjournment sine die.

Relating to health care; and prescribing an effective date.

BillTracker

Custom Report

Report Date: April 5, 2021

Bill Number	Bill Number	Bill Sponsor	Next Hearing
HB 2508	HB 2508 A	Rep Alonso Leon; Rep Bynum; Rep Campos; Rep Clem; Rep Fahey; Rep Grayber; Rep Marsh; Rep Neron; Rep Nosse; Rep Owens; Rep Prusak; Rep Reynolds; Rep Schouten; Rep Smith DB; Rep Wilde; Rep Williams; Rep Witt; Rep Zika; Sen Beyer; Sen Gorsek (Presession filed)	10:30AM 04/06/2021 Third Reading House Floor

Relating to telemedicine; declaring an emergency.

Requires Oregon Health Authority to ensure] Prescribes requirements for reimbursement by Oregon Health Authority and coordinated care organizations of health services delivered using telemedicine.

Modifies requirements for health benefit plan coverage of telemedicine.

Requires Department of Consumer and Business Services to report to interim committees of Legislative Assembly, no later than March 1, 2023, on impact of required reimbursement of telemedicine health services by health benefit plans on cost of health insurance premiums in Oregon.

Declares emergency, effective on passage.

Relating to telemedicine; creating new provisions; amending ORS 743A.058; and declaring an emergency.

Bill Number	Bill Number	Bill Sponsor	Next Hearing
HB 2528	HB 2528 INTRO	Rep Bynum; Rep Meek; Rep Sanchez; Rep Witt (Presession filed)	3:15PM 04/06/2021 House Committee Health Care Work Session Remote F

Relating to dental therapy; prescribing an effective date.

Directs Oregon Board of Dentistry to issue dental therapist license to qualified applicant. Prohibits unlicensed use of title "dental therapist" and practice of dental therapy. Provides exceptions to prohibition. Adds dental therapist member to board.

Takes effect on 91st day following adjournment sine die.

Relating to dental therapy; creating new provisions; amending ORS 679.010, 679.140, 679.170, 679.230 and 679.250 and section 1, chapter 716, Oregon Laws 2011; and prescribing an effective date.

Bill Number	Bill Number	Bill Sponsor
HB 2557	HB 2557 INTRO	Rep Fahey; Rep Meek; Rep Post; Rep Sanchez; Rep Schouten; Rep Wilde; Sen Beyer; Sen Dembrow; Sen Frederick; Sen Gelser; Sen Hansell (Presession filed)

Relating to dental care for Pacific Islanders legally residing in Oregon under the Compact of Free Association.

Establishes COFA Dental Program in Oregon Health Authority to provide dental care to low-income citizens of Pacific Islands in Compact of Free Association who reside in Oregon and lack access to affordable dental coverage. Specifies eligibility requirements for program and duties of authority in administering program.

Relating to dental care for Pacific Islanders legally residing in Oregon under the Compact of Free Association; creating new provisions; and amending ORS 413.032 and 735.608.

Bill Number	Bill Number	Bill Sponsor
HB 2591	HB 2591 INTRO	Rep Alonso Leon; Rep Dexter; Rep Neron; Rep Prusak; Rep Reardon; Rep Reynolds; Rep Smith DB; Rep Sollman; Rep Wilde; Rep Williams; Rep Witt (Presession filed)

Relating to school-based health center grants.

Allows mobile school-based health centers to qualify for safety net grants from Oregon Health Authority.

Relating to school-based health center grants; amending ORS 413.225.

Bill Number	Bill Number	Bill Sponsor	Next Hearing
HB 2627	HB 2627 INTRO	Rep Hayden; Rep Schouten (Presession filed)	10:30AM 04/05/2021 Third Reading House Floor

Relating to interim therapeutic restorations; prescribing an effective date.

Allows expanded practice dental hygienist to perform interim therapeutic restoration. Requires agreement between dentist and expanded practice dental hygienist to include expanded practice dental hygienist's scope of practice regarding interim therapeutic restorations. Defines "interim therapeutic restoration."

Directs Oregon Board of Dentistry to adopt rules to establish educational and instructional requirements for interim therapeutic restoration and to approve applications from education providers for training courses that meet requirements. Requires certain expanded practice dental hygienists to complete approved training course.

Takes effect on 91st day following adjournment sine die.

Relating to interim therapeutic restorations; creating new provisions; amending ORS 680.205; and prescribing an effective date.

Bill Number	Bill Number	Bill Sponsor
HB 2638	HB 2638 INTRO	Rep Bonham; Rep Boshart Davis; Rep Breese-Iverson; Rep Drazan; Rep Gomberg; Rep Levy; Rep Moore-Green; Rep Nearman; Rep Owens; Rep Post; Rep Reschke; Rep Smith DB; Rep Smith G (Presession filed)

Relating to limitations of liability during the COVID-19 emergency.

Limits liability for certain claims for damages arising out of acts or omissions taken during COVID-19 emergency period in reasonable compliance with government guidance related to COVID-19.

Relating to limitations of liability during the COVID-19 emergency.

Bill Number	Bill Number	Bill Sponsor
HB 2752	HB 2752 INTRO	Rep Noble (Presession filed) (at the request of Brittany Ruiz)

Relating to information regarding vaccines; prescribing an effective date.

Requires licensed health care provider to provide vaccine information packet to patient to whom licensed health care provider administers vaccine. Requires Oregon Health Authority to maintain website that provides specific vaccine information.

Takes effect on 91st day following adjournment sine die.

Relating to information regarding vaccines; and prescribing an effective date.

Bill Number	Bill Number	Bill Sponsor
HB 2816	HB 2816 INTRO	Rep Bynum; Rep Dexter; Rep Meek; Rep Nosse; Rep Prusak (Presession filed)

Relating to health care provider incentives; prescribing an effective date.

Establishes BIPOC health care provider loan forgiveness program within Oregon Health Authority to provide loan repayment subsidies to BIPOC health care providers. Defines "BIPOC."

Establishes BIPOC Health Care Provider Fund to carry out provisions of program.

Takes effect on 91st day following adjournment sine die.

Relating to health care provider incentives; and prescribing an effective date.

Bill Number	Bill Number	Bill Sponsor
HB 2891	HB 2891 INTRO	Rep Evans; Rep Lewis; Rep Meek; Rep Noble; Rep Post; Rep Williams (Presession filed) (at the request of former Representative Carla Piluso)

Relating to emergency preparedness; prescribing an effective date.

Requires health care facilities, health care providers, local public health authorities and public and private safety agencies to maintain capacity, including sufficient amounts of certain supplies, to continue in normal operation for 120 days at 25 percent mortality rate. Defines "25 percent mortality rate." Directs Oregon Health Authority and health professional regulatory boards to report to Office of Emergency Management. Directs office to report annually to interim committee of Legislative Assembly related to emergency preparedness.

Takes effect on 91st day following adjournment sine die.

Relating to emergency preparedness; and prescribing an effective date.

Bill Number	Bill Number	Bill Sponsor	Next Hearing
HB 2901	HB 2901 INTRO	Rep Evans; Rep Meek; Rep Post (Presession filed) (at the request of former Representative Carla Piluso)	

Relating to prescription drugs for veterans.

Requires coordinated care organization drug outlets to dispense seven-day supply of prescription drug to veteran with disability, at no cost to veteran, if veteran is unable to obtain prescription drug through United States Department of Veterans Affairs.

Relating to prescription drugs for veterans.

Bill Number	Bill Number	Bill Sponsor	Next Hearing
HB 2927	HB 2927 INTRO	Rep Drazan; Rep Evans; Rep Gomberg; Rep Grayber; Rep Lewis; Rep Meek; Rep Morgan; Rep Nathanson; Rep Neron; Rep Noble; Rep Post; Rep Power; Rep Prusak; Rep Rayfield; Rep Reynolds; Rep Sollman; Rep Wallan; Rep Williams (Presession filed) (at the request of former Representative Carla Piluso)	3:15PM 04/08/2021 House Committee Veterans and Emergency Management Work Session Remote 170

Relating to emergency management.

Renames Office of Emergency Management as Oregon Department of Emergency Management. Establishes department as independent state agency. Vests in department emergency authority regarding public health emergencies, emergency quarantines and conflagrations. Transfers rulemaking authority regarding nuclear emergencies from State Department of Energy to Oregon Department of Emergency Management. Directs department to carry out certain functions related to regional and statewide emergency preparedness.

Transfers Oregon Emergency Response System from Department of State Police to Oregon Department of Emergency Management.

Renames office of State Fire Marshal as Department of the State Fire Marshal and establishes department as independent state agency. Transfers search and rescue functions from Office of Emergency Management to department. Requires State Fire Marshal to establish guidelines for wildfire buffer zones that produce defensible spaces around lands in forestland-urban interface.

Transfers Oregon Homeland Security Council to Office of Governor and renames as Oregon Homeland Security Commission. Adds members to and modifies duties of commission.

Establishes Emergency Preparedness Advisory Council to advise and make policy recommendations to Oregon Homeland Security Commission regarding federal emergency support functions.

Establishes Local Government Emergency Management Advisory Council to provide advice and recommendations to Oregon Department of Emergency Management regarding department's emergency preparedness and response functions.

Becomes operative on July 1, 2023.

Relating to emergency management; creating new provisions; and amending ORS 30.269, 182.535, 183.457, 195.260, 244.050, 264.348, 276A.300, 276A.326, 377.833, 399.035, 401.052, 401.054, 401.062, 401.072, 401.076, 401.082, 401.088, 401.092, 401.094, 401.096, 401.109, 401.165, 401.239, 401.305, 401.358, 401.364, 401.368, 401.534, 401.536, 401.551, 401.552, 401.654, 401.655, 401.657, 401.658, 401.661, 401.667, 401.900, 401.902, 401.904, 401.910, 401.915, 401.922, 401.950, 401.952, 401.955, 401.975, 401.977, 401.978, 402.015, 402.020, 402.210, 402.230, 403.120, 403.130, 403.132, 403.160, 403.165, 403.170, 403.235, 403.240, 403.250, 403.415, 403.425, 403.430, 403.435, 403.450, 404.100, 404.105, 404.110, 404.120, 404.125, 404.200, 433.441, 433.443, 433.448, 443.760, 453.327, 453.342, 453.362, 453.392, 453.394, 453.520, 453.825, 465.505, 466.620, 466.635, 468B.365, 468B.431, 469.533, 469.534, 469.535, 469.536, 476.020, 476.030, 476.050, 476.055, 476.090, 476.130, 476.210, 476.220, 476.270, 476.290, 476.515, 476.590, 476.680, 476.685, 476.735, 476.765, 476.806, 476.925, 478.270, 478.940, 479.180, 480.230, 480.450, 480.460, 540.482, 561.560, 657.665, 689.645, 731.820, 735.470 and 824.088 and sections 1, 3 and 4, chapter 85, Oregon Laws 2016, and section 13c, chapter 581, Oregon Laws 2019.

BillTracker

Custom Report

Report Date: April 5, 2021

Bill Number	Bill Number	Bill Sponsor	Next Hearing
HB 3057	HB 3057 INTRO	Rep Dexter; Rep Noble; Rep Prusak; Rep Reynolds; Rep Salinas; Rep Schouten; Sen Patterson	10:30AM 04/05/2021 Third Reading House Floor

Relating to the disclosure of information related to COVID-19; declaring an emergency.

Authorizes Oregon Health Authority to disclose individually identifiable information related to COVID-19 to certain persons and under certain circumstances.
Sunsets June 30, 2022.
Declares emergency, effective on passage.

Relating to the disclosure of information related to COVID-19; creating new provisions; amending ORS 433.008; and declaring an emergency.

Bill Number	Bill Number	Bill Sponsor	Next Hearing
HB 3087	HB 3087 INTRO	Rep Witt	

Relating to vaccine administration; declaring an emergency.

Directs Oregon Health Authority to establish volunteer vaccine administration program to utilize specified volunteer health care providers to administer vaccines in emergency. Defines "emergency."
Declares emergency, effective on passage.

Relating to vaccine administration; and declaring an emergency.

Bill Number	Bill Number	Bill Sponsor	Next Hearing
HB 3159	HB 3159 INTRO	Rep Alonso Leon; Rep Campos; Rep Meek; Rep Nosse; Rep Pham; Rep Power; Rep Salinas; Rep Sanchez; Rep Schouten; Rep Williams	3:15PM 04/06/2021 House Committee Health Care Public Hearing Remote F

Relating to data collection; prescribing an effective date.

Requires health care provider and health insurer to collect from patient, client or member data on race, ethnicity, preferred spoken and written languages, disability status, sexual orientation and gender identity. Requires Oregon Health Authority to establish data system for receipt and storage of specified data.
Takes effect on 91st day following adjournment sine die.

Relating to data collection; creating new provisions; amending ORS 413.161; repealing sections 40, 41 and 43, chapter 12, Oregon Laws 2020 (first special session); and prescribing an effective date.

Bill Number	Bill Number	Bill Sponsor
SB 11	SB 11 INTRO	Sen Beyer (Presession filed)

Relating to telemedicine.

Requires health benefit plan to reimburse cost of covered telemedicine health service provided by health professional licensed or certified in this state if same health service is covered when provided in person.

Relating to telemedicine; creating new provisions; and amending ORS 743A.058 and 743A.185.

Bill Number	Bill Number	Bill Sponsor
SB 61	SB 61 INTRO	Presession filed (at the request of Governor Kate Brown for Oregon Government Ethics Commission)

Relating to advice offered by Oregon Government Ethics Commission.

Authorizes Oregon Government Ethics Commission to provide written commission advisory opinions, staff advisory opinions and oral or written staff advice on application of executive session provisions of Oregon public meetings law. Grants specified safe harbor provisions to persons who rely in good faith on commission opinions or advice.

Relating to advice offered by Oregon Government Ethics Commission; amending ORS 192.660, 244.280, 244.282 and 244.284.

Bill Number	Bill Number	Bill Sponsor
SB 99	SB 99 INTRO	Presession filed (at the request of Governor Kate Brown for Board of Medical Imaging)

Relating to Board of Medical Imaging; prescribing an effective date.

Allows Board of Medical Imaging designee to perform inspections related to medical imaging and X-ray machines.
Takes effect on 91st day following adjournment sine die.

Relating to Board of Medical Imaging; creating new provisions; amending ORS 688.595; and prescribing an effective date.

BillTracker

Custom Report

Report Date: April 5, 2021

Bill Number	Bill Number	Bill Sponsor	Next Hearing
SB 254	SB 254 INTRO	Presession filed (at the request of Senate Interim Committee on Rules and Executive Appointments)	

Relating to health care; declaring an emergency.

Removes ability of parent to decline required immunizations against restrictable diseases on behalf of child for reason other than child's indicated medical diagnosis. Allows child who is not immunized or exempt for reason of indicated medical diagnosis to attend school that provides education program through online courses. Prohibits child from attending in person specified school-related events, meetings and opportunities. Allows Oregon Health Authority to recommend diseases in addition to restrictable diseases against which children may be immunized.

Directs boards that regulate certain licensed health care practitioners to review documents completed by licensed health care practitioners granting exemptions from immunization requirements because of indicated medical diagnosis. Defines "licensed health care practitioner." Requires boards to annually report to authority on results of review. Requires authority to report annually to Legislative Assembly on reports submitted to boards.

Directs authority to establish outreach and education plan regarding disease control in schools.

Allows child who is not immunized to continue attending school in person until August 1, 2022. Allows child who is not immunized and has schedule for immunizations approved by authority to continue attending school in person after August 1, 2022.

Declares emergency, effective on passage.

Relating to health care; creating new provisions; amending ORS 433.102, 433.235, 433.255, 433.260, 433.267, 433.269, 433.273 and 433.284; and declaring an emergency.

Bill Number	Bill Number	Bill Sponsor	Next Hearing
SB 423	SB 423 INTRO	Sen Manning Jr (Presession filed) (at the request of Dale Penn - Providence Health and Services)	

Relating to telemedicine; prescribing an effective date.

Allows patient located in Oregon to receive health care services through telemedicine from specified out-of-state health care provider. Defines "telemedicine."

Takes effect on 91st day following adjournment sine die.

Relating to telemedicine; and prescribing an effective date.

Bill Number	Bill Number	Bill Sponsor	Next Hearing
SB 454	SB 454 INTRO	Sen Knopp (Presession filed)	

Relating to ingredients in vaccines; prescribing an effective date.

Requires licensed health care provider to provide vaccine information packet to patient to whom licensed health care provider administers vaccine. Requires Oregon Health Authority to maintain website that provides specific vaccine information.

Takes effect on 91st day following adjournment sine die.

Relating to ingredients in vaccines; and prescribing an effective date.

Bill Number	Bill Number	Bill Sponsor	Next Hearing
SB 488	SB 488 INTRO	Sen Manning Jr; Sen Taylor (Presession filed)	

Relating to the compensability of COVID-19 for the purposes of workers' compensation; declaring an emergency.

Adds exposure to or infection by SARS-CoV-2 to definition of occupational disease for purposes of workers' compensation. Specifies presumptions as to compensability for occupational disease or occupational injury that apply to subject worker's death, disability, impairment of health, loss of work time and expenses of medical treatment or services, including diagnostic or preventive medical treatment or services, as result of exposure to SARS-CoV-2 or COVID-19.

Sunsets provisions on 180th day following expiration or termination of Governor's declaration of emergency concerning COVID-19 pandemic, including any extension of declaration.

Declares emergency, effective on passage.

Relating to the compensability of COVID-19 for the purposes of workers' compensation; creating new provisions; amending ORS 656.802; and declaring an emergency.

Bill Number	Bill Number	Bill Sponsor	Next Hearing
SB 505	SB 505 INTRO	Sen Thatcher (Presession filed)	

Relating to ingredients in vaccines; prescribing an effective date.

Requires licensed health care provider to provide vaccine information packet to patient to whom licensed health care provider administers vaccine. Requires Oregon Health Authority to maintain website that provides specific vaccine information.
Takes effect on 91st day following adjournment sine die.

Relating to ingredients in vaccines; and prescribing an effective date.

Bill Number	Bill Number	Bill Sponsor	Next Hearing
SB 557	SB 557 A	Rep Fahey; Rep Meek; Rep Post; Rep Sanchez; Rep Schouten; Rep Smith G; Rep Wilde; Sen Beyer; Sen Dembrow; Sen Frederick; Sen Gelser; Sen Girod; Sen Hansell; Sen Kennemer; Sen Manning Jr (Presession filed)	

Relating to dental care for Pacific Islanders legally residing in Oregon under the Compact of Free Association.

Establishes COFA Dental Program in Oregon Health Authority to provide dental care to low-income citizens of Pacific Islands in Compact of Free Association who reside in Oregon, qualify for medical assistance through Oregon Supplemental Income Program and lack access to affordable dental coverage. Specifies eligibility requirements for program and duties of authority in administering program.

Relating to dental care for Pacific Islanders legally residing in Oregon under the Compact of Free Association; creating new provisions; and amending ORS 413.032 and 735.608.

Bill Number	Bill Number	Bill Sponsor	Next Hearing
SB 640	SB 640 INTRO	Sen Hansell (Presession filed)	

Relating to tribal health; declaring an emergency.

Establishes Indian Health Scholarship Program to provide free tuition and fees for qualifying Indian health profession students in exchange for student commitment to work at tribal service site after graduation.
Appropriates moneys for 2021-2023 biennium to Oregon Health and Science University for purpose of administering Indian Health Scholarship Program.
Declares emergency, effective July 1, 2021.

Relating to tribal health; creating new provisions; amending ORS 676.454 and 676.467; and declaring an emergency.

Bill Number	Bill Number	Bill Sponsor	Next Hearing
SB 655	SB 655 INTRO	Sen Linthicum (Presession filed)	

Relating to ingredients in vaccines; prescribing an effective date.

Requires licensed health care provider to provide vaccine information packet to patient to whom licensed health care provider administers vaccine. Requires Oregon Health Authority to maintain website that provides specific vaccine information.
Takes effect on 91st day following adjournment sine die.

Relating to ingredients in vaccines; and prescribing an effective date.

Bill Number	Bill Number	Bill Sponsor	Next Hearing
SB 666	SB 666 INTRO	Sen Linthicum (Presession filed)	8:15AM 04/06/2021 Senate Committee Judiciary and Ballot Measure 110 Implementation Work Session Remote A

Relating to public meetings.

Modifies public meeting notice requirements for meetings held in executive session. Removes labor negotiations exception for executive session.

Relating to public meetings; amending ORS 192.640 and 192.660.

BillTracker

Custom Report

Report Date: April 5, 2021

Bill Number	Bill Number	Bill Sponsor	Next Hearing
SB 697	SB 697 INTRO	Sen Knopp	

Relating to telemedical health services; prescribing an effective date.

Prescribes additional requirements for health benefit plan coverage of telemedical health services.
Takes effect on 91st day following adjournment sine die.

Relating to telemedical health services; amending ORS 743A.058 and 743A.185; and prescribing an effective date.

Bill Number	Bill Number	Bill Sponsor	Next Hearing
SB 758	SB 758 INTRO	Sen Prozanski	1:00PM 04/05/2021 Senate Committee Health Care Work Session Remote B

Relating to medical marijuana; prescribing an effective date.

Changes "Oregon Medical Marijuana Act" to "Oregon Medical and Therapeutic Cannabis Act." Allows person designated to produce marijuana by registry identification cardholder to enter into agreement with registry identification cardholder to transfer marijuana to another registry identification cardholder or primary caregiver. Directs Oregon Health Authority to adopt policies and make public statement regarding equitable access to marijuana for medical use. Allows medical marijuana dispensary and recreational marijuana retailer to transfer marijuana to individual who holds valid out-of-state medical marijuana patient card. Requires authority to ensure cybersecurity of personally identifiable information in authority databases and electronic systems. Exempts out-of-state medical marijuana patient from taxation on retail sale of marijuana items. Specifies health care providers who may recommend medical use of marijuana to registry identification cardholder. Provides that authority may not charge fee greater than $20 for registry identification card for certain individuals. Directs authority to issue permanent registry identification card to individual with lifetime debilitating medical condition. Requires organizations designated as primary caregivers to allow consumption of marijuana for medical use. Removes criminal records check requirements for applicants for authority registration. Provides that certain marijuana grow sites are not subject to tracking requirements or marijuana plant limits.

Requires marijuana retailers and medical marijuana dispensaries to make available online terpene testing results.

Directs Oregon Liquor Control Commission to establish care and accommodation program to ensure long-term access to marijuana products for registry identification cardholders. Allows certain recreational marijuana processors to receive marijuana from medical marijuana grow site for purposes of processing marijuana.

Requires distribution of moneys from Oregon Marijuana Account for purposes of administering medical marijuana program.

Takes effect on 91st day following adjournment sine die.

Relating to medical marijuana; creating new provisions; amending ORS 475B.020, 475B.139, 475B.220, 475B.531, 475B.570, 475B.630, 475B.707, 475B.759, 475B.788, 475B.791, 475B.797, 475B.801, 475B.807, 475B.810, 475B.816, 475B.822, 475B.831, 475B.837, 475B.840, 475B.858, 475B.885, 475B.898, 475B.901, 475B.904, 475B.913, 475B.916, 475B.952 and 475B.961; repealing ORS 475B.794, 475B.843 and 475B.861; and prescribing an effective date.

Bill Number	Bill Number	Bill Sponsor	Next Hearing
SB 5511	SB 5511 INTRO	Presession filed (at the request of Oregon Department of Administrative Services)	

Relating to the financial administration of the Oregon Board of Dentistry; declaring an emergency.

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

Declares emergency, effective July 1, 2021.

Relating to the financial administration of the Oregon Board of Dentistry; and declaring an emergency.

2021 AADB MID-YEAR MEETING

Program

We’re going virtual!

February 26-28, 2021

President Robert B. Zena, DMD

AADB Thanks Our Program Committee

Chair:

James Sparks, DDS (OK)

Vice Chair:

Tonia Socha-Mower, MBA, EdD (c) (AADB)

Brian Barnett (MO)

Sherry Campbell, RDH, CDHC (AL)

Bobby Carmen, DDS (OK)

Cliff Feingold, DDS (NC)

Frank Maggio, DDS (IL)

D. Kevin Moore, DDS (NV)

Laura Richoux, RDH (MS)

American Association of Dental Boards

211 E. Chicago Avenue, Ste. 760
Chicago, IL 60611
312-440-7464
info@dentalboards.org

American Association of Dental Boards

Attachment #5

About AADB

The American Association of Dental Boards is a national association that encourages the highest standards of dental education. The AADB promotes higher and uniform standards of qualification for dental practitioners. Membership is comprised of boards of dentistry, advanced education boards, present and past members of those boards, board administrators, board attorneys, educators, and oral health stakeholders.

Our Mission

To serve as a resource by providing a national forum for exchange, development, and dissemination of information to assist dental regulatory boards with their obligation to protect the public.

About AADB's Meeting

The AADB Meeting provides an excellent forum for keeping up to date with state board concerns. Programs are designed to allow opportunities for interaction among all participants, including board members, dentists, therapists, dental hygienists, dental assistants, educators, board attorneys, and dental specialty associations. Panels and small discussion groups exchange ideas and information. Participants take away valuable information on current issues and all aspects of dental and dental hygiene regulation.

- **For the best experience, we recommend joining the event in Google Chrome**. You can access the meeting by clicking on the link or copying the link into your web browser.
- **Please download the latest version of Zoom 24 hours before the meeting**: https://zoom.us/download
- **If you experience any technical difficulties during the event, please chat with tech support directly on the conference page**. You can also email, text or call:
    - Jill@CEExchange.io | 502 802 3909
    - John@CEExchange.io | 502 836 6535
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MEETING AGENDA

*****Please note the times listed below are in Eastern Standard Time *****

Friday, Feb. 26 - Welcome Reception

6:00 p.m. Virtual Check-in & Preview Sponsor Exhibits

7:00 p.m. Welcome Toast with President Zena

7:20 p.m. Comedy Set with Paul Morrissey

Paul was raised as a sports fanatic in the tiny town of Oswego, in upstate New York. After four years of playing college basketball, somehow he graduated. Aside from playing in the NBA, his dream job was to talk about sports for a living. Paul then moved to California after landing a television sports anchor job but found out quickly that he was "too much of a comedian" for TV news. After he was fired, Paul took his unique sense of humor to comedy club and college stages all over the country.

Paul was selected to perform at the HBO Comedy Festival in Las Vegas. Morrissey has also been a finalist in several national comedy competitions including Wendy's Comedy Challenge, Comedy Central's Open Mic Fight and Maxim's Real Men of Comedy. Morrissey's big break came when he made his network television debut on "The Late, Late Show" on CBS. He was so well received that Paul has been asked back 5 times!

Morrissey also released his debut CD, "Good Seats Still Available," which gets regular airplay on SiriusXM Satellite Radio. He has appeared twice on The Late Show with David Letterman on CBS and on Comedy Central.

8:00 p.m. Preview Sponsor Exhibits Cont.

Saturday, Feb. 27- General Assembly I

12:00 - 12:15 p.m. **President's Opening Remarks**
Robert B. Zena, DMD, President, AADB

12:15 - 12:20 p.m. **Executive Director's Report**
Tonia Socha-Mower, MBA, EdD (c), Executive Director

12:20 - 1:00 p.m. **U.S. Public Health Service**
Rear Admiral Timothy Ricks, DMD, MPH, FICD, Chief Dental Officer

1:00 - 1:10 p.m. **DentaQuest Partnership for Oral Health Advancement**
Michael Monopoli, DMD, MPH, MS, Vice President of Grant Strategy

1:10 - 1:35 p.m. **Sponsorship Recognition**

1:35 - 2:00 p.m. **Break**
Virtual Exhibit Hall Open for Networking

2:00 - 2:20 p.m.	**Centers for Disease Control and Prevention** Casey Hannan, MPH, Director of the Division of Oral Health
2:20 - 2:40 p.m.	**Update from Dental Educators in Response to COVID-19** Denice Stewart, DDS, MHSA, Chief Policy Officer, ADEA
2:40 – 3:00 p.m.	**Interprofessional Collaboration to Confront the Opioid Epidemic** Humayun 'Hank' Chaudry, DO, MS, MACP, FRCP, MACOI, President & CEO of the Federation of State Medical Boards Aisha Salman, Acting Director of the National Academy of Medicine Action Collaborative on Countering the US Opioid Epidemic
3:00 - 3:10 p.m.	**Break** **Virtual Exhibit Hall Open for Networking**
3:10 – 3:40 p.m.	**Attorney Round Table** Lori Lindley, Senior Assistant Attorney General, Oregon Grant Gerber, Assistant Attorney General, Maryland
3:40 - 4:00 p.m.	**Break** **Virtual Exhibit Hall Open for Networking**
4:00 - 5:00 p.m.	**Medical and Dental Parameters of Sleep Apnea** David Schwartz, DDS, President, American Academy of Dental Sleep Medicine Alejandra Lastra, MD, Director, Sleep Medicine Fellowship & Assistant Professor, Division of Pulmonary, Critical Care and Sleep Medicine, Rush University Hospital & President-Elect, Illinois Sleep Society

Sunday, Feb. 28 - General Assembly II

12:00 - 12:20 p.m.	**Diamond Sponsor Welcome** Susan Greenspon Rammelt, Chief Legal Officer, EVP Business Affairs, SmileDirectClub
12:20 - 1:00 p.m.	**Increasing Access to Care through Telehealth** Brant Herman, Co-Founder and CEO, MouthWatch, LLC Vincente Calderón, OD, CEO, Aspire Health Solutions ©
1:00 - 1:20 p.m.	**Break** **Virtual Exhibit Hall Open for Networking**

1:20 - 2:20 p.m.	**Anesthesia in the Dental Office** Jade Miller, DDS, Chair of the Safety Committee, American Academy of Pediatric Dentistry Michael Almeida, MSN, CRNA, President, Illinois Association of Nurse Anesthetists Eugene Vayman, DNAP, CRNA, Quantum Anesthesia Services
2:20 - 2:40 p.m.	**Break** **Virtual Exhibit Hall Open for Networking**
2:40 - 3:00 p.m.	**AADB Open Forum: State Board Issues** Frank Maggio, DDS, AADB Member and Moderator
3:00 p.m.	**Adjournment**

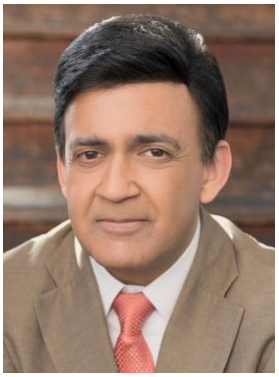
Thank you for participating in our first virtual meeting!

Speaker Biographies

Michael Almeida, MSN, CRNA

President, Illinois Association of Nurse Anesthetists

Undergraduate BSN from Saint Francis Medical Center College of Nursing in 2006.
Graduate degree from Decatur Memorial Hospital/Bradley University Nurse Anesthesia Program in 2012.
Mr. Almeida has been practicing as a CRNA in a variety of settings from a Level 1 trauma center to outpatient Surgery centers as well as Critical Access Hospitals. He is a current partner/owner in a CRNA group providing coverage in the central Illinois area. He is the current president of the Illinois Association of Nurse Anesthetists and has held a variety of positions within the organization throughout his career and has presented at CRNA conferences in the state of Illinois.



Humayun "Hank" Chaudhry, DO, MS, MACP, FRCP (Lon.)

President and Chief Executive Officer, Federation of State Medical Boards (FSMB) of the United States

Dr. Humayun "Hank" Chaudhry is the President and Chief Executive Officer (CEO) of the Federation of State Medical Boards (FSMB) of the United States, which represents all of the nation's state and territorial licensing boards for medicine and co-owns the United States Medical Licensing Examination (USMLE). From 2016 to 2018, Dr. Chaudhry served as the elected Chair of the International Association of Medical Regulatory Authorities (IAMRA), which has 118 member organizations from more than 49 nations. In 2016, Dr. Chaudhry was recognized by Modern Healthcare magazine as one of the 50 Most Influential Physician Executives and Leaders in America.

Dr. Chaudhry is a graduate of New York University, the New York Institute of Technology's College of Osteopathic Medicine and the Harvard TH Chan School of Public Health. He did his medical internship at St. Barnabas Hospital, New York, followed by an ACGME-accredited residency in Internal Medicine at NYU-Winthrop Hospital, New York, where he spent an additional year as Chief Medical Resident. He was a diplomate of the American Board of Internal Medicine from 1996-2006 and of the American Osteopathic Board of Internal Medicine from 2006-2016. He is a Master of the American College of Physicians and a Fellow of the Royal College of Physicians of Edinburgh and of London.

In New York, he served for six years as Assistant Dean and Chair of the Department of Medicine at his alma mater, and five years as a residency program director and hospital executive. He spent 14 years with the United States Air Force Reserve, rising to the rank of Major and serving as a Flight Surgeon attached to the 732nd Airlift Squadron at McGuire Air Force Base, New Jersey. Dr. Chaudhry spent more than two years as Health Commissioner for Suffolk County, New York, overseeing 1,300 employees and a budget of $400 million. He is a co-author of *Fundamentals of Clinical Medicine, 4th edition and of Medical Licensing and Discipline in America.*

Casey Hannan, MPH

Director of the Division of Oral Health

Mr. Hannan is the Director of the Division of Oral Health (DOH) in CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), where he is directs programs, and develops and implements policies and strategies to achieve the mission of the division. Previously, he was Chief of the Arthritis, Epilepsy, and Well-Being Branch in NCCDPHP's Division of Population Health. Mr. Hannan also previously served as the Associate Director of Policy, Partnerships, and Communications in CDC's Division of Nutrition, Physical Activity, and Obesity. Since coming to CDC in 1996, Mr. Hannan has received two HHS Secretary's Awards for Distinguished Service for developing national health objectives and health communication materials, and three Special Act of Service Awards related to his accomplishments in accountability measures, strategic planning, and national leadership conferences. He is a 30-year veteran of the public health workforce and has worked in community-based, medical center, university, and government settings. He holds an MPH from the School of Public Health at the University of Michigan.

Grant D. Gerber, Esq.

Grant D. Gerber is Board Counsel for the Maryland State Board of Dental Examiners, a position he assumed in November 2010. Grant began his career as a Staff Attorney, then Assistant Attorney General with Maryland's Office of the Attorney General in 2001. Initially, he was assigned to the Department of Budget and Management. Later, Grant was transferred to the Department of Health and Mental Hygiene in 2004. Grant's practice has centered on health law, administrative law, and civil litigation. Grant received his undergraduate (B.A.) from Baylor University and law degree (J.D.) from Georgetown University.

Brant E. Herman

Co-Founder and CEO, MouthWatch

Brant E. Herman, Co-Founder and CEO, is the executive leader of MouthWatch. His overall responsibilities include product development, industry relations, strategic partnerships, and day-to-day operations. Widely known in the field of teledentistry, Brant is a frequent public speaker and author of articles in leading oral health-related publications explaining the benefits of teledentistry to patients, practitioners, and policy makers.

Since starting the company in 2012, Brant has actively advocated the use of enhanced visual communication technology between patients and providers, overseeing the development of both hardware and software products.

Under his leadership, the company has experienced significant growth and market presence. MouthWatch products are used by over 18,000 practices in all states and in many countries across the globe. Brant also spearheaded the Teledentistry Innovation Awards to bring attention to innovators and pioneers of teledentistry.

Prior to forming MouthWatch, Brant founded a health and wellness company, worked as a Dental Practice Manager and as an Operations Manager in a medical billing and health insurance claims processing company.
Brant studied Organizational Communication at Sonoma State University and Uppsala University in Sweden and grew his passion for building companies during the first Silicon Valley technology boom. He currently lives in Central New Jersey, close to the MouthWatch headquarters, with his wife, son, and daughter. He loves cooking, running, traveling, coaching sports and spending time with family and friends.

Alejandra C. Lastra, MD

Director, Sleep Medicine Fellowship & Assistant Professor, Division of Pulmonary, Critical Care and Sleep Medicine, Rush University Hospital & President-Elect, Illinois Sleep Society

Alejandra C. Lastra, MD is the director of the Sleep Medicine Fellowship, and assistant professor in the Division of Pulmonary, Critical Care and Sleep Medicine at Rush University Medical Center in Chicago. She is a recognized member of the American Academy of Sleep Medicine (AASM), serving as Vice-Chair of the AASM Educational Committee. As President-Elect of the Illinois Sleep Society, she is currently leading the development of a multidisciplinary/multi-center educational platform in the region. Dr. Lastra is passionate about technology's role in medical education and is a graduate of the Online Teaching and Course Design class from Rush Center for Teaching Excellence and Innovation. She developed and is currently the director of the continuous medical education program at the Rush Sleep Disorders Service & Research Center, and the education co-director of the Rush Center for Sinus, Allergy and Asthma Care. Her clinical and research interests involve home sleep testing, COPD-OSA overlap syndrome, non-invasive positive pressure ventilation in cardiopulmonary conditions and central sleep apnea disorders. She leads clinical programs involving inpatient sleep screening with portable monitors and hypoglossal nerve stimulation in collaboration with otolaryngology.

Lori Lindley

Assistant Attorney General, Oregon Department of Justice

Lori Lindley has been Chair of the AADB Attorney Update Panel for years. She is well qualified to lead this discussion considering her expansive experience. Lori has worked for the Oregon Department of Justice since 1999 and currently is the Assistant Attorney General working with the General Counsel Division and Business Activities Section. Additionally, she was an Associate Attorney for Wiedner, Swanson & Paul, a Deputy District Attorney for the Polk County District Attorney's office, and a Senior Claims Consultant for the Risk Management Division with the Department of Administrative Services. Lori received degrees from Willamette University and Pepperdine University. She is also the recipient of the 2002 Outstanding Service Award from the Department of Justice.

Frank Maggio, DDS

Dr. Maggio was born in Chicago and raised in a dental family. From a young age he was involved with dentistry and it continues to be his passion. Upon completion of dental school, he served his country in the United States Army. It was at that time that he was able obtain a California dental license. He returned to Illinois and he completed his residency in Periodontics. In 1975 he established his practice of Periodontics and Implantology in Elgin, Illinois. For decades, Dr. Maggio has taught in the Department of Periodontology at multiple dental universities including Loyola University (his alma mater), University of Illinois Chicago and University of Buffalo. He is currently an Instructor for Dental Assisting at Elgin Community College near his hometown. Dr. Maggio is an active member of various dental associations including the ADA, ADEA, and Illinois State Dental Society where he served as President. He is currently a Board Member for Fox River Valley Dental Society and past Board Member of various organizations including the Illinois Society of Periodontology, ADA Foundation, American Board of Dental Examiners and National Foundation of Dentistry for the Handicapped.

Jade Miller, DDS

Chair Safety Committee, American Academy of Pediatric Dentistry

Dr. Jade Miller is a graduate of the University of the Pacific School of Dentistry and the residency program at Children's Hospital Medical Center in Cincinnati, Ohio. Board-certified in pediatric dentistry, Dr. Miller has maintained a private practice in Reno, Nevada, since 1983. Dr. Miller previously served as the president of the American Academy of Pediatric Dentistry (AAPD) from 2016-2017. He has held the role of member of the Board of Trustees American Academy of Pediatric Dentistry, member of the Board of Trustees for the AAPD Foundation, and chair of the AAPD Committee on Safety. In organized dentistry, he has held appointments as chair of the Committee on Anesthesiology for the ADA Council on Dental Education and Licensure, as member of the ADA Advisory Committee on Evidence-Based Dentistry, as the Nevada Delegate to the American Dental Association and as the president of the Nevada Dental Association and the Northern Nevada Dental Society. Dr. Miller served as chairman of the Nevada State Board of Health, and president, examiner and sedation examiner for the Nevada State Board of Dental Examiners. Additionally, he holds academic appointments at the University of Nevada's School of Medicine-Cranial Facial Anomaly Team, the University of the Pacific's Arthur Dugoni School of Dentistry and the University of Washington's School of Dentistry.

Michael Monopoli, DMD, MPH, MS

Vice President, Grants Strategy, DentaQuest Partnership for Oral Health Advancement

Dr. Monopoli leads grant making activities, coordinates best evidence, community input, and various data sources on improving health outcomes to design and manage strategies for the prevention of oral disease, health systems impact, and community-based solutions to oral health problems.

Dr. Michael Monopoli is a graduate of the Tufts University School of Dental Medicine. He received Master of Public Health and Master of Science degrees from the Harvard University School of Public Health. Dr. Monopoli also completed a fellowship in Geriatric Dentistry at the Harvard School of Dental Medicine and the Veterans Administration. Dr. Monopoli served as the dental director of the Office of Oral Health for the Massachusetts Department of Public Health. Dr. Monopoli is presently Vice President for Grants Strategy of the DentaQuest Partnership for Oral Health Advancement in Boston, MA. At the DentaQuest Partnership, Dr. Monopoli leads grant making activities and strategies to advance systems change by supporting a growing aligned national network to improve oral health and promoting health equity.

Dr. Monopoli also works across the DentaQuest Enterprise and with external entities, including federal and state government agencies, academia, other health organizations, and community groups to establish, promote and provide support to partnerships and collaborations that can impact positive oral health policy nationally. Dr. Monopoli is a past President of the American Association of Public Health Dentistry (AAPHD).

Susan Greenspon Rammelt

Chief Legal Officer, EVP Business Strategy & Corporate Secretary, SmileDirectClub

Susan Greenspon Rammelt is Chief Legal Officer Counsel, EVP of Business Strategy and Corporate Secretary of SmileDirectClub, the global oral care company and creator of the first medtech platform for teeth straightening. Susan Greenspon Rammelt has served as

SmileDirectClub's Chief Legal Officer since April 2018, Secretary since March 2019, and as a member of SmileDirectClub's board since August 2019.

She has also served as General Counsel of Camelot since April 2018. Prior to joining SmileDirectClub, she was a corporate law partner at Foley & Lardner LLP since 2017, where she represented domestic and international enterprises. Prior to that, Susan was a partner at Dentons US LLP. Susan Greenspon Rammelt has over 30 years of experience as a corporate attorney, focusing on mergers and acquisitions, financings, restructurings, corporate governance, and general corporate counseling, particularly in the retail and beauty industries.

Rear Admiral Timothy Ricks, DMD, MPH, FICD

Chief Dental Officer, US Public Health Service

RADM Timothy L. Ricks, DMD, MPH, FICD has served as the Chief Professional Officer for the Dental Category since September 2018. As the Chief Professional Officer, RADM Ricks advises the Office of the Surgeon General and the U.S. Department of Health and Human Services (HHS) on the recruitment, assignment, deployment, retention, and career development of oral health professionals. He is also responsible for overseeing the development of the second-ever Surgeon General's Report on Oral Health, and he chairs the USPHS Oral Health Coordinating Committee.

Dr. Ricks holds a Bachelor of Science degree from Delta State University, a Master of Public Health Degree from the University of Nevada, Reno, and received his dental degree from the University of Mississippi. He completed a dental public health residency with the Indian Health Service and is a board-certified Diplomate of the American Board of Dental Public Health and a Fellow of the International College of Dentists.

Aisha Salman, MPH

Program Officer, National Academy of Medicine

Aisha Salman is a Program Officer at the National Academy of Medicine (NAM) and is the interim director of the Action Collaborative on Countering the U.S. Opioid Epidemic. Prior to joining the NAM in 2019, she served as a Program Implementation Manager with the University of Pennsylvania's Center for Community and Population Health, where she helped translate clinical research into pilot programs. She also has experience as a Strategy and Operations Consultant for the Federal Healthcare Practice at Deloitte. Aisha has a Masters of Public Health from the George Washington University with a concentration in global health program design, monitoring, and evaluation.

David Schwartz, DDS

President, American Academy of Dental Sleep Medicine

David Schwartz, DDS is President of the American Academy of Dental Sleep Medicine (AADSM) and a Diplomate of the American Board of Dental Sleep Medicine (ABDSM). He has lectured on many aspects of dental sleep medicine and authored and co-authored various articles with the specific intent of continuing to change patients' lives worldwide. He has a

general restorative dental practice in Chicagoland and has focused on dental sleep medicine for more than 22 years. He is also the director of dental sleep medicine at The Center for Sleep Medicine, a multidisciplinary sleep center.

Denice Stewart, DDS, MHSA

Chief Policy Officer, American Dental Education Association

Denice Stewart, D.D.S., M.H.S.A., is Chief Policy Officer at the American Dental Education Association (ADEA), leading the Office of Policy, Research and Diversity. ADEA's members include all 76 U.S. and Canadian dental schools, over 800 allied and advanced dental education programs, 66 corporations and more than 20,000 individuals.

She received her D.D.S. at the University of North Carolina at Chapel Hill School of Dentistry, completed a General Practice Residency at Wilmington Medical Center (now Christiana Medical Center) in Delaware, and obtained a Master's in Health Services Administration from the University of Michigan School of Public Health. Prior to taking her position at ADEA, Dr. Stewart served as Senior Associate Dean for Clinical Affairs and Professor of Community Dentistry at the Oregon Health & Science University School of Dentistry. She has also held faculty positions at the University of Michigan School of Dentistry and the University of Pennsylvania School of Dental Medicine and she currently is an adjunct faculty at Rutgers University School of Dental Medicine. In addition, Dr. Stewart practiced dentistry in both a private practice and a community health center and was dental program administrator for Blue Cross Blue Shield of Michigan.

Eugene Vayman DNAP, CRNA

Quantum Anesthesia Services

-17 years of clinical experience in all surgical specialties, including trauma anesthesia and OB.

-Current owner of Quantum Anesthesia Services, a mobile anesthesia service providing turn key dental anesthesia services to 60+ dental practitioners throughout Illinois and Wisconsin

-Anesthesia provider for UIC School of Dentistry, department of Oral & Maxillofacial Surgery

-Teach anesthesia didactics at UIC School of Dentistry oral surgery residency program

AADB Speaker Disclosures

No other speakers have relevant financial relationships to disclose.

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Cincinnati, OH 45202

Tonia Socha-Mower, MBA, EdD (c), Executive Director
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211 E. Chicago Avenue, Suite 760
Chicago, IL 60611

Our Sponsors

The AADB Board of Directors is excited to introduce SmileDirectClub as our Diamond Sponsor. We are excited to invite them back to our meeting to open communication between our organizations. We appreciate their generosity and commitment to increasing access to safe and efficacious oral care, a mission that is shared with our State/Territory Dental Boards.

The AADB Board of Directors is appreciative of our other sponsors, many of whom have been long-term supporters of the AADB:

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ADSO® Association of Dental Support Organizations

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ATDA American TeleDentistry Association

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ASF American Association for Accreditation of Ambulatory Surgery Facilities

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ADEA THE VOICE OF DENTAL EDUCATION AMERICAN DENTAL EDUCATION ASSOCIATION

AADA
American Association of Dental Administrators

American Association of Dental Administrators
Mid-Year Meeting Preliminary Agenda
Tuesday March 2, 2021
1:00 p.m. – 4:00 p.m. CST

This meeting will be held virtually using Zoom. Use the link below to join.

https://us02web.zoom.us/j/86447742023?pwd=ZStMTmJnaldlcldzZEJuU203RTkrZz09

Welcome and Introduction of Attendees

Minutes from October 30, 2020 Annual Meeting

Treasurer's Report

Membership Report

Web Site Report

Annual Meeting October 30-31, 2021
-Preliminary Agenda Planning
-Accommodations

AADB Administrator Member Update

Roundtable Discussion of pre-selected topics:
COVID-19 Issues
Teledentistry
Occupational licensing
Interstate Compact Develpoments

Adjourn

Oregon
Kate Brown, Governor

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

TO: OBD Board Members

FROM: Stephen Prisby, OBD Executive Director

DATE: April 5, 2021

SUBJECT: Strategic Planning Possible Next Steps

I recommend the Board utilize our current Administrative Workgroup or create an ad hoc workgroup to make recommendations to the full Board for work on the next OBD Strategic Plan.

We can convene a virtual or teleconference meeting to accommodate participants and keep this important work moving forward before the June or August Board Meetings.

Some of the planning and details the Workgroup could discuss include:

- Dates for Strategic Planning
- Location
- Budget
- Facilitator and Speaker Ideas
- Other important factors to consider

The Workgroup's guidance and suggestions would be brought forward to a future Board Meeting, for discussion, acceptance and approval by the full Board.

I look forward to your input and our discussion at the April 16, 2021 Board Meeting.

OREGON BOARD OF DENTISTRY
2021-2022
MEETING DATES

EVALUATORS	BOARD
February 5, 2021	February 19, 2021
April 2, 2021	April 16, 2021
June 4, 2021	June 18, 2021
August 6, 2021	August 20, 2021
October 8, 2021	October 22, 2021
December 3, 2021	December 17, 2021
February 11, 2022	February 25, 2022
April 8, 2022	April 22, 2022
June 3, 2022	June 17, 2022
August 5, 2022	August 19, 2022
October 7, 2022	October 21, 2022
December 2, 2022	December 16, 2022

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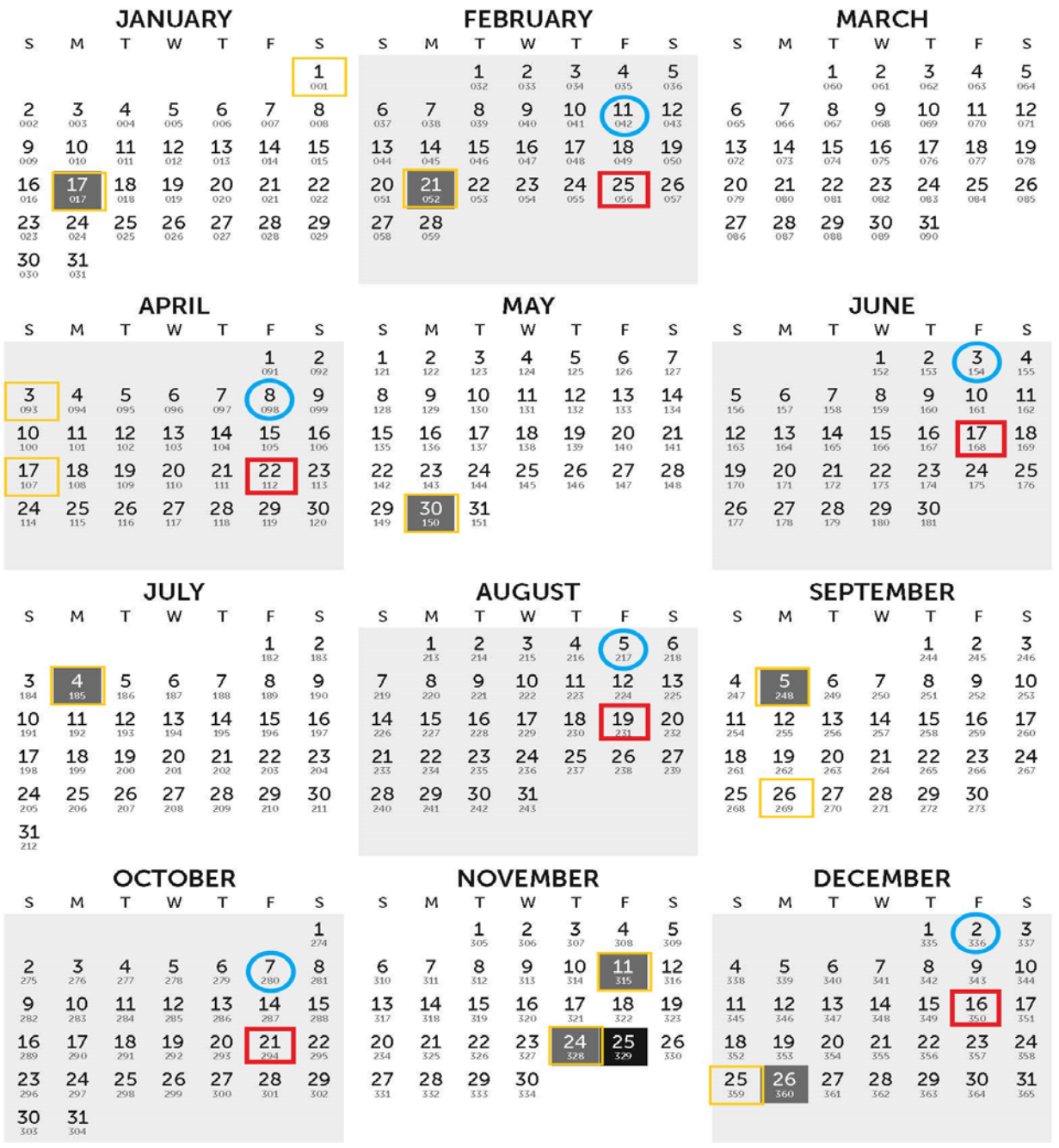

State holiday State holiday/courts remain open Julian dates – perpetual count of days per year

Jan 01 – New Year's Day
Jan 17 – Martin Luther King Day
Feb 21 – President's Day
Apr 03 – Ramadan Begins
Apr 17 – Easter
May 30 – Memorial Day
Jul 04 – Independence Day
Sep 05 – Labor Day
Sep 26 – Rosh Hashanah
Nov 11 – Veteran's Day
Nov 24 – Thanksgiving
Nov 25 – Staff Holiday
Dec 25 – Christmas Day
Dec 26 – Staff Holiday

UNFINISHED BUSINESS & RULES

Nothing to report under this tab

CORRESPONDENCE

March 1, 2021

Board of Directors
American Association of Dental Boards
211 E. Chicago Ave., Ste. 760
Chicago, IL 60611

Dear Directors:

We are writing on behalf of the American Association of Orthodontists, the American Academy of Pediatric Dentists and the American Association of Oral and Maxillofacial Surgeons to express concerns regarding the new for-profit corporate sponsorships instituted by the AADB and the potential conflicts of interest these appear to have created.

As an initial matter, we are concerned the Directors and/or Staff of the AADB have exceeded their authority in establishing a new level of AADB membership, the "AADB Corporate Member." However, the AADB has already begun accepting new members under this classification. Section 5 of the Bylaws of the AADB establishes the types of Membership in this organization, and there is currently no "Corporate Member" level included therein. As a Member-Governed organization, it is concerning that the AADB's leadership appear to have made this material change without the direction or approval of its General Assembly, the body to which the Bylaws grant the authority to "determine the policies which govern the Association" and "the power to enact, amend and repeal the Bylaws of this Association."

Further, by allowing membership of "any for-profit business involved in the practice or regulation of dentistry," the AADB may invite participation from entities whose interests directly conflict with the Association's own objectives—even so far as entities currently involved in litigation against state board members of the AADB. One such for-profit business granted Membership under the new Corporate Member classification, SmileDirectClub, is currently involved in multiple lawsuits it brought against Members and Agency Members of the AADB. These lawsuits challenge actions the Members/Agency Members believed to be in the best interest of patient health and safety. Allowing for such conflict of interest between Member entities, or between Member entities and the Association itself, is unlikely to be in the best interest of the AADB.

In addition to the above, it appears the Directors and/or Staff of the AADB have instituted a new level of meeting sponsorship, the "Diamond Sponsor" (at a rate significantly greater than those of previous meeting sponsorships), which may create similar instances of conflicts of interest. While obtaining sponsors for AADB events is certainly important to managing the Association's costs, decisions to accept for-profit corporate sponsorships should not be made without consideration for the conflicts of interest that could arise. For the reasons previously discussed, accepting SmileDirectClub as a sponsor for the Mid-Year Meeting may have created such a conflict. In particular, the AADB may not wish to put its Members/Agency Members in the position of attending a meeting whose primary sponsor is a for-profit company currently suing them.

We hope that you understand our concerns and appreciate your attention to this matter.

Please contact any of the undersigned if you would like to discuss further.

Sincerely,

American Association of Orthodontists

American Academy of Pediatric Dentistry

American Association of Oral and Maxillofacial Surgeons

From: Kannan Ramar, MD <kramar@aasm.org>
Sent: Friday, March 5, 2021 1:12 PM
To: PRISBY Stephen *OBD <Stephen.PRISBY@oregondentistry.org>
Cc: Eric Albrecht <ealbrecht@aasm.org>
Subject: Dental Scope of Practice & Sleep Apnea Concerns

Stephen Prisby,

Attached for your review is a letter requiring your immediate attention. The American Academy of Sleep Medicine, American Thoracic Society, American Academy of Neurology, and American Academy of Otolaryngology – Head and Neck Surgery would like to express our concerns regarding a recently published position statement issued by the American Academy of Dental Sleep Medicine on the use of home sleep apnea tests (HSATs) by dentists. Please see the attached letter outlining our concerns; we urge you to adopt language clarifying the scope of practice for dentists in your state in relation to the use of HSAT.

Contact Eric Albrecht, AASM Advocacy Program Manager, at ealbrecht@aasm.org with any questions regarding this.

Kannan Ramar, MD
AASM President

AASM American Academy of SLEEP MEDICINE™
2510 North Frontage Road, Darien, IL 60561
P: 630-737-9700 | **F:** 630-737-9790 | **aasm.org**
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March 5, 2021

Dear Dental Board:

On behalf of the undersigned organizations, we are writing to express our concerns regarding a recently published position issued by the American Academy of Dental Sleep Medicine (AADSM). This statement encourages the use of home sleep apnea tests by dentists for the diagnosis of obstructive sleep apnea (OSA). We argue that ordering, administering, and interpreting home sleep apnea tests is outside the scope of practice for dentists, and herein are requesting that your board protect both patients and dentists in your state by adopting a policy to clarify this fact.

The AADSM position states that it is within the scope of practice for dentists to identify patients who are at risk for OSA and then order or administer diagnostic home sleep apnea tests. Furthermore, since most state dental boards have no policy addressing this issue, the AADSM position indicates that this "silence" gives dentists tacit permission to provide this medical service, which is a dangerous interpretation. This position statement is in direct conflict with that of the American Academy of Sleep Medicine (AASM) and a policy of the American Medical Association (AMA), both of which emphasize that a home sleep apnea test is a medical assessment that must be ordered by a medical provider and, moreover, must be reviewed and interpreted by a physician who is either board-certified in sleep medicine or overseen by a board-certified sleep medicine physician. The AADSM position also is not supported by the policy statement of the American Dental Association (ADA) or by a white paper from the American Association of Orthodontists (AAO).

An evidence-based AASM clinical practice guideline indicates that the decision to order a home sleep apnea test should be made by a medical provider only after reviewing the patient's medical history and conducting a face-to-face examination. The medical evaluation should include a thorough sleep history and a physical examination of the respiratory, cardiovascular, and neurologic systems. The sleep history is important because many patients have more than one sleep disorder or present with atypical sleep apnea symptoms. The medical provider also should identify chronic diseases and conditions that are associated with increased risk for OSA, such as obesity, hypertension, stroke, and congestive heart failure. An evaluation by a medical provider also is necessary to rule out conditions that place the patient at increased risk of central sleep apnea and other forms of non-obstructive sleep-disordered breathing, which typical home sleep apnea tests are insufficient to detect. While dentists can use questionnaires and examine the oral structures to screen patients for symptoms of OSA, they are untrained in conducting the comprehensive medical evaluation needed to assess OSA risk.

Based on this medical evaluation, the medical provider can determine if diagnostic testing is indicated to confirm a clinical suspicion of OSA. The selection of the appropriate diagnostic test — either in-lab polysomnography or a home sleep apnea test — is critical. Because a home sleep apnea test is less sensitive than polysomnography, it is more likely to produce false negative results when ordered inappropriately. The resulting misdiagnosis can lead to significant harm for the patient. Because dentists lack the required medical education and training needed to order, administer, and interpret diagnostic tests for OSA, implementing the AADSM position could jeopardize the quality of patient care.

In addition, the AADSM position does not align with the current national and local coverage determination policies of the Centers for Medicare & Medicaid Services (CMS) and the policies of private insurers for reimbursement of home sleep apnea tests and oral appliances for OSA.

These medical insurance policies also require a comprehensive clinical evaluation by a medical provider to determine that the test or treatment is reasonable and necessary. Patients will have to pay full price for the uncovered services provided by a dentist, dramatically increasing their out-of-pocket costs.

It is for the aforementioned reasons that our organizations urge your board to adopt a policy clarifying that ordering and administering a home sleep apnea test is outside the scope of practice for dentists in your state. We encourage you to use as a model the policy adopted by the Georgia Board of Dentistry, "Prescribing and Fabrication of Sleep Apnea Appliances":

> *Depending upon the diagnosis of the type and severity, one possible treatment option for obstructive apnea is the use of oral appliances. The design, fitting and use of oral appliances and the maintenance of oral health related to the appliance falls within the scope of practice of dentistry. The continuing evaluation of a person's sleep apnea, the effect of the oral appliance on the apnea, and the need for, and type of, alternative treatment do not fall within the scope of dentistry. Therefore, the prescribing of sleep apnea appliance does not fall within the scope of the practice of dentistry. It is the position of the Board that a dentist may not order a sleep study. Home sleep studies should only be ordered and interpreted by a licensed physician. Therefore, only under the orders of a physician should a dentist fabricate a sleep apnea appliance for the designated patient and conduct only those tasks permitted under O.C.G.A. Title 43, Chapter 11. (adopted 04/01/16)*

We thank you for your consideration of our concerns. For any additional information or to discuss this issue, please contact AASM Executive Director Steve Van Hout at (630) 737-9700.

Sincerely,

Kannan Ramar, MD, FAASM
American Academy of Sleep Medicine
President

James C. Stevens, MD, FAAN
American Academy of Neurology
President

Carol R. Bradford, MD, MS
American Academy of Otolaryngology-Head and Neck Surgery
President

Juan C. Celedón, MD, DrPH, ATSF
American Thoracic Society
President

From: Matthew Glans <mglans@aadsm.org>
Sent: Friday, March 26, 2021 1:34 PM
To: PRISBY Stephen *OBD <Stephen.PRISBY@oregondentistry.org>
Subject: AADSM Response to AASM Letter on Home Sleep Apnea Testing

Dear Mr. Prisby,

In early March, your board received a letter from the American Academy of Sleep Medicine (AASM) on a policy issue related to home sleep apnea testing. Unfortunately, this letter misrepresents the American Academy of Dental Sleep Medicine's (AADSM) position on the issue. The AADSM respectfully requests that the attached documents be provided to your board members to provide additional information about the dentist's role in home sleep apnea testing. If you have any questions, please let me know.

Regards,

Matthew Glans

Matthew Glans
Health Policy and Market Access Manager
American Academy of Dental Sleep Medicine
www.aadsm.org
Phone: (630) 686-9875 | Direct: (630) 686-9883
AADSM Facebook
AADSM Twitter

March 25, 2021

Yadira Martinez, RDH
Oregon Board of Dentistry
SENT VIA EMAIL: stephen.prisby@oregondentistry.org

1001 Warrenville Road,
Suite 175
Lisle, IL 60532
Phone: 630-686-9875
Fax: 630-686-9876
Web: AADSM.org

Dear Dr. Martinez:

Recently you received a letter from the American Academy of Sleep Medicine, American Academy of Neurology, American Academy of Otolaryngology - Head and Neck Surgery, and the American Thoracic Society urging you to declare that ordering and administering home sleep apnea tests (HSATs) is outside the scope of practice for dentists in your state.

The claim in the letter is that the American Academy of Dental Sleep Medicine (AADSM) position statement encourages the use of HSATs by dentists for the diagnosis of obstructive sleep apnea (OSA). Our position (Attachment A) contains no such claim. Rather, our position affirms a collaborative care model in which:

- Dentists must be trained in dental sleep medicine to order or administer HSATs.
- Licensed medical providers are responsible for initial diagnosis and verification of treatment efficacy.
- Trained dentists must communicate and collaborate with physicians to determine a mutually agreed criteria for identifying patients who are candidates for HSATs.

Our position statement outlines a model of care in which trained dentists utilize their knowledge and developed patient relationships to work in concert with physicians to help the 43 million Americans suffering from undiagnosed OSA navigate a pathway to diagnosis and treatment. Rather than encouraging dentists to diagnose OSA, our position is in fact intended to dissuade dentists from using HSATs if they are not trained or working in collaboration with physicians.

While the definition of ordering a test is universal across medicine and dentistry, the definition of administering a test can vary considerably. Administering a HSAT involves providing the test to the patient along with instructions for use; the patient is responsible for attaching sensors at home prior to bedtime.

It is important to clarify that both the American Dental Association's policy statement (Attachment B) and the American Association of Orthodontics' white paper (Attachment C) support dentists using a comprehensive medical and dental history and clinical examination to screen for OSA and state that trained dentists may use HSATs (commonly referred to as portable monitors) for the titration of oral appliances.

These papers were established prior to the publication of our position statement and offer a foundation for our collaborative care model. We have shared our position statement with both organizations, as well as with the American Association of Dental Boards.

The AADSM believes that every patient is entitled to effective treatment for OSA. We also believe that dentists and physicians need to have the ability to develop a practice model that works best for the patients in their community. In many communities, the agreed upon practice model involves the trained dentist ordering or administering HSATs for appropriate patients during certain points of the care continuum.

Dentistry provides a valuable resource for so many aspects of our health care system, and dentists are an essential resource in helping to get more patients access to treatment for OSA.

Should you have any questions about our position, please do not hesitate to reach out via email to dschwartz@aadsm.org.

Sincerely,
David Schwartz, DDS
President

SPECIAL ARTICLES

http://dx.doi.org/10.15331/jdsm.7156

American Academy of Dental Sleep Medicine Position on the Scope of Practice for Dentists Ordering or Administering Home Sleep Apnea Tests

David Schwartz, DDS[1]; Michael Adame, DDS[2]; Nancy Addy, DDS[3]; Michelle Cantwell, DMD[4]; James Hogg, DDS[5]; Nelly Huynh, PhD[6]; Paul Jacobs, DDS[7]; Mitchell Levine, DMD[8]; Kevin Postol, DDS[9]; Rosemarie Rohatgi, DMD[10]

[1]North Shore Family Dentistry, Skokie, IL; [2]Adame Dental Sleep Medicine; [3]Snoring and Sleep Apnea Dental Treatment Center, Leawood, KS; [4]Wellspan Pulmonary and Sleep Medicine, Lancaster, PA; [5]Carolina Smiles Family Dentistry, Brevard, NC; [6]Faculty of Dentistry, Universite de Montreal, Montreal, Canada; [7]Upper Peninsula Sleep Dentistry, Escabana, MI; [8]Department of Orthodontics, University of Tennessee Health Science Center, Memphis, Tennessee; [9]Sleep Disordered Dentistry, Ballwin, Missouri; [10]San Diego Sleep Therapy, San Diego, CA

It is the position of the American Academy of Dental Sleep Medicine (AADSM) that it is within the scope of practice for a qualified dentist, defined by the American Dental Association (ADA) as a dentist treating sleep-related breathing disorders who continually updates his or her knowledge and training of dental sleep medicine with related continuing education, to order or administer home sleep apnea tests (HSATs). Data from HSATs should be interpreted by a licensed medical provider for initial diagnosis and verification of treatment efficacy.

Historically, state dental practice acts have not addressed the dentist's role in using HSATs. It is commonly understood that practice acts are intentionally broad in nature. They tend to be more specific only when prohibiting a practice or use of equipment. Based on this, it is the AADSM's interpretation that it is within the scope of practice for dentists to order and administer HSATs in states where it is not specifically prohibited. For the few states where the use of HSATs is prohibited, dentists should abide by state guidance. The AADSM maintains a list of these states on its website and will be actively encouraging them to reconsider their policies.[1]

There are other medical conditions for which dentists order and dispense medical tests. Dentists screen and perform biopsies for oral cancer. Dentists routinely administer oxygen and anesthesia and prescribe drugs, including controlled substances. In some states, dentists with training provide flu vaccinations. Dentists also routinely take blood pressure and some test hemoglobin A1C levels. Given the public burden of obstructive sleep apnea (OSA), dentists must embrace that it is within their scope of practice to order and administer HSATs.

In 2016, the American Academy of Sleep Medicine commissioned a report from Frost & Sullivan.[2] This report indicates that there were 29.4 million adults with obstructive sleep apnea, and in 80% of that group the condition was undiagnosed - costing the United States approximately $149.6 billion per year. The same report indicated that OSA is also linked to comorbidities, mental health, productivity, and accidents. It goes on to further explain that the most significant barrier to treatment of OSA is patients' disregard of symptoms and their failure to report them to primary care physicians and that once an individual is screened or informed about OSA, a significant financial and personal time investment is often necessary to address the problem. New studies published in 2019 indicate that approximately 54 million adults in the United States have sleep apnea.[3] If 80% of these adults also have undiagnosed OSA, there could be as many as 43 million adults with undiagnosed OSA.

In 2017, the ADA recognized that dentists should play an essential role in addressing the public burden of OSA.[4] In their policy, the ADA suggests that all dentists screen patients for OSA as part of a comprehensive medical and dental history and refer as needed to the appropriate physicians for diagnosis. The policy indicates that dentists may use HSATs to define the optimal target position of the mandible.

By building on the ADA policy and recognizing that qualified dentists have the training and education necessary to order or administer HSATs, qualified dentists can provide a more streamlined and cost-effective model of care. A short algorithm outlining this model of care is shown in Figure 1. Communication and collaboration with physicians are key in this process. In this model of care, qualified dentists screen patients for sleep apnea. If patients are at risk and appropriate candidates for HSAT, the qualified dentist orders or administers the HSAT directly from his or her practice. Patients complete the HSAT. Pertinent patient information and HSAT data are provided to a physician for diagnosis, and, if appropriate, the physician prescribes an oral appliance. The qualified dentist then determines whether the patient is a suitable candidate, and then fabricates and delivers the appliance. After the appliance is at the appropriate therapeutic position, the qualified dentist once again orders or

administers the HSAT. Pertinent patient information and HSAT data are shared with the physician who verifies treatment efficacy.

This model of care achieves several outcomes:

1. Dentists identify patients at risk for sleep apnea.
2. The process of obtaining a diagnosis for sleep apnea requires fewer appointments, reducing expenses and patient inconvenience while increasing the likelihood of treatment if sleep apnea is diagnosed in a patient.
3. The workload of primary care physicians and board-certified sleep medicine physicians related to ordering and dispensing HSATs is reduced, allowing them to better allocate their resources to the diagnosis and treatment of sleep disorders.
4. The diagnosis of medical diseases and verification of treatment efficacy remains the responsibility of the medical provider.

With the public burden of OSA and technologic advances, new models of care are being implemented at a rapid pace. Patients can now purchase HSATs directly from online sources. It is hard to find an argument against allowing a qualified dentist who will collaborate directly with patients' physicians when patients can order the test directly from the Internet, entirely bypassing their health care providers.

As health care providers who live by the ethical code of "do no harm" and understand the harmful consequences of OSA, we owe it to the public to implement models of care that reduce barriers to diagnosis and treatment, ensure that sleep apnea is diagnosed and treatment efficacy is verified by physicians, and maximize the training and skills of qualified dentists.

CITATION

Schwartz D, Levine M, Adame M, Addy N, Cantwell M, Hogg J, Huynh N, Jacobs P, Postol K, Rohatgi R. American Academy of Dental Sleep Medicine Position on the Scope of Practice for Dentists Ordering or Administering Home Sleep Apnea Tests. *J Dent Sleep Med.* 2020;7(4).

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SUBMISSION AND CORRESPONDENCE INFORMATION

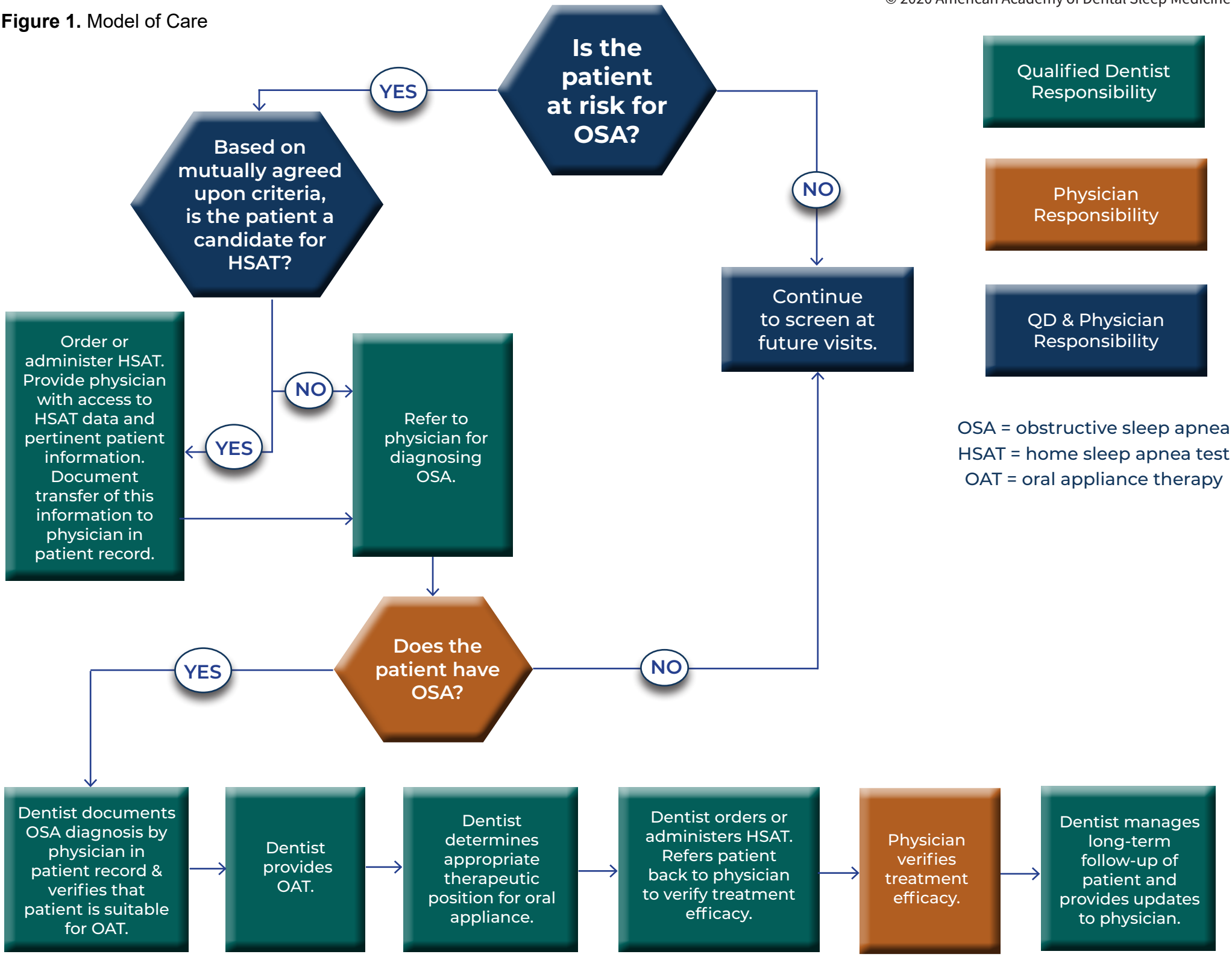
Submitted in final revised form August 28, 2020.

Address correspondence to: David Schwartz, DDS; Email: dschwartz@aadsm.org

DISCLOSURE STATEMENT

All authors are members of the AADSM Board of Directors. Dr. Schwartz declares investments in Prosomnus Sleep.

Figure 1. Model of Care



The Role of Dentistry
in the Treatment of Sleep Related Breathing Disorders

Adopted by ADA's 2017 House of Delegates

Sleep related breathing disorders (SRBD) are disorders characterized by disruptions in normal breathing patterns. SRBDs are potentially serious medical conditions caused by anatomical airway collapse and altered respiratory control mechanisms. Common SRBDs include snoring, upper airway resistance syndrome (UARS) and obstructive sleep apnea (OSA). OSA has been associated with metabolic, cardiovascular, respiratory, dental and other diseases. In children, undiagnosed and/or untreated OSA can be associated with cardiovascular problems, impaired growth as well as learning and behavioral problems.

Dentists can and do play an essential role in the multidisciplinary care of patients with certain sleep related breathing disorders and are well positioned to identify patients at greater risk of SRBD. SRBD can be caused by a number of multifactorial medical issues and are therefore best treated through a collaborative model. Working in conjunction with our colleagues in medicine, dentists have various methods of mitigating these disorders. In children, the dentist's recognition of suboptimal early craniofacial growth and development or other risk factors may lead to medical referral or orthodontic/orthopedic intervention to treat and/or prevent SRBD. Various surgical modalities exist to treat SRBD. Oral appliances, specifically custom-made, titratable devices can improve SRBD in adult patients compared to no therapy or placebo devices. Oral appliance therapy (OAT) can improve OSA in adult patients, especially those who are intolerant of continuous positive airway pressure (CPAP). Dentists are the only health care provider with the knowledge and expertise to provide OAT.

The dentist's role in the treatment of SRBD includes the following:

- Dentists are encouraged to screen patients for SRBD as part of a comprehensive medical and dental history to recognize symptoms such as daytime sleepiness, choking, snoring or witnessed apneas and an evaluation for risk factors such as obesity, retrognathia, or hypertension. If risk for SRBD is determined, these patients should be referred, as needed, to the appropriate physicians for proper diagnosis.

- In children, screening through history and clinical examination may identify signs and symptoms of deficient growth and development, or other risk factors that may lead to airway issues. If risk for SRBD is determined, intervention through medical/dental referral or evidenced based treatment may be appropriate to help treat the SRBD and/or develop an optimal physiologic airway and breathing pattern.

- Oral appliance therapy is an appropriate treatment for mild and moderate sleep apnea, and for severe sleep apnea when a CPAP is not tolerated by the patient.

- When oral appliance therapy is prescribed by a physician through written or electronic order for an adult patient with obstructive sleep apnea, a dentist should evaluate the patient for the appropriateness of fabricating a suitable oral appliance. If deemed appropriate, a dentist should fabricate an oral appliance.

- Dentists should obtain appropriate patient consent for treatment that reviews the proposed treatment plan, all available options and any potential side effects of using OAT and expected appliance longevity.

- Dentists treating SRBD with OAT should be capable of recognizing and managing the potential side effects through treatment or proper referral.

- Dentists who provide OAT to patients should monitor and adjust the Oral Appliance (OA) for treatment efficacy as needed, or at least annually. As titration of OAs has been shown to affect the final treatment outcome and overall OA success, the use of unattended cardiorespiratory (Type 3) or (Type 4) portable monitors may be used by the dentist to help define the optimal target position of the mandible. A dentist trained in the use of these portable monitoring devices may assess the objective interim results for the purposes of OA titration.

- Surgical procedures may be considered as a secondary treatment for OSA when CPAP or OAT is inadequate or not tolerated. In selected cases, such as patients with concomitant dentofacial deformities, surgical intervention may be considered as a primary treatment.
- Dentists treating SRBD should continually update their knowledge and training of dental sleep medicine with related continuing education.

- Dentists should maintain regular communications with the patient's referring physician and other healthcare providers to the patient's treatment progress and any recommended follow-up treatment.

- Follow-up sleep testing by a physician should be conducted to evaluate the improvement or confirm treatment efficacy for the OSA, especially if the patient develops recurring OSA relevant symptoms or comorbidities.

Obstructive sleep apnea and orthodontics: An American Association of Orthodontists White Paper

Rolf G. Behrents,[a,b] Anita Valanju Shelgikar,[c] R. Scott Conley,[d] Carlos Flores-Mir,[e] Mark Hans,[f,g] Mitchell Levine,[h] James A. McNamara,[i,j] Juan Martin Palomo,[k] Benjamin Pliska,[l,m] John W. Stockstill,[n] John Wise,[o] Sean Murphy,[p] Norman J. Nagel,[q] and Jackie Hittner[r]

St. Louis, Mo, Ann Arbor, Mich, Orchard Park, NY, Edmonton, Alberta, and Vancouver, BC, Canada, Cleveland and Berea, Ohio, Memphis, Tenn, Atlanta, Ga, Frisco and McKinney, Tex, and Simi Valley, Calif

The Board of Trustees of the American Association of Orthodontists asked a panel of medical and dental experts in sleep medicine and dental sleep medicine to create a document designed to offer guidance to practicing orthodontists on the suggested role of the specialty of orthodontics in the management of obstructive sleep apnea. This White Paper presents a summary of the Task Force's findings and recommendations. (Am J Orthod Dentofacial Orthop 2019;156:13-28)

The specialty of orthodontics involves much more than just moving teeth, and the management of sleep apnea bears witness to this. As such, there is increasing interest in the role of the orthodontist both in screening for obstructive sleep apnea (OSA) and as a practitioner who may be valuable in the multidisciplinary management of OSA in both children and adults. As experts in the science of facial growth and development, combined with our knowledge of oral devices, orthodontists are well suited to collaborate with physicians and other allied health providers in the treatment of OSA.

Although OSA can be definitively diagnosed only by a physician, the orthodontist may be called on to screen for OSA, contribute to the identification of underlying dentofacial components, and assist the physician in managing the disease. As such, the orthodontist is not able to manage this care alone, and a cooperative shared effort between the orthodontist and other medical professionals is preferred to optimize care of patients with OSA.

Patients with suspected OSA may come to the orthodontist in several different ways. A patient who has been medically diagnosed with OSA may be referred to the orthodontist by a physician who prescribes an oral appliance or suggests orthodontic or orthopedic therapy to assist in the management of the OSA. Other patients or caregivers may present to the orthodontist with concerns about breathing during sleep. In addition, patients may present to the orthodontist unaware of their OSA, and orthodontic screening may reveal the need for further evaluation by a physician.

In November 2017, the Board of Trustees of the American Association of Orthodontists (AAO) tasked a panel of medical and dental experts in sleep medicine and dental sleep medicine to create a document

[a]American Journal of Orthodontics and Dentofacial Orthopedics, St. Louis, Mo.
[b]Graduate Orthodontic Program, Saint Louis University, St. Louis, Mo.
[c]Neurology, University of Michigan, Ann Arbor, Mich.
[d]Department of Orthodontics, University of Buffalo, Orchard Park, NY.
[e]Orthodontics Division, University of Alberta, Edmonton, Alberta, Canada.
[f]Department of Orthodontics, Case Western Reserve University, Cleveland, Ohio.
[g]Private practice, Berea, Ohio.
[h]Department of Orthodontics, Department of Oral Medicine, Division of Orofacial Pain, University of Tennessee Health Science Center, Memphis, Tenn.
[i]Department of Orthodontics and Pediatric Dentistry and Center for Human Growth and Development, University of Michigan, Ann Arbor, Mich.
[j]Private practice, Ann Arbor, Mich.
[k]School of Dental Medicine, Case Western Reserve University, Cleveland, Ohio.
[l]Division of Orthodontics, University of British Columbia, Vancouver, BC, Canada.
[m]Private practice, Vancouver, BC, Canada.
[n]Georgia School of Orthodontics. Atlanta, Ga.
[o]Private practice, Frisco and McKinney, Tex.
[p]Advocacy and General Counsel, American Association of Orthodontists, St. Louis, Mo.
[q]American Association of Orthodontists, Simi Valley, Calif.
[r]American Association of Orthodontists, St. Louis, Mo.

All authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest, and none were reported.

A White Paper is an authoritative report or guide that informs readers concisely about a complex issue, presents the issuing body's philosophy, and offers proposals on the matter.

This document was subject to editorial changes prior to publication.

Address correspondence to: Rolf G. Behrents, Chair of the Task Force, Professor Emeritus, Graduate Orthodontic Program, Saint Louis University, 3320 Rutger Street, St. Louis, MO 63104-1122; e-mail, behrents@gmail.com.

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0889-5406/$36.00

https://doi.org/10.1016/j.ajodo.2019.04.009

designed to offer guidance to practicing orthodontists on the suggested role of the specialty of orthodontics in the management of OSA. The panel completed an exhaustive review of the available literature as well as contributed their own personal expertise gleaned from managing these patients in both academic centers and within private practice settings. In considering the literature, it was obvious that there is broad interest in OSA, as evidenced by the development of guidelines for the consideration and treatment of OSA around the world and involving many different communities. The topic has been covered by physicians, dentists, and scientists from a variety of organizations, including the American Dental Association, American Academy of Dental Sleep Medicine, American Academy of Sleep Medicine, European Respiratory Society, Australian Dental Association, American Association of Oral and Maxillofacial Surgeons, American College of Prosthodontists, American Academy of Pediatric Dentistry, Canadian Dental Sleep Medicine, Canadian Thoracic Society, American Academy of Pediatrics, and U.S. Preventative Respiratory Society, among others.

However, the Task Force could not identify any formal OSA guidance for orthodontists. This was surprising because orthodontists have specialized knowledge, skill, and experience that would be beneficial in the management and care of patients with OSA. In addition, orthodontists typically have a broad patient population (children, adolescents, and adults), with contact maintained over a long period of time. Moreover, orthodontists have a long and productive history of working with others in medicine and dentistry to provide collaborative care for patients with special needs (eg, cleft lip and palate, craniofacial syndromes, complex restorative cases, orthognathic surgery).

Given that OSA can be a serious, even life-threatening, disorder and the quality of patient management and care that can be provided by orthodontists, the Task Force determined that it was very important to develop specific recommendations that would be useful to an orthodontist in practice. The following represents a summary of their findings and recommendations.

ADULT OSA

Sleep-related breathing disorders (SRBDs) constitute a diagnostic category of disease that encompasses obstructive phenomena, including primary snoring, upper airway resistance syndrome, and OSA, along with the related entities of central sleep apnea and sleep-related hypoventilation. This document focuses on OSA, beginning with this section on the adult patient (ie, 18 years of age or older). Clinical concerns for other forms of SRBD and additional types of sleep disorders (eg, insomnia, central disorders of hypersomnolence, circadian rhythm sleep-wake disorders, sleep-related movement disorders, and parasomnias), if identified, should be referred to a physician for evaluation and treatment; a sleep medicine physician is preferred.

Etiology

Obstructive sleep apnea occurs as a function of increased collapsibility of the upper airway. The pharyngeal critical closing pressure (Pcrit) is the pressure at which the upper airway collapses. This collapsibility is influenced further by impaired neuromuscular tone. Respiratory effort increases to maintain airflow through a constricted airway, accompanied by relative increase in serum carbon dioxide (hypercarbia) and decrease in serum oxygen (hypoxemia). The increased work of breathing causes a cortical arousal from sleep, which in turn raises sympathetic neural activity, leading to increased heart rate and blood pressure and a tendency for cardiac arrhythmia. With the cortical arousal from sleep comes an increase in airway patency and resumption of normal airflow, with subsequent return to sleep and recurrence of sleep-related upper airway collapsibility. This disruption in breathing may occur multiple times per hour for the entire duration of the patient's sleep.

The complexity of OSA is exemplified by its multifactorial etiology. Such etiologies involve the craniofacial structures, neuromuscular tone, and other related factors. Collapsibility of the upper airway is influenced further by hormonal fluctuation (eg, pregnancy or menopause), obesity, rostral fluid shifts, and genetic predisposition that influences craniofacial anatomy. OSA severity is heterogeneous among patients with the disorder. This wide range of presentation leads to variations in management approach and differences in treatment response.

Prevalence

Estimates of the prevalence of OSA in adults vary in the literature; OSA is commonly thought to involve 14% of men and 5% of women. Prevalence rates are higher in certain populations, such as obese patients considered for bariatric surgery and post-stroke patients. Underrecognition of OSA likely leads to underdiagnosis and a false reduction of the true prevalence of disease.

Risk factors

Individuals with certain characteristics appear to be predisposed to OSA. Conditions that may be risk factors for the development of OSA in adults include obesity (body mass index [BMI] $\geq$30 kg/m^2), menopause, male

sex, and increasing age. Genetic influences on craniofacial structure leads to higher OSA prevalence in certain ethnic groups that have been studied. Some genetic syndromes, particularly those with associated craniofacial anomalies, also are associated with an increased risk of OSA.

Craniofacial morphologies that may predispose to OSA include retrognathia, long and narrow faces, dolichocephalic facial type, narrow and deep palate, steep mandibular plane angle, anterior open bite, midface deficiency, and lower hyoid position. It should be noted, however, that the strength of the relationship between these craniofacial morphologies and the development of OSA is not well established.

Symptoms

Patients with OSA often have a history of snoring, gasping respiration or choking, and witnessed pauses in breathing (apneas) during sleep. Common clinical symptoms of untreated OSA include frequent nocturnal awakenings, nonrestorative sleep, morning headaches, and excessive daytime sleepiness. Patients with OSA often describe difficulty with attention and concentration, mood disturbance, and difficulty controlling other medical comorbidities such as diabetes mellitus, hypertension, and obesity.

Diagnosis

Diagnostic confirmation of OSA is performed by a sleep medicine specialist with the use of the gold standard of an in-center overnight sleep study (polysomnography [PSG]) or out-of-center sleep testing (OCST) for appropriately selected patients. Home sleep apnea testing (HSAT) is a type of OCST. Attended PSG includes at least 7 channels of recording, including electroencephalography (EEG), electrocardiography, and monitoring of sleep, airflow through the nose and mouth, pulse oximetry, respiratory effort, and leg movement. HSAT includes 4-7 channels. It is important to note that HSAT typically does not include EEG monitoring of sleep.

According to the International Classification of Sleep Disorders,[1] OSA can be diagnosed by either of 2 sets of criteria. The first set of diagnostic criteria for OSA includes the presence of at least 1 of the following: (1) the patient has sleepiness, nonrestorative sleep, fatigue, or insomnia symptoms, (2) the patient wakes with breath holding, gasping, or choking, (3) a bed partner or other observer reports habitual snoring, breathing interruptions, or both during the patient's sleep, and (4) the patient has been diagnosed with hypertension, a mood disorder, cognitive dysfunction, coronary artery disease, stroke, congestive heart failure, atrial fibrillation, or type 2 diabetes mellitus; and polysomnography or OCST shows at least 5 predominantly obstructive events (obstructive or mixed apneas, hypopneas, or respiratory effort–related arousals (RERAs) per hour of sleep during a PSG or per hour of monitoring on OCST.

In the second criteria, OSA can be diagnosed if PSG or OCST shows 15 or more predominantly obstructive events (obstructive or mixed apneas, hypopneas, or RERAs per hour of sleep during a PSG or per hour of monitoring on OCST). Examples of apnea and hypopnea are presented in Appendix 1.

A few different terms are used in the classification of OSA. The respiratory disturbance index (RDI) includes the number of apneas, hypopneas, and RERAs per hour of sleep. The apnea-hypopnea index (AHI) includes the number of apneas and hypopneas per hour of sleep. Thus, a patient's RDI may be higher than the AHI. Some publications refer to AHI and others RDI, so it is important for clinicians and researchers to understand the difference between these 2 measurements. Compared with PSG, OCST often underestimates the frequency of obstructive events per hour because OCST typically does not measure total sleep time as determined by EEG. The respiratory event index can be used to indicate the frequency of respiratory events based on total recording time (rather than total sleep time).

Severity

Severity of obstructive sleep apnea is classified based on the AHI or RDI per hour; categories are mild (AHI or RDI $\geq$5 and $<$15), moderate (AHI or RDI $\geq$15 and $<$30), and severe (AHI or RDI $\geq$30). The minimum oxygen saturation also should be considered when making clinical assessment of the magnitude of OSA, although there are no consensus classifications for the severity of oxygen desaturation.

Significance

Untreated OSA can lead to many serious consequences. Excessive daytime sleepiness increases the risk of motor vehicle accidents and diminishes quality of life. Neurocognitive impairment leads to decreased scholastic and occupational performance. Chronic intermittent hypoxemia and heightened sympathetic neural activity, endothelial damage, and heightened inflammation are related to metabolic dysfunction and end-organ

sequelae. Untreated OSA increases risk of insulin resistance, coronary artery disease, congestive heart failure, myocardial infarction, hypertension, stroke, cardiac arrhythmia, and sudden cardiac death.

ROLE OF ORTHODONTICS IN ADULT OSA

The orthodontist is well positioned to perform an OSA screening assessment and refer at-risk patients for diagnostic evaluation. Once the diagnosis of OSA is confirmed, physicians (and advanced practice providers supervised by physicians) may prescribe orthodontic appliances or procedures in appropriately selected adult patients as part of OSA management.

Medical and dental history

Orthodontists should be familiar with the signs and symptoms of OSA in adult patients. Thorough history taking is critically important to establish the presence of preexisting conditions, a basis for a diagnosis, the need for referral, and a baseline for evaluating the effects of treatment. Orthodontists also should include assessment of a patient's height, weight, and neck size to screen adult patients for OSA.

The following items should be considered when constructing a health history that is sensitive to OSA: a previous diagnosis of OSA, excessive daytime sleepiness,* a previous diagnosis of other forms of SRBDs, fatigue during the day, height,* choking or gasping respirations during sleep, weight,* habitual or loud snoring,* sex,* observed episodes of pauses in breathing,* age,* abrupt awakening and shortness of breath, high blood pressure,* awakening with dry mouth or sore throat, mouth breathing, morning headaches, menopause, difficulty staying asleep, alterations in performance, enuresis or unexplained nocturia, disordered mood, attention, or memory problems, restlessness during sleep, sweating, nasal obstruction, bruxism, type 2 diabetes, and neck circumference (*component of the STOP-Bang questionnaire; see next section).

Screening tools

In adults, a validated tool for OSA risk assessment is the STOP-Bang questionnaire (Appendix II),[2,3] which asks yes or no questions based on its acronym: snoring (S), tiredness (T), observed pauses in breathing (O), high blood pressure (P), BMI >35 kg/m^2 (B), age >50 years (A), neck circumference of ≥ 17 inches in men, or ≥ 16 inches in women (N), and male gender (G). A patient is considered to be at low risk for OSA if the questionnaire has no more than 2 "yes" answers, at intermediate risk if here are 3 or 4 "yes" answers, and at high risk if there are 5 or more "yes" answers.

The patient is considered at high risk also if there are 2 "yes" answers from the STOP section, combined with either male gender, high BMI, or large neck size. Using a cutoff score of ≥ 3 to detect any OSA (AHI >5), moderate to severe OSA (AHI >15), and severe OSA (AHI >30), the sensitivities were 84%, 93%, and 100% and specificities 56%, 43%, and 37%, respectively.[4] The STOP-Bang questionnaire has a high sensitivity for identifying patients with moderate to severe OSA. This sensitivity gives the practitioner an excellent tool for identifying patients who have the condition. This questionnaire can be completed in a few minutes as part of an orthodontist's workflow.

Clinical examination

The clinical examination is an important part of the screening process. In addition to regular orthodontic screening, the orthodontist can use the modified Mallampati (MM) classification to describe the patency of the oral airway (Appendix III).[5–11] Three steps are followed to determine the MM class: step 1, patients are asked to take a seated or supine position; step 2, patients are asked to protrude their tongue as far forward as they can without emitting a sound; and step 3. The examiner observes the relationship between the palate, tongue base, and other soft tissue structures to determine the MM classification defined as class I, soft palate, fauces (the arched opening at the back of the mouth leading to the pharynx), uvula, and tonsillar pillars are visible; class II, soft palate, fauces, and uvula are visible; class III, soft palate and base of uvula are visible; and class IV, soft palate is not visible.

This clinical assessment framework can help orthodontists identify patients who may be at risk for upper airway obstruction during sleep. It should be noted that the MM class may vary over the course of a pregnancy, so the MM class may need to be reassessed at various times during pregnancy. The MM classification is a helpful part of the OSA screening process; it should not, however, be used in isolation to predict OSA presence or severity.

Many other OSA screening questionnaires have been developed and studied in various populations, with wide-ranging specificities and sensitivities. The Epworth Sleepiness Scale (Appendix IV)[12] asks patients to self-rate their level of sleepiness in 8 different sedentary situations. The Epworth Sleepiness Scale may be used to gauge or track symptomatic impairment (or response to treatment). However, it is not a screening tool for OSA, because it detects abnormalities in level of daytime sleepiness regardless of the cause of sleepiness.

Practitioners also may find the Friedman tongue classification system (Appendix V),[13] the Kushida index,[14] and the Berlin Questionnaire for Sleep Apnea[15] useful.

Orthodontic radiographs

The use of imaging in the assessment of OSA is often limited in a typical orthodontic setting. Conventional cephalometric images are dimensionally limited. Therefore, airway imaging with the use of a lateral cephalogram does not portray mediolateral information in the oropharyngeal airway and may give misleading information as to the volume and minimal cross-sectional area.

Cone-beam computed tomographic (CBCT) images have been shown to be useful in diagnostic and morphometric analysis of the hard and soft tissues in routine orthodontic treatment, but they have certain limitations regarding the diagnosis of OSA. CBCT provides no information on neuromuscular tone, susceptibility to collapse, or actual function of the airway. There are significant positional and functional differences when the patient is asleep versus awake. It is a snapshot of a specific moment of the breathing cycle. In addition, there is currently no minimal cross-sectional area or volume of the airway that has been validated as a minimal threshold level at which an individual is at higher risk of having OSA. Thus, orthodontic records may be taken by the orthodontist, but currently no radiographic methods have been reported to have high enough sensitivity or specificity to serve as a risk assessment tool for OSA.

Three-dimensional imaging of the airway should not be used to diagnose sleep apnea or any other SRBDs, because such imaging currently does not represent a proper risk assessment technique or screening method. On the other hand, 3-dimensional imaging of the airway, when available, may be used for monitoring or treatment considerations. If radiographic records are taken as part of orthodontic diagnosis and treatment planning, the airway and surrounding structure should be analyzed comprehensively.

DIAGNOSIS AND TREATMENT PLANNING IN ADULT OSA

Obstructive sleep apnea and other SRBDs can be definitively diagnosed only by a physician. It is not in the scope of the orthodontist or any other dentist to definitively diagnose OSA or any other SRBD. If the patient is found to have OSA, the physician will prescribe the appropriate course of action; the orthodontist should consider working in a collaborative way with the physician, providing related orthodontic treatment when necessary and when it does not interfere with medical treatment.

The OSA treatment plan should be based on careful consideration of the patient's individual needs and treatment goals. If the treatment plan involves orthodontics, a plan for treatment, monitoring, and long-term follow-up care should be developed by all practitioners involved. Care should be coordinated via communication between the orthodontist and any other practitioners participating in the treatment of the patient. It is recommended that treatment and management of OSA not take place without a referral from a physician (or provider supervised by a physician).

TREATMENT OF OSA IN ADULTS BY PHYSICIANS AND SURGEONS

Positive airway pressure (PAP) therapy is the gold standard treatment for OSA in adults. PAP acts as a pneumatic splint that maintains patency of the upper airway. PAP is delivered through a mask interface as either continuous positive airway pressure (CPAP), bilevel positive airway pressure (BPAP), or autotitrating positive airway pressure (APAP). Of note, CPAP and BPAP devices are available in conventional and autotitrating modes. CPAP use can decrease OSA-related cognitive impairment along with improving objective and subjective measures of sleepiness, particularly in patients with severe OSA (AHI $\geq$30/h).[16] BPAP may be used for patients with OSA who are intolerant of CPAP or those who have other forms of SRBDs (eg, sleep-related hypoventilation). APAP may be considered for patients with OSA who do not have contraindications to APAP use (eg, congestive heart failure, lung disease such as chronic obstructive pulmonary disease, obesity hypoventilation syndrome, or central sleep apnea).

Studies on PAP nonadherence report wide-ranging results. Although definitions of nonadherence vary across studies, a common definition of PAP nonadherence is mean use $\leq$4 hours per night. Estimates of PAP nonadherence range from 29% to 83%.[17,18] Early adherence to PAP use predicts longer-term PAP use; a study of 100 patients started on CPAP showed that CPAP use for at least 4 hours per night 3 days after starting therapy was predictive of CPAP adherence 30 days after treatment initiation.[19] Factors that affect PAP adherence include OSA severity, ability to tolerate the prescribed pressure setting, mask fit, spousal support, and other psychologic and social influences.[17]

Other treatment options include positional therapy (avoidance of sleeping on back) and long-term weight reduction as indicated. Nasal congestion and allergic rhinitis may be managed with the use of nasal steroids and other oral medications as indicated. For some patients, nasal surgery may be performed as adjunctive

therapy to decrease intranasal resistance and facilitate better adherence to PAP therapy. For selected patients, multilevel surgery including nasal and palatal surgery with or without mandibular surgery, genioglossus advancement, and hyoid suspension may be considered. Other soft tissue surgeries might be indicated that involve the tonsils, adenoids, frena, and tongue. Hypoglossal nerve stimulation addresses the impaired neuromuscular tone in OSA and may be considered in certain patients with OSA.

ORTHODONTIC MANAGEMENT IN ADULT OSA

After diagnosis of OSA by a physician, a patient may be referred to (or back to) an orthodontist for one or more types of care.

Informed consent

Before initiating care, informed consent appropriate to OSA must be obtained before any treatment is provided. The proposed treatment plan should be described in detail, and treatment alternatives also should be discussed. The orthodontist should describe the benefits, risks, short- and long-term side-effects, and complications that might arise. The need for compliance, long-term monitoring, and follow-up care should be discussed. An estimate of the nightly duration of oral appliance (OA) therapy use should be provided, and a realistic estimate of the probability of success with the treatment protocol should be presented. Given the serious nature of untreated OSA, it is recommended that the orthodontist carefully document the informed consent process.

Oral appliance therapy

Oral appliances, which include both mandibular advancing oral appliances (OAms) and tongue-retaining devices, are usually effective options for OSA management in appropriately selected patients. OAms are intended to hold the mandible or the associated soft tissues forward, resulting in an increased caliber of the upper airway at the oropharyngeal level. A substantial body of research supports the use of OAs for patients with OSA. Specifically, OAs may be used for treatment of mild to moderate OSA and for treatment of patients with severe OSA who are unwilling or unable to use PAP therapy. Published guidelines (American Academy of Sleep Medicine/American Academy of Dental Sleep Medicine) describe how OAs fit into the OSA management paradigm.[20,21]

Functional appliances and OAms are considered to be the first line of treatment for patients with OSA that prefer OAs over PAP and for those patients that do not respond to PAP therapy. Although typically well tolerated, it should also be noted that not all patients with OSA respond to OAm treatment; this form of therapy is reported to be completely effective in 36%-70% of OSA cases.

Many types of OAs are used in the treatment of OSA in adults. The appliances vary based on the coupling design, mode of fabrication and activation, titration capability, degree of vertical opening, lateral jaw movement, and whether they are custom made or prefabricated. Proper indications for each design should be considered.

Oral appliance titration

Oral appliances initially are delivered with the mandible advanced to a position approximating two-thirds of maximum protrusion. After a period of accommodation, based on subjective feedback from the patient regarding their OSA symptoms and sleep quality, the amount of protrusion can be titrated or increased until optimum symptom relief is obtained. Unattended (type 3 or 4) portable monitors may be used by the orthodontist to help define the optimal target position of the mandible. Then typically the physician involved will request a sleep study with the OAm in place. Should the physician deem the calibrated position to be subtherapeutic, the physician and orthodontist should discuss the possibility of further titration or alternate treatment.

Monitoring

During treatment for OSA, the patient should be monitored, which may involve subjective reports as well as objective observations. Reports on usage of the OA may be obtained from the patient and bed partner or caregiver. Compliance should be evaluated, and the appliance should be checked for fit and comfort, the need for titration, and the development of undesirable side-effects. At present, most data on adherence to OA therapy rely on subjective reports. Use of a thermal sensor[22] has been studied in an effort to have objective measurement of OA adherence, although such measures currently are not part of routine clinical care.

It has been suggested that monitoring be conducted at least once every 6 months during the first year and then annually. Routine monitoring should result in regular communications between the physician and

orthodontist. If the patient has worsening of OSA-related symptoms, or changes to overall health, a consultation with the physician is strongly recommended.

Goals of treatment

The end points of treatment include reduced or eliminated snoring, resolution of the patient's initial symptoms of OSA, normalization of the AHI, and normalization of oxyhemoglobin saturation. No pretreatment risk factors have been consistently shown to predict success for OAs in reaching treatment goals.

Change in occlusion

Oral appliances used in sleep apnea treatment move teeth. In the field of dentistry, orthodontists are generally considered to be the experts in the management of malocclusion owing to their education and clinical experience. Improved awareness of both OSA and the effectiveness of OAs has resulted in increased numbers of OSA patients being treated with the use of OAs by nonorthodontists. Although successful OSA treatment may be evident over the short term in many of these patients, nonorthodontic providers may be unaware of the unwanted effects that OAs can have on their patient's occlusion over the long term. Orthodontists can be helpful in providing our medical and dental colleagues valued oversight, and sometimes treatment, of unexpected and unwanted occlusal changes occurring with long-term OA wear.

Changes are progressive with ongoing OA use. Because many patients will be treated for a protracted period, OA-generated malocclusions often become significant over the long term and may require treatment to reverse the dentoskeletal adaptations that may occur. Typical changes include a reduction in overjet and overbite, changes in facial height, development of anterior crossbites, and posterior open bite.

Orthodontists may be asked to assess and treat OA-related malocclusions, a condition that has become a more frequent occurrence in recent years. When considering treatment of these malocclusions, orthodontists need to be aware that the patient will not be able to wear the OA during treatment; therefore, the patient may need to use PAP therapy during the period of orthodontic care. Communication with the physician helps to ensure that the patient's OSA is still being managed appropriately.

Should the patient return to using an OA for OSA after orthodontic treatment, then the malocclusion may also return. Consequently, such patients often switch to PAP therapy or may be evaluated for surgical treatment options.

Maxillomandibular advancement and surgically assisted rapid maxillary expansion

Patients who are unable to tolerate or adhere to PAP or OA therapy with an underlying sagittal skeletal discrepancy may be candidates for maxillomandibular advancement (MMA) or telegnathic (>10 mm) jaw advancement surgery. MMA is generally reserved for patients with severe OSA who are unable to tolerate PAP therapy and patients who also have an orthodontic indication for the procedure. The severity of OSA is not the only determinant of candidacy for MMA; these patients often require detailed evaluation and counseling before MMA is selected as a treatment option.

Such patients typically should proceed with routine orthodontic diagnosis and treatment planning, including comprehensive soft tissue facial evaluation to assure optimal presurgical preparation and that the surgery performed will not adversely affect facial esthetics. Orthodontic care is usually a beneficial adjunct for patients to facilitate obtaining optimal occlusion while simultaneously reducing the risk of postoperative malocclusion. Patients with ideal or minimal Class I malocclusion may not require extensive presurgical orthodontics in that the 2 jaws may have a similar interdigitation after symmetric maxillary and mandibular advancement. Telegnathic surgery is not recommended for patients who are already bimaxillary protrusive; such patients should usually be reevaluated by the team to explore alternate treatment options. One of the concerns of telegnathic surgery in this situation involves esthetics. As such, each practitioner and patient should decide for themselves if the benefits of the surgery outweigh the risks involved.

Significantly less data exist for surgically assisted rapid maxillary expansion (SARME), which aims to correct a maxillary transverse deficiency. In OSA patients with maxillary transverse deficiency, normalizing the width of the maxilla with the use of SARME and developing a functional and esthetic occlusion with comprehensive orthodontic treatment afterward has been suggested to improve PSG parameters.[23]

Possible treatments on the horizon

New treatment modalities, such as mini-implant (miniscrew or temporary anchorage device)–supported rapid maxillary expansion, are appearing as possible alternatives for SARME. However, to date there is very limited PSG evidence for its use in the management of OSA patients. Future studies are needed, and with time

mini-implant–supported expansion may become a viable adjunctive form of treatment for OSA management in adult patients.

PEDIATRIC OSA (UNDER 18 YEARS OF AGE)

Etiology

As with adult OSA, impaired neuromuscular tone underlies upper airway collapsibility in children. In addition to etiologic factors similar to those in adults, exacerbating factors for pediatric OSA often include lymphoid hyperplasia and growth-related changes in the size of the upper airway.

As the upper airway is narrowed or completely occluded, the patient's effort during breathing progressively increases. Owing to the airflow restriction, there is a relative increase in serum carbon dioxide (CO_2; hypercarbia) and decrease in serum oxygen (hypoxemia). The escalating respiratory effort causes a cortical arousal from sleep, which results in the upper airway opening so that normal airflow is reestablished. Once the patient falls back to sleep, the upper airway may collapse again with recurrence of the above-noted process. This breathing sequence may have significant consequences for the child.

Risk factors

Because the obesity epidemic also affects children, obesity is becoming a greater factor for childhood OSA. However, because untreated OSA may contribute to growth restriction, some children with OSA paradoxically may be underweight. Therefore, it is recommended that a clinical risk assessment for OSA be performed even in normal-weight and underweight children.

In addition, it is thought that certain craniofacial morphologies can increase a child's risk for having OSA. For example, mandibular retrognathia, long and narrow faces, narrow and deep palate, steep mandibular plane angle, anterior open bite, and midface deficiency may predispose a child to developing OSA. However, the presence of OSA cannot be determined by craniofacial morphology alone; these physical findings should be interpreted in the context of the clinical history.

Genetic syndromes that are associated with craniofacial anomalies can confer an increased risk of OSA. For example, patients with Pierre Robin sequence[24] and syndromic craniosynostosis[25] have a high prevalence of OSA. Children with Down syndrome[26] also have an increased OSA prevalence. Orthodontists who care for children with these and other genetic syndromes that affect craniofacial morphology should pay attention to clinical features that may suggest the presence of untreated OSA.

Symptoms

Children with OSA may present with snoring, witnessed apneas, and choking or gasping during sleep. Parents or caregivers may describe that the child sleeps in unusual positions, such as having the neck hyperextended or with the head hanging off the side of the bed, as well as appearing very restless with frequent position changes during sleep.

Some children with OSA may present with sleepiness; those who previously had discontinued daytime napping may resume daily or near-daily naps. In other children, untreated OSA may manifest as hyperactivity rather than excessive sleepiness. Whereas obesity may be a contributor to the pathogenesis of OSA in some children, others may present with failure to thrive. As such, it is recommended that the evaluation for OSA in every child should be part of an orthodontist's comprehensive clinical assessment.

Diagnosis

Diagnosis of OSA in children is confirmed only by the gold standard PSG. Diagnostic evaluation of childhood OSA has evolved in recent years. In addition to standard recording channels, all pediatric PSG is now conducted with CO_2 monitoring. Measurement with either end-tidal CO_2 (the partial pressure of CO_2 present at the end of exhalation) or transcutaneous CO_2 monitoring is acceptable.

According to the International Classification of Sleep Disorders,[1] OSA can be diagnosed by either of 2 sets of diagnostic criteria. The first set of criteria for OSA includes the presence of at least 1 of the following: (1) snoring, (2) labored, paradoxic, or obstructed breathing during the child's sleep, or (3) sleepiness, hyperactivity, behavioral problems, or learning problems; and polysomnography shows one or more obstructive apneas, mixed apneas, or hypopneas per hour of sleep.

Alternatively, OSA can be diagnosed if the PSG shows a pattern of obstructive hypoventilation, which is defined as at least 25% of total sleep time with hypercapnia ($PaCO_2$ >50 mm Hg) associated with at least 1 of the following: (1) snoring, (2) flattening of the inspiratory nasal pressure waveform, or (3) paradoxic thoracoabdominal motion. These OSA diagnostic criteria are for children under the age of 18 years, although adult OSA diagnostic criteria may be used for children of ages 13-18 years, according to the American Academy of Sleep Medicine Manual for the Scoring of Sleep and

Associated Events.[27] HSAT is not indicated in patients under 18 years of age.[28,29]

Severity

Published studies on childhood OSA have included various diagnostic criteria; some studies use the adult criteria of AHI ≥5/h. Other studies define childhood OSA as mild (AHI or RDI ≥1 and <5/h), moderate (AHI ≥5 <10/h) and severe (AHI ≥10/h). Of note, scoring of obstructive apneas and hypopneas on PSG differs slightly for children than for adults. For adults event duration is defined as is at least 10 seconds, whereas for children obstructive event duration is defined as at least 2 breaths.

Prevalence

Prevalence of childhood OSA is obscured by different diagnostic criteria used in published studies. Epidemiologic data from 2008 indicate prevalence of parent-reported "always" snoring to be 1.5%-6%, prevalence of parent-reported apneic events during sleep to be 0.2%-4%, and OSA diagnosed by varying criteria to be 1%-4%. Multiple studies have shown that during certain phases of growth, childhood OSA remits without any intervention. These data indicate that prevalence of childhood OSA changes across periods of growth and development. Specific populations, such as children with certain craniofacial or other genetic syndromes and those who are obese, have a higher prevalence of OSA compared with the general population.

Significance

Consequences of OSA in children include impaired growth and cardiovascular dysfunction. The impaired neurocognitive function seen in children with untreated OSA can have an effect on academic performance. Behavioral problems also can result. Persistent snoring and nocturnal enuresis (bedwetting), which can result from untreated OSA, can be embarrassing for children in social settings and thus affect interpersonal interactions.

PEDIATRIC OSA: SKELETAL AND SOFT TISSUE GROWTH

Orthodontists are aware of the impact that facial growth has on orthodontic treatment outcome. Facial growth also influences the size and shape of the upper airway in the pediatric population. One approach to understanding the interaction of hard and soft tissue growth on upper airway morphology can be described as follows. The hard tissue boundaries of the upper airway include the upper and lower incisors and the piriform rim in the anterior, the cranial base superiorly, the cervical vertebrae posteriorly, and the hyoid bone inferiorly. Laterally, the size of the airway is related to the width of the palate, the middle cranial fossa, and the distance between the ascending rami. Together these structures define the bony skeletal boundaries of the airway. Soft tissues then line this hard tissue framework. These tissues include the pharyngeal muscles, tongue, soft palate, turbinates, and the pharyngeal tonsils, adenoids, and nares.

Importantly, growth of the bony components effectively increases the size of the skeletal boundaries in the following ways. The anterior cranial base increases in length via growth at the sphenoethmoidal synchondrosis up to the age of 7 years. Increases in posterior cranial base length are similarly related to growth at the sphenooccipital synchondrosis up to the age of 13 years. The anterior cranial base carries the nasomaxillary complex forward at the same time that the individual bones of the midface are displaced in an anterior and inferior direction. Simultaneously, the mandible elongates and is displaced downward and forward with deposition of bone on the posterior and superior borders of the ramus, increasing the height of the rami (bony pharyngeal height) and increasing the distance between the ascending rami (bony pharyngeal width). Concurrently, resorption on the anterior border of the ramus increases corpus length (oropharyngeal length). While all these bony changes are occurring, the hyoid bone is displaced anteriorly and inferiorly. Thus, the normal facial growth process results in dramatic increases in all 3 dimensions of the skeletal framework.[30]

While the skeletal boundaries of the airway are increasing, the major lymphatic tissues of the upper airway (tonsils and adenoids) are shrinking. This combination of increases in skeletal dimensions along with decreases in soft tissue mass results in enormous increases in the size of the upper airway over infancy, childhood, and adolescence. These changes in airway due to growth far exceed any orthodontic or orthopedic effects on airway shape or size. Knowledge of these changes is important to understanding the dynamics of OSA in children.[31]

ROLE OF ORTHODONTICS IN PEDIATRIC OSA

It is strongly recommended that the orthodontist perform a clinical risk assessment for OSA and refer at-risk patients to the appropriate physician for definitive diagnosis of OSA. Subsequently, orthodontists may be involved in treatment of pediatric OSA if the treating physician refers the patient back to the orthodontist to address an underlying skeletal discrepancy thought to contribute to the child's OSA.

Medical and dental history

Orthodontists should be familiar with the signs and symptoms of OSA in pediatric patients. Questions concerning the health history of a pediatric patient should solicit information on snoring, sleep-related behaviors, daytime sleepiness, difficulty concentrating, and formal diagnosis of attention deficit–hyperactivity disorder. The American Academy of Pediatric Sleep Physicians recommends that if a patient reports snoring, more thorough questioning is warranted; the guidelines state, "If they snore, you must do more."[32]

Thorough history and examination are critically important in that they establish the presence of preexisting conditions, a basis for a diagnosis, the need for referral, and a baseline for evaluating the effects of treatment. Orthodontists also should include assessment of a patient's height, weight, and neck size to screen pediatric patients for OSA.

The following items should be considered when performing a pediatric evaluation that is sensitive to OSA: previous diagnosis of OSA, loud snoring, previous diagnosis of other forms of SRBDs, mouth breathing during sleep, height, poor school performance, weight, aggressive behavior, medications, developmental delays, age, bed wetting that is not age appropriate, attention problems, hard to wake up in the morning, trouble breathing during sleep, morning headaches, pauses in breathing during sleep, fall asleep quickly, nasal obstruction, and attention deficit–hyperactivity disorder.

Screening tools

One potential screening tool that has been validated and used in orthodontic offices is the Pediatric Sleep Questionnaire (PSQ; Appendix VI).[33–35] This questionnaire has a positive predictive value of 0.4 (ie, 40% of patients with a positive PSQ score will be diagnosed with OSA) and a negative predictive value of 0.99, (ie, only 1% of patients with a negative PSQ score will be diagnosed with OSA). The PSQ often is a valuable first step in screening patients presenting to the orthodontic office without a history of OSA. The Epworth Sleepiness Scale for Children and Adolescents (Appendix VII)[36] may be helpful to assess for problematic sleepiness, but it cannot identify a specific cause of daytime sleepiness. The Epworth scale has been validated only for children 12-18 years of age.[12]

Clinical examination

In addition to the usual orthodontic clinical examination that evaluates dental occlusion, range of mandibular motion, soft tissue frenum attachments, gingival health, and temporomandibular disorder, the orthodontist should also note the degree to which the tonsils impinge on the pharyngeal airway. A commonly accepted tonsil classification system, the Brodsky scale, grades the clinical manifestation of tonsil hypertrophy from 1 to 5 based on the percentage of the oropharyngeal airway taken up by the 2 tonsils (Appendix VIII).[37] The Friedman tonsil grading system (Appendix IX)[38] may also be a useful tool to evaluate the size of the tonsils. Because tonsil size does not correlate with OSA severity, there is no set cutoff point for tonsillar hypertrophy necessitating a referral to an otolaryngologist for further evaluation[39]; therefore, this decision is best made in the patient-specific context of symptoms and physical examination findings. The clinical evaluation of OSA in children should include evaluation of tongue size and position, the presence of obesity, and the patient's overall growth and development.

Orthodontic records

The typical orthodontic record set captures some important information that can be useful for further evaluation of the upper airway. For example, the adenoid mass and the hyoid bone can be seen on both the lateral cephalogram and the CBCT image. A low position of the hyoid bone when measured from the inferior border of the mandible has been shown to be an indicator of low muscle tonicity and has been linked with OSA.

Three-dimensional imaging is more accurate than 2-dimensional imaging for assessment of airway volume and area of maximum constriction. Airway imaging with the use of a cephalogram does not portray mediolateral changes in the oropharyngeal airway and may give misleading information as to the volume and minimal cross-sectional area. As in adult patients, although CBCT images have been shown to be useful in diagnostic and morphometric analysis of the hard and soft tissues in routine orthodontic treatment, there are limitations regarding the screening of OSA. CBCT provides no information on neuromuscular tone, susceptibility to collapse, or actual function of the airway. Although both 2-dimensional and 3-dimensional imaging of the airway are helpful, they cannot be used to diagnose sleep apnea or any other SRBDs alone, and they do not provide a proper risk assessment technique or screening method.

Importantly, there is no direct link between any radiographic measures of airway size or shape and PSG results. Therefore, imaging values should be interpreted cautiously and in conjunction with other clinical signs and symptoms. Three-dimensional imaging of the airway, when available, may also be used for monitoring

or treatment planning. If radiographic records are taken for orthodontic purposes, the airway and surrounding structures, specifically the adenoids in children, should be evaluated.

DIAGNOSIS AND TREATMENT PLANNING IN PEDIATRIC OSA

As mentioned previously, orthodontists should not assume the responsibility for the definitive diagnosis of OSA. The definitive diagnosis is appropriately made by a physician. If the patient is found to have OSA, the physician should decide on an appropriate course of action for the treatment of OSA. The orthodontist may choose to work in a collaborative way with the physician, providing orthodontic treatment when necessary and when it does not interfere with ongoing medical treatment.

The plan for treating pediatric OSA should be based on consideration of the patient's individual needs and treatment goals. If the OSA treatment regimen involves orthodontics, a plan for treatment, monitoring, and long-term follow up care should be considered by all medical and dental practitioners involved. Care should be coordinated via communication between the orthodontist and all other practitioners who are working to treat the patient's OSA.

The orthodontic treatment plan for patients with OSA should follow the same orthodontic principles for correction of dental and skeletal deformities. Two orthodontic procedures that may change upper airway physiology are rapid maxillary expansion (RME) and mandibular advancement appliances for Class II correction. With both types of interventions, the primary objective of the orthodontic appliance should be to improve the occlusion and address the underlying skeletal discrepancy.

It would be appropriate, for example, to recommend rapid maxillary expansion (RME) for patients diagnosed with maxillary transverse deficiency. In this situation, the primary treatment goals would be to normalize the transverse width of the maxilla and establish a normal occlusion. Secondary effects of this treatment may result in reduction of nasal airway resistance and increase in the volume of the nasopharynx and nasal cavity. Both secondary effects of RME have the potential to improve OSA.

In the case of mandibular advancement devices for mandibular retrognathia, the primary goals should be to correct the skeletal discrepancy and the Class II molar relationship. A secondary effect of mandibular advancement devices may be the increase in the caliber of the oropharyngeal airway. The same applies to maxillary advancement appliances used in the treatment of Class III malocclusions.

It is possible that an OSA patient might be referred for expansion but does not have a transverse discrepancy. Likewise, it is possible a patient with OSA might be referred for mandibular advancement (or maxillary advancement) where no sagittal discrepancy exists. In such situations, the treatment alternatives should be considered on a case-by-case basis by the medical and dental practitioners involved. In such situations, it is appropriate to prioritize the treatments to serve the best interests of the patient.

TREATMENT OF PEDIATRIC OSA

In the growing child, OSA management is dramatically different than for the adult. It is recommended that orthodontists become aware of the vast array of potential treatment modalities that are available and that they work in unison with medical and dental practitioners when managing pediatric OSA. Hypertrophic tonsils and adenoids are the most common risk factors for OSA in the pediatric population, with tonsillectomy and adenoidectomy typically considered as the first line of treatment.

Various forms of pharmacologic agents may be prescribed by the attending physician to reduce the size of the nasal soft tissues if there is suspicion of these tissues being a potential cause of OSA. Nasal surgery, including turbinate reduction and deviated septum correction, also may be considered in selected cases. For the obese child, weight reduction management should be considered as part of the treatment plan. PAP may be used in severe cases. Possible negative craniofacial consequences of longitudinal usage of PAP on the developing facial structures should be considered.

Dentofacial orthopedic management, which is within the scope of the orthodontic specialist, also may be considered. For example, RME is a well known orthodontic treatment option for patients with a narrow maxilla. There is growing evidence, though low level, that in mixed-dentition patients who are properly diagnosed with OSA, RME can decrease AHI in the short and long terms.[40] Unfortunately, untreated control groups generally were not used in the studies considered. Regardless of the presence of OSA, it is recommended that the orthodontist use these devices only when there is an appropriate underlying skeletal condition. There is no indication in the literature that prophylactic application of maxillary expansion prevents the future development of OSA.

Based on a few studies that were performed on mixed dentition samples, mandibular anterior repositioning appliances can produce a decrease in AHI. Long-term stability of these changes has not been studied; untreated control groups generally were not used in those studies as well. Regardless of the presence of OSA, it is recommended that the orthodontist use these devices only when there is an indication that a related retrognathic condition exists. As with RME, there is no clear indication in the literature, however, that prophylactic use of mandibular anterior repositioning appliances prevents later development of OSA.

In addition, the orthodontist should be aware that some children who remain PAP intolerant may require airway support while sleeping. The use of mandibular advancing devices may be prescribed by the physician, and this prescription is not predicated solely on the Angle classification of occlusion. In this case, treatment with the use of an oral device is directed primarily toward airway maintenance and less toward dentofacial orthopedic management. Careful monitoring of facial growth and development is important during this time.

For Class III patients, there are no studies that have assessed the impact of maxillary protraction on AHI. Only an assessment of pharyngeal dimensions has been published so far. It appears inappropriate for the clinician to make the jump from enlarged airway dimensions to improvement in airway function or sleep-related breathing parameters. Again, regardless of the presence of OSA, it is recommended that the orthodontist use these devices when there is an underlying skeletal issue.

Orthognathic surgery usually is not indicated until craniofacial growth is completed. As a result, the pediatric patient that presents with clear skeletal issues should typically be managed to adulthood in the normal fashion with corrective jaw surgery planned later when the timing of the surgery is appropriate. An exception might be considered in a case where the patient has OSA and a severe skeletal discrepancy. After considering the potential benefits and risks involved (including the need for later surgical revision), orthognathic or telegnathic surgery could be considered.

In summary, much is known regarding treatment for OSA in adults, whereas information on the treatment of OSA in pediatric patients is much more limited. Therefore, care should be taken regarding the indications for orthodontic and orthopedic treatment intended to treat OSA in the young patient. Clearly defined treatment goals, focusing on the orthodontic and orthopedic components, should be articulated to the responsible parties involved. Improvement of the OSA should be highlighted as a "possible," or some studies say "anticipated," outcome of treatment. But, no guarantees of OSA resolution can be implied or stated emphatically by the treating orthodontist.

FALLACIES ABOUT ORTHODONTICS IN RELATION TO OSA

Conventional orthodontic treatment has never been proven to be an etiologic factor in the development of OSA. When one considers the complex multifactorial nature of the disease, assigning cause to any one minor change in dentofacial morphology is not possible. However, misinformation exists regarding the potential airway-related sequelae of orthodontic treatment performed with the use of dental extractions or orthopedic headgear (HG).

The specific effects on the dental arches and the muscles and soft tissues of the oral cavity after orthodontic extractions can differ significantly, depending on the severity of dental crowding, the amount of protrusion of the anterior teeth and the specific mechanics used to close the extraction spaces. The indication for extractions varies from patient to patient, as does the resulting change to the width, length, and arch perimeter of the dentition—all may increase, decrease, or stay the same after treatment. The impact that orthodontic treatment with or without dental extractions may have on the dimensions of the upper airway also has been examined directly, first with the use of 2-dimensional cephalography and more recently with 3-dimensional CBCT imaging.[41]

In certain instances, namely, in patients with significant protrusion of both upper and lower anterior teeth where skeletal anchorage or extractions are used to retract the anterior teeth as much as possible to reduce lip protrusion in profile, reductions in the cross-sectional area of the oropharynx have been reported. More frequently, as in patients where extractions are performed to help address dental crowding or improve the occlusion, there is no discernible change in airway dimensions when extractions are used.[42,43] The studies examining these effects in children and adolescents have reported increases in airway volumes and cross-sectional areas in patients both with and without extractions performed as part of their orthodontic treatment.[44–46] These effects may likely be related to normal growth changes.

In discussing orthodontic treatment and changes in the dimensions of the upper airway, it is helpful also to understand that an initial small or subsequently reduced or increased size does not necessarily result in a change in airway function. Reflecting the higher significance of neuromuscular control on airway function during sleep, it has been demonstrated that a narrow airway does not result in OSA, but rather it is an inability for a patient's

airway muscles to compensate adequately that leads to obstruction and sleep-disordered breathing.[47]

As such, future investigations should aim to place greater emphasis on the effects of airway function after orthodontic treatment, instead of focusing solely on quantifying airway dimensions. One such study assessed dental extractions as a cause of OSA later in life by means of a large retrospective examination of dental and medical records.[48] Researchers reviewed the health records of more than 2700 adults with 4 missing premolars and evaluated whether this group had a higher prevalence of OSA compared with an equal-size group of patients with no missing teeth who were matched for the most significant confounding variables of OSA in adults, namely age, BMI, and sex. The study concluded that the prevalence of OSA was essentially the same in both groups, and that dental extractions were not a causative factor in OSA.

Overall, it can be stated that existing evidence in the literature does not support the notion that arch constriction or retraction of the anterior teeth facilitated by dental extractions, and which may (or may not) be the objective of orthodontic treatment, has a detrimental effect on respiratory function.

Headgear therapy

Growth modification, including orthopedic HG, which alters the direction of growth of the maxilla, has long been a staple of certain orthodontic treatments. Although dentoalveolar movement can be significant, the absolute skeletal change to the position of the maxilla elicited by HG is relatively small. Consequently, meaningful effects on volume or morphology of the upper airway should not be expected. A few studies with small sample sizes or methodologic limitations have examined this relationship directly. The best evidence available at this time indicates that HG does not pose an increased risk to the airway in that the airway remains the same or increases over the study periods reported.

Anecdotal concern exists about whether HG used during adolescence could contribute to the future development of OSA as an adult. To date, no studies have been performed using objective PSG to demonstrate an elevated risk of OSA in HG patients. Studies have investigated this concern indirectly by evaluating the radiographic airway in 2 dimensions with the use of lateral cephalograms of HG patients. One study concluded that the absolute value of the airway dimension was smaller in HG patients than in activator patients, but the differences were both small and not statistically significant.[49] A longitudinal study examined patients over a 12-year period and reported that the radiographic dimension of the airway decreased during the treatment phase but increased to the level of control subjects during follow-up.[50] A prospective, randomized, blinded study demonstrated an increase in the airway during the 6-year study period.[51] In summary, the best evidence available at this time indicates that HG does not pose an increased risk to the airway in that the airway dimension remains the same or increases over the study periods reported.

Frenectomy

Functional deficits regarding suction, swallowing, masticatory, and speech difficulties are known consequences of ankyloglossia or tongue-tie. However, uncertainty remains as to what degree of frenum attachment would contribute to a deviation of normal form or function in all but the most severe forms of ankyloglossia. More recently a 4-point severity scale of tongue mobility was reported, with the most severely restricted tongues graded as 4.[52] The investigators reported a reduced maxillary intercanine width and a longer soft palate in patients with more severe levels of tongue restriction compared with patients with no such restriction. However, the relationship between tongue mobility and function of the airway is complex. Future research efforts should aim to assess airway function during sleep as it relates to tongue mobility. At this time, frenectomy remains an appropriate treatment for speech and mastication deficiencies, but such procedures are not supported as a treatment to prevent future development of OSA.

LEGAL ISSUES

Obstructive sleep apnea is a medical disorder that can have serious consequences on overall health. Given some of the possible medical conditions associated with OSA, it is strongly recommended that orthodontists work with qualified and appropriately trained physicians in addressing OSA.

With that in mind, it is strongly recommended that orthodontists screen orthodontic patients for known OSA risk factors. Should the screening indicate an elevated risk for having OSA, it is strongly recommended that the patient be referred to an appropriate physician for definitive OSA diagnosis and treatment. Depending on the physician's diagnosis and plan for treatment, the orthodontist may be involved in the treatment after proper referral by the physician.

Any orthodontist involved in the treatment of adult or pediatric OSA should confirm that they are legally permitted to do so under the dental laws and standards of care in their jurisdiction. That is, orthodontists must not perform out of their scope of practice or involve

themselves in any treatment that would be noncompliant with applicable laws or outside the standards of care.

An orthodontist who provides prescribed treatment of OSA needs to have the appropriate training and qualifications and must operate within the laws and standards of care. Failure to do so may subject the orthodontist to civil and criminal penalties. In situations in which a qualified and appropriately trained orthodontist has confirmed their ability to treat OSA, they should also consult with their insurance carrier to confirm coverage in this domain.

EXECUTIVE SUMMARY

Obstructive sleep apnea is a medical disorder that can have many serious consequences if left untreated. OSA can affect adults and children and can present at any point in the lifespan. All orthodontists should consider incorporating OSA screening into their history-taking and examination of patients. When an orthodontist has a clinical suspicion that a patient may have OSA, it is strongly recommended that referral to a physician be made; a sleep medicine physician is preferred. The definitive diagnosis of OSA should be made by a physician. Individual orthodontists may elect to participate in the treatment and monitoring of OSA patients as appropriate and permissible under applicable laws, standards of care, and insurance coverages.

1. It is strongly recommended that orthodontists be familiar with the signs and symptoms of OSA.
2. It is strongly recommended that orthodontists screen patients with regard to the signs and symptoms of OSA. A thorough history and clinical examination are critically important in that they establish the presence of preexisting conditions, a basis for diagnosis, the need for referral, and a baseline for evaluating the effects of treatment.
3. It is strongly recommended that the orthodontist refer patients with risk factors for OSA to a physician for further evaluation and a definitive diagnosis. A sleep medicine physician is preferred.
4. It is recommended that the orthodontist refer pediatric patients with nasal obstruction or adenotonsillar hypertrophy to an otolaryngologist.
5. It is recommended that the orthodontist refer adult patients to an otolaryngologist when nasal obstruction or adenotonsillar hypertrophy is present.
6. The decision for an orthodontist to participate in the treatment of OSA is a choice that should be made based on interest as well as training, skills, experience, laws, standards of care, and insurance coverage applicable to the orthodontist.
7. If involved in the treatment of OSA, an orthodontist should monitor OA treatment efficacy.
8. An orthodontist may elect to manage adverse side effects of OA therapy.
9. No orthodontic treatments have been shown to cause or increase the likelihood of OSA. Rather, some forms of orthodontic treatment have been shown to be important in the treatment of OSA.
10. Interdisciplinary treatment of OSA helps to serve the best interests of patients with OSA.

ACTION PLAN

Future research

Meaningful research concerning OSA can be enhanced dramatically with the use of the PSG, which objectively assesses airway function, to measure outcomes of the long list of treatment possibilities, especially in growing children. There is a substantial leap of faith when researchers make the jump from "enlarged airway" to "OSA cure" or even "OSA improvement."

Areas of study worthwhile of future research include the following. Which craniofacial variables contribute to the pathogenesis of OSA? How is airway function affected by various orthodontic treatments? At what age can OSA be detected? Does OSA progress from childhood into adulthood? Does OSA treatment in childhood prevent OSA in adulthood? What are the end points expected for OSA therapy?

Education

At this time, the subject of OSA in pediatric and adult populations is not included in the curricula of most dental school predoctoral and postdoctoral programs. Before the introduction of OSA as a curriculum subject, it is paramount for the American Dental Education Association (along with the American Dental Association and Commission on Dental Accreditation) to adopt educational standards for this subject, so that OSA subject matter is taught with the proper endorsements and qualifications. A standardized curriculum should be developed and incorporated into all predoctoral and postdoctoral programs.

Additional recommendations

It is recommended that the AAO consider developing a health history form for OSA for children and adults or include OSA questions in current health history forms. When screening for possible OSA in their patients, practitioners should consider recording their patient's height, weight, and neck size. They should also consider

calculating the patient's BMI (Appendix X). An informed consent document for OSA might also be useful. The use of validated tools for risk assessment of OSA is recommended to develop more efficient and standardized screening methods. The AAO might also consider whether the definition of orthodontics needs modification relative to OSA.

LITERATURE RESOURCE FOR AAO MEMBERS

A Literature Resource for Orthodontics and OSA is being developed by Jackie Hittner, AAO librarian. It will be available via the AAO Library Web page.

The Literature Resource now contains more than 4,000 article citations. It is estimated that eventually it will contain around 5,000 article citations. If AAO members want to access the collection, they may access the searchable file and select articles. Initially, they will see only the abstract. If they want to view the entire article, they may then request the article from the AAO Library by means of the journal request form. It is intended that this resource will be updated periodically.

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APPENDICES

Appendix material will be available on the AAO Library Web site. They include the following:
Appendix I: Examples of apnea and hypopnea
Appendix II: STOP-Bang questionnaire
Appendix III: Modified Mallampati score
Appendix IV: Epworth Sleepiness Scale
Appendix V: Friedman tongue position
Appendix VI: Pediatric Sleep Questionnaire
Appendix VII: Epworth Sleepiness Scale for Children and Adolescents
Appendix VIII: Brodsky tonsil grades
Appendix IX: Friedman tonsil grading system
Appendix X: Body mass index tables 1 and 2

March 31, 2021

Stephen Prisby
Executive Director
Oregon Board of Dentistry
1500 SW 1st Avenue, Ste 770
Portland, OR 97201

Delivered by email to: Stephen.Prisby@state.or.us

Dear Mr. Prisby

I am taking this opportunity to inform you about a teledentistry program we are implementing for children covered under ODS Community Dental. This program is a component of our overall outreach efforts to ensure children ages 1-5 and 6-14 receive a preventive dental service in 2021. We are mailing packets to households with children within this age range. The packet includes educational information about preventive dental services, an insert regarding dental sealants, contact numbers for transportation services, and steps to take to find a dentist in their area.

The COVID-19 pandemic added an additional layer to the difficulties parents and guardians encounter when seeking dental services for children under their care. To address these challenges, we have defined a teledentistry program that will provide dental assessments and topical fluoride services to ODS members. The ODS expanded practice dental hygienist (EPDH) will conduct the teledentistry services. ODS will advise parents and guardians of the teledentistry option in the educational letter and will schedule the teledentistry appointments.

ODS will mail a follow-up packet to the parent or guardian prior to the appointment. The packet will include a single topical fluoride application, a child's toothbrush kit, detailed instructions for fluoride application, a preventive dental service booklet, and steps to take to access the teledentistry visit. The ODS EPDH will conduct the assessment and guide the parent or guardian through the application of the topical fluoride. She will provide clinical advice to the parent or guardian, assistance finding a dentist, and prepare the child for their visit to the dentist.

We are pleased to advise you of this new program. We plan to launch the pilot in early May and will offer this option to 500 families. We will expand the program based on the results of the pilot. I would also like to mention our EPDH has been successfully conducting dental assessments via teledentistry for ODS children recently placed in foster care and has been offering this option for over six months. Please let me know if you have any questions or comments regarding our teledentistry services.

Sincerely,

Teri Barichello, DMD
Vice President and Chief Dental Officer, ODS Community Dental
Teri.Barichello@modahealth.com
Cell: 503-349-5587

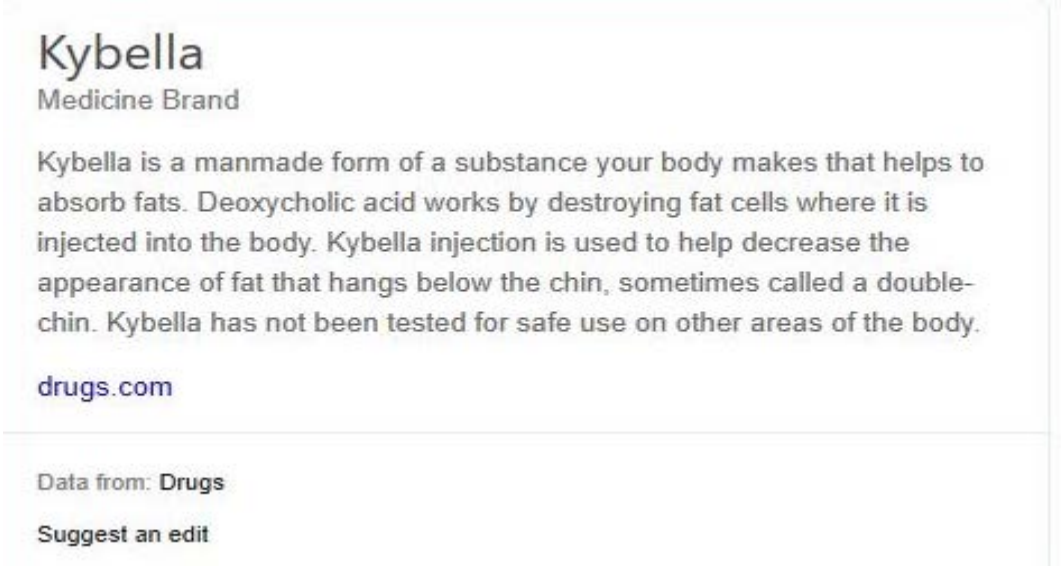
From: Levi Shull <levishulldmd@gmail.com>
Sent: Wednesday, March 10, 2021 10:04 AM
To: HAYNES Teresa * OBD <teresa.haynes@oregondentistry.org>
Subject: Question

Teresa,

I'm not sure if you're the correct contact for this. I had a question regarding administering kybella. I don't see anything in the dental practice act that says anything. Not sure if it's regarded like botox but was wondering if it's within our scope to administer once properly trained.

Thank you for your time!

--
Levi J.O. Shull, DMD
Shull Family Dentistry, LLC
P: 503-362-5019
F: 503-316-9135
C: 971-269-8004



OTHER ISSUES

From: Commission on Dental Accreditation <ada@messaging.ada.org>
Sent: Thursday, March 25, 2021 9:50 AM
To: Stephen.Prisby@state.or.us <Stephen.Prisby@state.or.us>
Subject: Call for Nominations to CODA Review Committee Positions

CODA Alert

Call for Nominations to CODA Review Committee Positions

The Commission on Dental Accreditation (CODA) requests nominations to fill vacancies on Review Committees. This call for nominations is for 2021 Vacancies:

Six (6) General Dentists

- Two (2) General Dentist Predoctoral Educators* – Predoc RC
- One (1) General Dentist AEGD/GPR Graduate – AGDOO RC
- Three (3) General Dentists: Anesthesiology, Oral Medicine & Orofacial Pain RCs (one each)

One (1) Dental Assisting Educator* – DA RC

One (1) Dental Laboratory Technology Educator* – DLT RC

Seven (7) Public Members

- Five (5) Review Committee Members (DLT, Anesthesiology, Oral Medicine, Orofacial Pain and Periodontics)
- Two (2) Public Members for the Commission (includes training year)

*Prior or current experience as a Commission site visitor required

Review Committee Nomination Forms are due to CODA staff by **June 1, 2021** for consideration at the Commission's Summer 2021 meeting.

When submitting nominations to the Review Committee and Commission (for public member only), CODA requests that strong consideration be given to assisting this agency to achieve diversity, including underrepresented groups, geographic diversity and varied educational philosophies. Review the nomination criteria and explanation of time commitment (PDF) for

additional information.

If you or someone you know may be interested in volunteering for an open position on the Commission, please review the materials below:

- Review Committee Nomination Form (DOCX)
- Review Committee Public Nomination Form (DOCX)
- Review Committee and Commission Meeting Dates (PDF)

Once the nomination form is completed, please submit to hooperm@ada.org.

The Nominating Committee will review the nominations and submit recommendations to the Commission. Nominations may not be directed toward a specific review committee and requests to be placed on a specific review committee will not be honored. Appointments are made for one four-year term, beginning and ending in October of each year.

Click the button below to access selection criteria and Review Committee Nomination Forms.

Call for Nominations Webpage

From: Phetnouvong, Fiona <phet4123@pacificu.edu>
Sent: Wednesday, March 31, 2021 10:54 PM
To: PRISBY Stephen *OBD <Stephen.PRISBY@oregondentistry.org>
Cc: Simonne Soudan <soud5365@pacificu.edu>; Amanda Musgrave <musg5639@pacificu.edu>
Subject: Proposal for Administration of Local Anesthesia

Fiona Phetnouvong
Kat Soudan
Amanda Musgrave
Pacific University
222 SE 8th Ave.
Hillsboro, OR 97123

March 31, 2021

Director Stephen Prisby
Executive Director for the Oregon Board of Dentistry
1500 SW 1st Avenue, Suite 770
Portland, OR 97201

Hello Director Prisby,

As senior year students in the dental hygiene program at Pacific university, we have participated in an amazing year long collaboration with our advisory board members focused solely on creating a proposal for our capstone project.

We are delighted to share this capstone project with you, which proposes to allow dental assistants to expand their scope of practice to include the administration of local anesthesia. We respectfully submit this proposal for consideration by the Oregon Board of Dentistry.

We wish to express our utmost gratitude for this opportunity, and are incredibly thankful for your time and effort in considering our submission at this time. We look forward to our upcoming meeting with the Oregon Board of Dentistry.

Sincerely,
Fiona Phetnouvong, Kat Soudan, Amanda Musgrave

Dental Assistant Administration of Local Anesthesia - Oregon Students: Kat Soudan, Fiona Phetnouvong, Amanda Musgrave
Proposal
The creation of a Local Anesthesia Expanded Functions certificate that would allow administration of local anesthesia procedures, (placement of topical anesthetic, determination of the type of anesthetic needed, calculation of MRD, evaluation of indications and contraindications for local anesthesia, documentation of patient's medical history, loading and unloading of syringe, needle placement, delivery of local anesthetic, identification of a medical emergency, responding to medical emergencies), to appropriately educated dental assistants, under the indirect supervision of a dentist and/or dental hygienist that maintains their current anesthesia endorsement.
Justification
The creation of a Local Anesthesia Expanded Functions certificate in Oregon would provide an additional professional pathway for interested dental assistants. It would allow dental assistants to demonstrate their current knowledge, and expand on that through continuing education of head and neck anatomy, pharmacology, medical emergencies, and additional continuing education courses. Utilization of an Expanded Functions Dental Assistant that is able to administer local anesthesia would allow interested dentists to increase productivity in practice, provide effective quality care, increase practice income, serve more "at-risk" or low income patients, and improve significantly in time management. According to Kracher C, "As the dental delivery system evolves in the next 25 years, the demand for dental assistants to have more advanced clinical skills will increase, creating a need for their education to change. This

demand may grow as evidence accumulates that use of expanded function dental assistants can increase the profitability of a practice." This indicates the potential to serve greater numbers of patients in Oregon through the use of local anesthesia by an Expanded Functions Dental Assistant.

National Perspective

Several states allow educated dentists, dental hygienists and dental assistants to expand their scope of practice in many skills such as restorative, nitrous, IV sedation, gingival curettage, etc. During the development of this proposal we looked at the provisions in Oregon, Kentucky Minnesota, North Dakota, Oklahoma, South Dakota, and Washington State which currently authorize Dental Hygienists and Dental Assistants to initiate an IV line. In reference to the Dental Assisting National Board Inc; dental assistants can obtain certification to prepare for IV medication, sedation, or general anesthesia under the indirect supervision of a dentist or registered dental hygienist.

According to Mike DeWine, a U.S. Senator from the State of Ohio In December 1997, however, the Health Care Finance Administration (HCFA) issued a proposed rule that would eliminate the physician supervision requirement for Certified Registered Nurse Anesthetists (CRNA's). HCFA acknowledged that there has been no new studies comparing outcomes between patients who have received doctor-supervised anesthesia versus those who received anesthesia without the supervision of a doctor. Instead, the rationale offered for the proposed rule was essentially that the HCFA is interested in decreasing regulatory requirements and increasing state flexibility. HCFA argued that anesthesia regulations are an appropriate area to do so, given that the anesthesia-related death rate is extremely low. Patients can receive the same level of care at a lower cost, and have more available clinics to choose from if the practices have employees that have an expanded scope of practice.

Similarly, in dentistry, all members of the dental field are continually working to expand their scope of practice in order to provide these types of services. This speaks to confidence in the education and skill of expanded functions dental assistants afforded them by both the dental community and the patients they serve.

Recommendations

The Local Anesthesia Expanded Functions Advisory Board proposes the following criteria for dental assistants for application for the permit to deliver local anesthesia. Upon the completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association or other course approved by the Board, a dental assistant may administer local anesthesia under the indirect supervision of a licensed dentist and/or dental hygienist that maintains their current anesthesia certificate in accordance with the Board's rules regarding anesthesia under the expanded functions certificate.

- Prerequisite Requirement:
  - Dental Assisting National Board (DANB), Certified Dental Assistant (CDA)

    and
  - Oregon Expanded Functions Certificate (OR-EFDA)
- Successful completion of an Oregon Board of Dentistry approved local anesthesia curriculum from a program accredited by the Commision on Dental Accreditation.
  - Curriculum should be not less than 65 hours of didactic and clinical instruction and successfully with a grade point average of 75% and above.
  - Proposed curriculum should include content in all of the following:
    - Theory of pain control

        - Selection of pain control modalities
        - Medical history and documentation
        - Dental history and documentation
        - Contraindications of local anesthesia
        - Head & Neck Anatomy
        - Neurophysiology
        - Pharmacology of local anesthetics
        - Pharmacology of vasoconstrictors
        - Psychological aspects of pain control
        - Systemic complications
        - Techniques of maxillary anesthesia
        - Techniques of mandibular anesthesia
        - Infection control
        - Local anesthesia medical emergencies
- Dental Assisting National Board (DANB), Certified Dental Assistant (CDA) annual requirements for recertification:
    - Must complete 12 hours of annual CE to main the CDA must include:
        - Bloodborne Pathogen Training (1 hour)
        - Infection Control Training (2 hours)
        - CPR Certificate Training
        - Clinical Education as it pertains to dentistry/dental assisting
- Applicants for the Local Anesthesia Expanded Functions certificate must successfully pass the Western Regional Examination Board both written and clinical within 18 months of the completion of required coursework.
- Dental Assistants must hold, maintain, and show evidence of current certification in basic or advanced cardiac life support.
    - Renewal requirement every 2 years

Conclusion

Expanded Functions Dental Assistants who are interested in expanding their scope of practice to include delivering local anesthesia is a highly considerable notion. Abiding by the rules and regulations to obtain this certification, it is clear that as part of dental health care, dental assistants are an essential contributor in adequate patient care. This certificate will assist in improving quality patient care, providing care to more individuals, increasing time management, increasing profit and increasing production. In dentistry, dental hygienists and dentists are regulated through the state legislature. To obtain their licensure, they have to pass state licensing exams and be regulated by their own state boards. There is no reason why dental assistant regulation is unable to be performed by those same organizations, after they have received additional education to allow them the ability to perform additional tasks- including local anesthesia. If dental assistants are properly educated in providing local anesthesia (just as dentists and hygienists are) they should be fully capable of providing local anesthesia for their patients just as dentists and hygienists are. “As the dental delivery system evolves over the next 25 years, the demand for dental assistants to have more advanced clinical skills will increase, creating a need for dental education to change.” (Kracher C, et al. 2017). The requirements to practice after obtaining credentials and licensure should follow the same exact protocols for renewal to continue in clinical practice.

Resources

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Corvallis Dental Health
Tina Clarke, RDH, MEd, Owner of TeacherTina RDH
Leslie Greer Lane Community College Dental Assisting Program & Co-op Coordinator
Jill Lomax EDM, CDA, EFDA-RF, FADAA Chemeketa Community College Dental Assisting Program Chair
Peggy Lewelling EFDA, CDA, RDH, BSDH, M.Ed. Portland Community College Full-Time Faculty | Dental Sciences
Stacey Gerger BS, CDA, EFDA Linn Benton Community College Department Chair of the Dental Assisting Department
Ginny Jorgensen, CDA, EFDA, EFODA Portland Community College Dental Assisting Program
Dawn DeFord, RDH

***Affiliations are listed for identification purposes only and are not necessarily an indication of endorsement.

NEWSLETTERS & ARTICLES OF INTEREST

Dental Amalgam Recommendations

U.S. FOOD & DRUG ADMINISTRATION

Dental amalgam / uh-mal-guhm /, sometimes called "silver-fillings," is a mixture of mercury, silver, copper, tin, and zinc used to fill cavities in teeth.

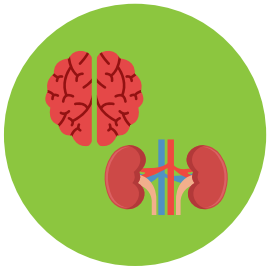
What Should I Know Before Getting A Dental Amalgam Filling?

Dental amalgam fillings may release small amounts of mercury in the form of a vapor (gas) that can enter the body through inhalation. While there are no known health risks associated with swallowing small particles of dental amalgam, breathing in mercury vapors may be harmful to certain groups of people. At this time, the FDA does not support a ban of the use of dental amalgam.

The FDA recommends that high-risk populations (listed below) avoid dental amalgam, if possible and appropriate. Talk to your dental provider about other available treatment options.

Who Is High-Risk And Should Consider Other Treatment Options?

Children, especially those younger than six



People with neurological impairment or kidney dysfunction

Should Dental Amalgam Fillings Be Removed?

If your filling is in good condition and your dentist or health care professional says there is no decay below the filling, the FDA recommends you **should not** have your amalgam filling removed, unless medically necessary.

People who are sensitive to mercury, silver, copper, tin, or zinc

Nursing mothers

Women who are pregnant or planning to become pregnant

For more information, please visit **www.fda.gov/dental-amalgam**.

February 2021

HealthProChoices

A newsletter for participants in the Health Professionals' Services Program (HPSP)

After Hours Phone Number

Recent inclement weather is a great reminder to save the IBH Monitoring after-hours line, 503-802-9818, in your phone. The IBH Monitoring after-hours line is available for collection site emergencies. During business hours, you should continue to use our regular line, 888-802-2843, or your agreement monitor's direct extension.

Inclement Weather

We hope you have recovered from the recent winter storms! As we continue through the colder months of the season, please remember that if a collection site is closed due to inclement weather, you must inform HPSP of the closure. This will be verified by your agreement monitor. If the site is confirmed to be closed and you have been in compliance with all requirements for nine consecutive months (or have been compliant thus far if enrolled less than nine months), then one of your allotted 21 toxicology exemptions per year may be used. Be sure to review the HPSP Guideline for Inclement Weather and Toxicology Testing at hpspmonitoring.com.

"You the warrior must look forward to the future but not live in it." – Darrel James Woodr

CCF Request Form

Great thanks and appreciation to the licensee who noted on the January survey that the CCF Request function of the portal, hpspmonitoring.com, was not working properly. We reported this to our IT team upon receiving the survey results and we are pleased to report it is back up and running.

You can resume using this request form:

- Simply log into your account at hpspmonitoring.com
- Look for the section labeled "CCF Request Form"
- Fill out the BRIEF form and hit "submit"
- Your request will be received by our staff and processed quickly!

IBH POPULATION HEALTH SOLUTIONS MONITORING

New Addendums Out for Signature

Due to the recent passage of voter initiative Measure 110 (2020) the HPSP Advisory Committee is requiring IBH Monitoring to have HPSP licensees sign an updated addendum. The addendum adds the requirement of reporting any citation of Class E violations for possession of DEA scheduled drugs. This requirement is in addition to the standing obligation of reporting any misdemeanor or felony arrest and/or conviction.

Addendums have been sent to all Oregon Medical Board and Oregon Board of Dentistry participants. If you have not done so already, please sign/return immediately. The Oregon State Board of Nursing and Oregon Board of Pharmacy are reviewing the addendum language. As soon as a final copy is approved by these boards, it will be sent to all participants. Please be on the lookout for the updated addendum in the coming days.

Updated Guidelines

HPSP's internal Policy Advisory Committee (PAC) has begun the process of reviewing all of the program guidelines. In January, The HPSP Advisory Committee approved changes to two guidelines. The first guideline was expanded and renamed; It was originally called the "Guideline for Brief Periods of Employment and Volunteer Work." This has been replaced with a broader guideline covering all employment and volunteer opportunities. The new document is named "Guideline for Workplace and Volunteer Work Monitoring." Make sure to review this updated document.

Participants from the Oregon Medical Board will also want to be sure to review the updates to the "Guideline for Approving CME requirements for the Oregon Medical Board."

*Both guidelines will be updated on the portal (hpspmonitoring.com) shortly. In the meantime, copies were sent along with the newsletter.

HPSP January 2021 Satisfaction Survey

Thank you to all of those who participated in the January 2021 Health Professionals' Services Program (HPSP) Satisfaction Survey. This was our nineteenth consecutive biannual survey since January 2011. For this survey, 20% of active participants from all four participating boards who had been enrolled for at least four months responded. The survey serves as an ongoing quality improvement tool and provides a feedback loop for participants. Survey results are reviewed by the internal HPSP Policy Advisory Committee (PAC) comprised of the HPSP Medical Director, Consulting Psychiatrist, Program Director, and two Agreement Monitors.

Participant Survey Highlights:

- Just over 97% of participants "agree" or "strongly agree" that they understand the program's statutory monitoring requirements.
- Most participants feel that they are treated with dignity (77.8%) and respect (80.5%).
- 86.2% of participants feel that HPSP provides a "significant amount" or between a "significant amount" and "some" structure. 88.9% of respondents feel this way about the program's accountability.
- A minimum of 86% of participants respondents agreed or strongly agreed that:
  - questions/concerns are responded to within one business day;
  - questions/concerns are addressed fully;
  - information is communicated clearly and professionally; and
  - the agreement monitor is knowledgeable about his/her case.
- Just over 80% of respondents indicated that they had used the portal and, of those, just over 75% find the portal "useful" or "extremely useful."
- 83.4% rated the program as "excellent," "above average," or "average."

HPSP January 2021 Satisfaction Survey (Continued)

The survey provides an opportunity for participants to leave open ended comments. For this reporting period, 16 participants left responses. All comments are appreciated and have already been reviewed by the PAC. Seven responses were negative and have been internally investigated. Four responses were positive with comments of thanks and noted appreciation of the support from the licensee's agreement monitor. The other responses were programmatic in nature with two licensees asking for reminders during the day if they had not already checked the app to see if they had to test. Additionally, several participants made note of the difficulties COVID has placed on their schedules on days they have to test due to shortened collection hours at some collection sites. HPSP's staff has been working diligently throughout the pandemic to provide alternate testing sites whenever possible. As noted earlier in the newsletter, another licensee commented about the CCF Request form not working on the portal and this has been corrected.

Many suggestions, including removing the workplace monitor requirement, are not possible as they are explicit monitoring program components. The boards require a workplace monitor in order to ensure that public safety is being upheld. This is one way that HPSP is able to serve our dual purposes of providing licensees a second chance while protecting public safety. The PAC does consider program changes that are in the participant's benefit and within the program's span of authority.

Your next opportunity to participate in the HPSP Satisfaction Survey is July. We look forward to your participation.

Resource Center: Mindfulness

Insight Timer - Free App for Sleep Anxiety and Stress: https://insighttimer.com
Calm - App for Sleep, Meditation and Relaxation: https://www.calm.com
Nothing Much Happens - Podcast featuring "bedtime stories for grown ups" in a mindfulness-focused format: www.nothingmuchhappens.com

News

Good News Network - Positive news stories from around the globe: www.goodnewsnetwork.org

Continuing Education

Under Pressure: Nursing Care During Community Crises. March 10, 2021 at 10AM via Zoom.

Moderated by Susan King, RN, MS, CEN, FAAN, retired Executive Director of the Oregon Nurses Association, this free event highlights the struggles and triumphs of Oregon nurses as they have cared for our community and themselves during this long emergency including a pandemic and social, political and economic upheaval. Speakers will consider the mental and physical health of our essential health care workers and of the patients, young and old, under their charge.

Click Here to Register

March 2021

HealthProChoices

A newsletter for participants in the Health Professionals' Services Program (HPSP)

"Help! I have a concern..."

Your agreement monitor is here to help you with any concerns. If your agreement monitor is not available, call the general number at 888.802.2843, and one of our other agreement monitors will step in to help. Regardless of who helps you, if you are not satisfied with the resolution of the situation, please let your agreement monitor know. Your agreement monitor may present your concern to our Policy Advisory Committee which consists of senior staff members and both our Medical & Psychiatric Consultants. One additional option is to reach out to the HPSP Manager, Kate Manelis, LMSW at 503.802.9848 or kate.manelis@ibhsolutions.com. Again, please know that we are here for you.

"But I already submitted it by fax!"

Does this sound familiar? It does to our ears because all too often a fax fails to complete successfully and the sender does not realize it. So that you don't find yourself in this position we encourage you to ensure you wait for confirmation that every page of the fax was successfully delivered. That said, we find that participants are often more consistently successful emailing documentation to us at hpsp@ibhsolutions.com. Need more ideas? Talk to your agreement monitor!

Connecting in a New Way

The last year has pushed many of us to experiment with using Zoom and other platforms in both our work and social lives. Most have found that, although they may not be able to physically get together, at least they can SEE each other and interact in a different way. We are excited to begin rolling that same idea out at IBH Monitoring after a successful pilot study. As part of your recovery support, your agreement monitor can setup a video conference meeting with you at the time of your annual review or another mutually agreeable time. During the video conference you will review your progress and plans for the year ahead. We hope this opportunity to interact with your agreement monitor in a new way will be helpful!

IBH POPULATION HEALTH SOLUTIONS
MONITORING

Herbal Supplements

One of the most common questions agreement monitors are asked by participants is,"Can I take XYZ supplement?" We recognize that vitamins and herbal supplements are an increasingly popular choice and we want to provide some guidance around how supplements may interfere with your success in monitoring.

Remember that herbal supplements are not regulated by the FDA and are not required to undergo clinical trials and testing. There are no guarantees that the ingredients listed on the bottle are actually in the supplement (the opposite is also true – there may be ingredients in the supplement that are not listed). As such, remember that you are proceeding at your own risk when you use supplements. We strongly recommend that you seek guidance from your primary care provider prior to starting any new supplement.

There are some supplements that we know should NOT be used by participants in monitoring because they may interfere with toxicology testing and cause positive toxicology results.

- Many tinctures and elixirs are made using alcohol – these are not permitted by HPSP. If you are interested in taking a tincture or elixir, you are encouraged to look for an alcohol-free version.
- Poppy seeds and California poppy can cause toxicology tests to be positive for morphine or codeine. Any food, drink, or supplement with poppy/poppy seeds as an ingredient is not permitted by HPSP.

If you have a question about a specific supplement, your agreement monitor may be able to provide guidance as to whether the ingredients listed on the product would be contraindicated for monitoring. However, HPSP will not guarantee that any vitamin or supplement product is "safe" or "approved." There may be ingredients in the product that are not listed on the packaging, and it is impossible for HPSP to know how every ingredient may metabolize. If a supplement results in a positive test, please remember that we must follow the guidelines for non-negative toxicology results; this may include a report of non-compliance to the licensing Board and a requirement to step-down from practice pending a third-party evaluation.

We are here to support you on your wellness journey. We hope this information provides some clarity. Please let your agreement monitor know if you have any questions.

More Fall-Out from the Pandemic

We have been carefully monitoring the research on the impact of the pandemic on mental health and addictions. The results are not surprising but are extremely concerning. The research below highlights the increase in alcohol use, anxiety, and depression. You should be proud of yourself for your continued success in leading a healthy lifestyle throughout this pandemic. That said, we know that more support and help is going to be needed in the coming months and we are here for you!

- APA survey (February 2021) found: "Nearly 1 in 4 adults (23%) reported drinking more alcohol to cope with their stress." (Source: https://www.apa.org/news/press/releases/2021/03/one-year-pandemic-stress)
- From the Kaiser Family Foundation: "The COVID-19 pandemic and the resulting economic recession have negatively affected many people's mental health and created new barriers for people already suffering from mental illness and substance use disorders. During the pandemic, about 4 in 10 adults in the U.S. have reported symptoms of anxiety or depressive disorder, a share that has been largely consistent, up from one in ten adults who reported these symptoms from January to June 2019 (Figure 1). A KFF Health Tracking Poll from July 2020 also found that many adults are reporting specific negative impacts on their mental health and

(continued on next page)

well-being, such as difficulty sleeping (36%) or eating (32%), increases in alcohol consumption or substance use (12%), and worsening chronic conditions (12%), due to worry and stress over the coronavirus. As the pandemic wears on, ongoing and necessary public health measures expose many people to experiencing situations linked to poor mental health outcomes, such as isolation and job loss." (Source: www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/)

Your Stress Management "Urgency Kit"

There are many techniques for managing stress, but you may only be aware of a few, such as exercising, meditation, journaling, or talking things over with a friend. Experimenting with different ways of managing stress can help you discover a collection of dependable techniques that fit your life and work for you—a personal stress management "urgency kit." Try these quick, "on the fly" stress management techniques to see if they qualify for your kit. 1) Peel an orange. Studies show the smell of citrus can help reduce stress; 2) take a walk in green space; 3) listen to classical music for five minutes; 4) drink black or green tea; 5) try a guided imagery exercise using all five senses; 6) declutter your desk; 7) spend ten minutes in the sun. (Source: DFA Publishing)

Continuing Education

Medical and Behavioral Health Providers: Join us to better serve Veterans and Military Service Members in your community! Oregon Veterans face a higher suicide rate than their civilian peers. Veterans face unique barriers to accessing medical and behavioral healthcare. Many providers, although highly skilled, are unfamiliar with Military culture and the unique needs of Veterans as they pertain to behavioral health, and more specifically, to suicidality.

Military Culture Awareness and Suicide Prevention Training for Providers is a two-day training that addresses in-depth knowledge and skills to bridge this gap between providers and Veterans who seek care.

By educating providers on Veteran and Military-specific language and other cultural cues, as well as providing access to specific suicide prevention and intervention assessments, we hope to improve providers' familiarity with Service Members' needs around mental health and suicide.

Earn up to 12 AMA PRA Category 1 Credits™*
The two-day trainings are **free** and held virtually on **Zoom** between March and May 2021. There are two types of trainings available:

1. Regional trainings where Providers can share local resources and challenges as a cohort
2. Statewide trainings focusing on under-served populations, including Veterans and Military Service Members who are LGBTQ+, Women, and/or Tribal Members. Click **here** for additional information on training dates.

Addictions 2021: May 14-15, 2021 | Live Virtual Program| Register Today
Prior to the COVID-19 pandemic, it was estimated that 22 million Americans suffered from an addiction to alcohol or drugs and approximately 20% of all Americans smoked cigarettes. Early reports suggest these numbers have grown significantly as a result of the pandemic and other national and world events in 2020. The surge of opioid addiction and deaths from overdose are a national crisis.

(continued on next page)

McLean Hospital, the largest psychiatric hospital of Harvard Medical School, is pleased to offer this annual conference bringing together some of the foremost authorities in the addiction field. Topics will include new, evidence-based treatments, the nuances of treating comorbid disorders along with addiction, and special populations. We are honored to have a prestigious and accomplished faculty. Smaller, breakout sessions each afternoon will allow for in-depth exploration of topic areas in an interactive and stimulating format that should enhance learning and skill-building.

Who Should Attend: This course is targeted to Primary Care and Specialty Physicians, Nurses, Nurse Practitioners, Physician Assistants, Psychologists, and Counselors. This course may also be of interest to physicians who practice in Anesthesiology, Emergency Medicine, Family Medicine, Internal Medicine, Lifestyle and Mind-Body Medicine, Pain Medicine, Pediatrics and Adolescent Medicine, Psychiatry, Neurology, and Psychology and Mental Health.

The Harvard Medical School is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

Harvard Medical School designates this course for a maximum of 13.75 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity. **Register Today**

Unique Opportunity: Addiction Medicine Fellowship

The Department of Psychiatry and Health Behavior at the Medical College of Georgia is actively recruiting for Addiction Medicine Fellowship candidates. This is a one-year fellowship. Physicians board eligible in any medical specialty with a minimum of one year of sobriety are eligible to apply. We believe that physicians with both practical work experience and in recovery are an asset to our program in that their experiences add depth to our program and is helpful to trainees right out of residency. If you have a physician in your program that may be considering a career transition, please encourage them to reach out to Tina Hall at 352.665.5104.

SRTA
Southern Regional Testing Agency, Inc.
Modern Assessment for Today's Dental Professional

SRTA EXPANDS TO NEW STATES WITH LIVE- AND MANIKIN-BASED TESTING

Idaho and Oklahoma now accept SRTA exams

The Southern Regional Testing Agency (SRTA) expands to Idaho and Oklahoma, making the agency accepted in 38 states.

The Idaho and Oklahoma state boards have evaluated SRTA's exams, the requirements and the policies and have determined it to meet their standards for evaluating the clinical competencies for dental students.

"SRTA has remained at the forefront of dental licensing for several years, and we're excited to see more of our neighboring states accept SRTA," said President Gerry Walker, DMD. "Our exams are cutting-edge, with modern and advanced technology that allows for us to give a clinically sound assessment of skills," he added.

SRTA offers the traditional live-patient exam as well as the manikin-based exam. SRTA was the first of the five testing agencies to fully develop and test its complete manikin-based exam – which many states have adopted and used since the start of the COVID-19 pandemic.

The manikin-based exam is becoming more widely accepted as the preferred testing methodology because of the leading and evolving technology that accurately and safely evaluates candidates' clinical skill set.

Today, **SRTA's exam results can be used alone or in conjunction with other testing agencies to supplement state licensure requirements**. The state of Washington's emergency ruling removed the requirement that all licensing exam sections be completed with the same testing agency. This ruling allows candidates to take portions of the exam by two separate exam organizations, including SRTA. This ruling is valid through April 7, 2021, where it will then be reevaluated.
Each state differs in its rules and regulations, and it remains up to the candidates to ensure those requirements are fulfilled.

“SRTA prides itself on being responsive and adaptive to the evolving dental practice,” said SRTA Executive Director Jessica Bui. “We are constantly updating and improving our exams and the processes, making us the most modern and approachable agency in the industry.”

Visit srta.org to learn more about its cutting-edge exam, competitive fees, one free sectional retake, and the other programs offered to schools and students to ensure they are well-prepared on exam day. We are the only testing agency that **offers a complimentary mock board** for students, giving them knowledge and confidence on what to expect when taking an exam.

Spring Newsletter

Inside This Issue

On March 17, 2021, the CDCA Board of Directors approved the Texas State Board of Dental Examiners' request to become a member state. Texas is the 37th member of the CDCA.

Letter from the Chairman
Harvey Weingarten, DDS

Dear CDCA Colleagues,

As the winter ends and a new spring welcomes many changes throughout the US and world, the CDCA is in the midst of its fullest exam season yet. It will be a year of milestones, a remarkable reflection of the many concerted efforts of those serving in every facet of our mission. On the heels of an ever-changing exam landscape in 2020, more schools and more candidates than ever will rely on the expertise of members like you at ADEX examinations this year.

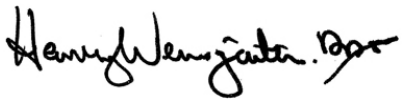
Acceptance of non-patient based ADEX examinations continues to develop. We continue to serve and be available to state dental boards as they determine what is best for their jurisdictions. Our role in communicating to schools and candidates continues with enhanced maps and features on our website and is highlighted further in this newsletter.

These ADEX non-patient examinations, delivered utilizing the state-of-the-art CompeDont™ and specially-developed dental hygiene typodont product, mean CDCA can provide the most thorough, comprehensive evaluations of clinical knowledge, judgment, and psychomotor performance ability with a patient or a simulated patient. And while all ADEX exams include important OSCE examination sections, independent 3rd party, criteria-based testing of hand skills and psychomotor performance remain essential licensure exam components for almost all states and jurisdictions charged with public protection.

I also am proud to acknowledge the team responsible for the development of the innovative new virtual exam calibration platform. This platform will help us not only enable this core practice to be handled safely and consistently wherever CDCA examines, but also helps further our ability to reinforce appropriate examiner decisions and remediate deficiencies as needed while also gathering data to help evaluate trends for learning purposes. My sincere appreciation to Ms. Hannah Vannoy, Dr. Stuart Blumenthal, Dr. Guy Shampaine, Dr. Pete Yaman, Dr. Mark Armstrong, in concert with Dr. Bill Pappas of ADEX's guidance, for their outstanding dedication in development of virtual calibration.

And while we will soon say farewell to Dr. Ellis Hall, a true fixture and asset to CDCA throughout his career, we are proud to welcome new team members to help continue and further his legacy. As a witness to so much of the evolution of examinations, while also never yielding in his pursuit for quality administration, I invite you to follow along, in his words, for a brief retrospective of his career at CDCA.

As always, I look forward to seeing you and working with you at an examination soon.



Farewell & Welcome

The CDCA appreciates the leadership and dedication of its two outgoing Board members. Included are Dr. Daniel Nunley (WV) and Michelle Gallant, RDH (ME), who had respectively served as Dental and Dental Hygiene Members-at-Large. Chairman Dr. Harvey Weingarten recognized each of them at the Virtual General Assembly Meeting on January 9th.

Members elected Dr. David Baasch (VT) pictured left, and Kathleen Gazzola, RDH, MA (RI) pictured right, to serve in these positions for 2021. Read more about them and all sitting board members by clicking here.

Dr. William K. Collins' name is engraved on a plaque inside the conference room bearing his name at Central Office. Collins was a founding father in the early years of the North East Regional Board of Dental Examiners, now known as the CDCA. The "Collins Conference Room" is the largest within the Linthicum facility and was established in 2015.

From the Director of Examinations: A Career in Retrospect

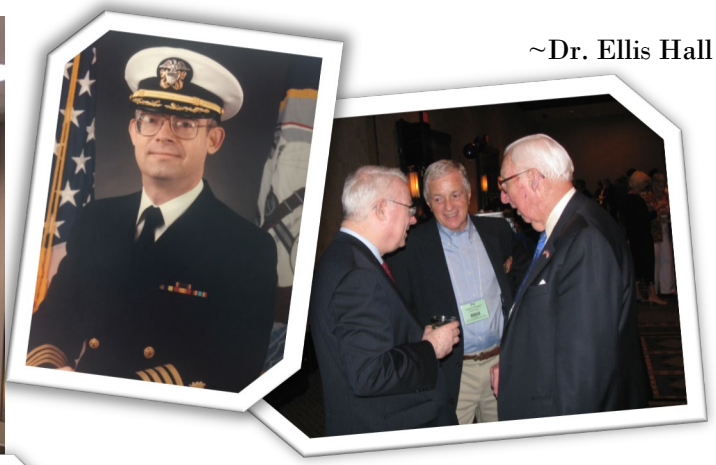
"Twenty-seven years ago, I retired from the Navy Dental Corps and was looking for a second career that perhaps involved giving back to the community and profession. I heard from a friend that NERB was looking for a new Assistant Director of Examinations, but all I knew was NERB was the exam I had taken 20 years prior in dental school. However, I realized that this was a unique opportunity, and I decided to see what it was like. My first job was to create a case-based written examination. Of course, it was all on paper in those days, and I can't tell you how many trips I made to Kinkos for color copies and to the Kodak processing plant in Gaithersburg, Maryland, for hundreds of slides. We loaded 50 or 60 carousels with slides and shipped all the exam materials to sites in large metal boxes.

As you know, there have been many changes since those days. The Central Office moved twice, from DC to Silver Spring, Maryland, and now to Linthicum, Maryland. We have gone from being accepted in 15 states to virtually the whole country plus Puerto Rico and Jamaica and seven employees to more than 20. During this time, I became Director of Examinations, now responsible for the actual examinations and their administration. We went from fill in the bubble Scantron forms and Scantron readers to an electronic grading platform based on hand-held tablets. We switched from on-site written exams with slides to a computer-based exam given at Prometric Testing Centers, and we went from weeks to just a couple of days to release grades. In all, over the last 27 years, we have provided more than 130,000 exams in clinical dentistry, dental hygiene, and dental specialties and revolutionized OSCE examinations.

But the thing that I am most proud of is our examiners. They always came through, whether it was a blizzard, hurricane, power outage, flood, or any number of last-minute emergencies. They have always been willing to make the extra effort, go the additional mile. This last year they have also shown real courage in braving the pandemic to maintain the exam process and graduates' ability to become licensed and move on with their lives. To one and all, I say thank you."

~Dr. Ellis Hall

A glass encased conference room, constructed in Fall 2020 will be named "Hall's Corner," a moniker first afforded a small sitting area near the center of CO's team workstations.



Top left: Dr. Hall in US Navy uniform, ~1990.

Right: Dr. Hall with Dr. Pat DeAngeles (center) and Dr. Charles Cartwright (right), innovator of criteria-based evaluations, at Annual Meeting, 2009.

Left: Dr. Hall (right), Michael Zeder (left) and another staffer ship exam boxes themselves with a U-Haul truck during a shipping strike in 1997.

Innovations in Dental Calibrations

As of February 2, a portion of dental examiner calibrations moved to a virtual platform. CDCA Board of Directors, in concert with ADEX guidance, aimed to enhance examiner and school educators' safety in light of post-COVID protocols while optimizing examiner training for high-stakes licensure exams, including real-time feedback loops.

If you haven't already participated in a dental exam since, here's an overview of what you need to know now and how the move will impact you.

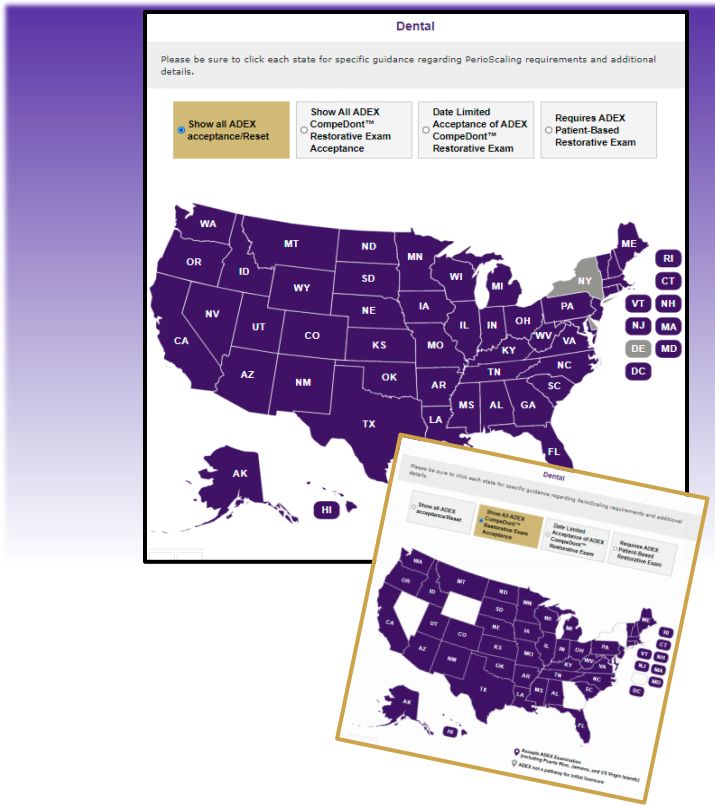
Who will calibrate online?
Chiefs/Captains/CFEs/Examiners for Dental Perio/Restorative examinations. *Development for a similar product in other exam types is in process.*

When will online calibrations take place?
A calibration test will be available to each examiner, on-demand 24/7, seven days before your scheduled exam date. Visit the "My Standardizations" area of your Member Resources profile, complete all standardizations, and click the Calibration Test button if you are within a 7-day window for an upcoming assignment.

What if I do not pass my calibration?
You will be able to take the required calibration test as many times as necessary to achieve the required 75% score. Questions are randomized and may be different each time.

Will examiners still be paid a calibration day honoraria?
Passing this on-demand virtual calibration test before your exam is essential in helping to ensure CDCA meets ADEX quality assurance standards. Passage will trigger CDCA's related $400 calibration day honoraria. CDCA will automatically calculate this payment.

I am a Chiefs/Team Lead. How will I know my team has completed virtual calibrations?
In Member Resources, Look for the Chief/Team Lead Portal button under "My Tools." You will see a list of upcoming exams within seven days. When you click on the upcoming exam button, you'll see two options, Team Discussion Topics and Team Calibration Report. Discussion topics will be generated from items that team members may have missed on the calibration exams. Visit Contact Us with questions.



CDCA ADEX Acceptance Maps Get Upgrade for 2021

The ADEX Acceptance Maps have a fresh look! New grouping technology helps candidates understand limitations and opportunities to consider when scheduling an examination. The maps now serve three functions:

- Click the buttons above each map to show Non-Pt/Patient Restorative acceptance
- When clicking a state, the first level of information in the pop-up shows "Licensure Rule Modifications."
- The second level of information in the pop-up is "General Requirements."

"We are pleased to catalog these details and maintain them as a service for not only candidates and educators but also our members who participate on State Boards. The resource is the most shared and most visited page on our website," said CDCA CEO Alex Vandiver.

Purple ADEX maps first appeared in 2007, the violet hue indicating portability of the ADEX examinations. The maps gained gold dots and interactive state functionality in April 2020 as a visual means of demonstrating acceptance of non-patient exams.

Mid-Year Virtual Steering Committee Meeting
July 22, 2021

Annual Meeting & Educators Conference, 2022
January 6-8, 2022
Gaylord Rockies Resort & Convention Ctr.
Denver, CO

Annual Meeting & Educators Conference, 2023
January 5-7, 2023
Gaylord Texan Resort & Convention Ctr,
Grapevine, TX

And the Winner Is...

Yvette Hogan, RDH, is the 2021 Guy Shampaine Award Honoree. The award recognizes a member for "outstanding efforts on behalf of the CDCA that embody the values of service, dedication, and integrity." Ms. Hogan is the first Dental Hygienist to receive the annual honor first awarded in 2016.

Virtual Conference Meetings Prove Effective for Members, Educators

Educators Conference Overview

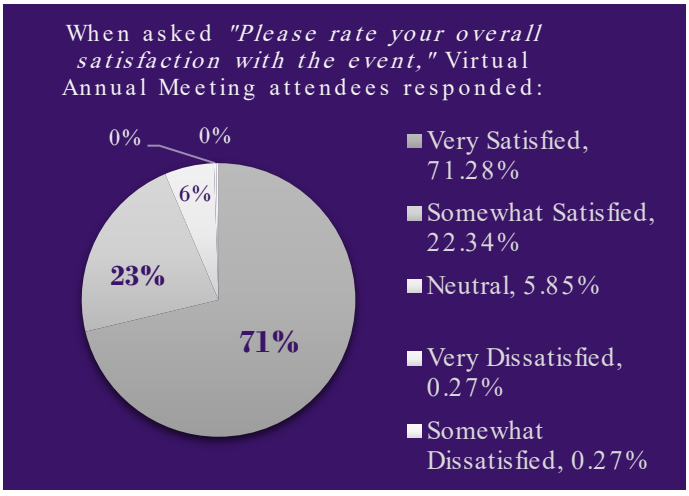
More than 400 educators took part in the Virtual Educators Conference, 2021, with more than a quarter of first-time attendees. Attendees participated in sessions tailored by oral professions and moderated by Mr. Michael Zeder, Sr. Director of Testing Operations and Technical Services (Dental), and Ms. Shayna Overfelt, Director of School Programs with CDCA Advisor Patricia Connolly-Atkins, RDH (Dental Hygiene). The CDCA wishes to thank members who participated in forums helping educators understand the issues facing state boards at this time, including Dr. Ruedi Tillman (UT), Dr. Robert Taylor (AZ), Dr. James Goldsmith (MD), Ms. Christy Jo Fogarty, RDH (MN), Ms. Heather Hardy, RDH (AZ), and Ms. Michelle Carr, RDH (OH).

"With the development of the manikin exam, I appreciated all of the valuable information. Now that I have the knowledge obtained in the Educators Conference, I feel the manikin exam is an equal or potentially better alternative to patient exams. It levels the playing field, and the variables related to the patient are a non-factor." ~ Conference Attendee

"This was well organized as usual. The presentations are detailed, and (the) presenters very knowledgeable. It was also nice to have other faculty with me to hear what only I have heard before. Of course, I miss the travel and in-person collaboration and networking. I am excited about the direction these exams are going." ~ Conference Attendee

CDCA Annual Meeting Overview

Virtual Annual Meeting's series of events took place over four days in January. CDCA sought to provide a beneficial business event for its members incorporating essential functions such as New Member Orientation, the Chairman's State of the CDCA Address, and reports from multiple committees and State Caucus sessions. Members also heard statistical reports on 2020 examinations. The State Boards of 30 jurisdictions took part in a virtual Presidents/VP & Executive Directors event.



Meeting Videos Available On-Demand

The virtual format provided the CDCA with the unique opportunity to provide recordings of selected meeting content. You can access the playlist via Member Resources by clicking on the "Virtual Annual Meeting: View Videos" featured content or clicking CDCA Meetings in the top menu.

Get to Know Kimber Cobb

Kimber Cobb joined the CDCA in January as its National Director, Licensure Acceptance and Portability. As a liaison to State Dental Boards, Kimber will provide and coordinate support for stakeholder needs within the licensure process's evolving landscape for dentists, dental hygienists, and the allied dental health professions.

"I grew up in a dental family, my dad was a dentist, and my mom, myself, and one sister are hygienists."

The mother of four didn't envision dentistry as her career of choice as a child. "I loved the idea of helping animals, especially horses, so I wanted to be a veterinarian. But when I learned more about it, I didn't want to see animals in pain," recalls Cobb.

Cobb grew up in Oklahoma and held fond memories of waterskiing with her dad, an instructor. Absent from the water for years, she tested her ski legs again for a special birthday not so long ago.

"I never imagined I'd slalom again. It was very short-lived, but it was great, something I'll remember."

A Registered Dental Hygienist, Cobb has an extensive licensure and Dental Hygiene Education background in the oral professions. Message her at kcobb@cdcaexams.org.

Read the announcement shared with Executive Directors of State Dental Boards by clicking here.

Wishing you a great 2021 exam season!

New Mask, Apparel Guidance for CDCA Examiners

Central Office mailed masks to members who recently attended the Virtual Annual Meeting. Similar masks are now available for purchase (see below). The masks are not FDA-approved PPE and can only be worn as advised by the Director of Examinations.

Click here to read the advisory statement.

CDCA branded apparel, including traditional dress shirts, scrubs, and masks, is now available on Member Resources. Visit the *Apparel* section under "My References."

The official CDCA Dress Code is also posted for review.

Please note that examiners are not required to wear CDCA apparel at examination sites, nor does CDCA profit from any branded sales from 3rd party vendors on its behalf.

State Spotlight: Arizona

5,181 Dentists, 4,834 Dental Hygienists, and 21 active CDCA Members call Arizona home.

AT Still University, Midwestern University Dental Institute, Mesa Community College, Phoenix College, and Rio Salado College host CDCA ADEX Dental or Dental Hygiene examinations.

Arizona became a CDCA member state in 2017, the same year as Wyoming and Arkansas.

LICENSE RATIFICATION

16 . RATIFICATION OF LICENSES

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

DENTAL HYGIENISTS

H8179	AMY ASH , R.D.H.	2/11/2021
H8180	SOZE JABBARY , R.D.H.	2/11/2021
H8181	KELSEA KUBLI , R.D.H.	2/11/2021
H8182	SAVANNAH FOWLER , R.D.H.	2/11/2021
H8183	KATELYN CLEONE MULDER , R.D.H.	2/11/2021
H8184	COURTNEY CAHILL , R.D.H.	2/11/2021
H8185	KYLA KARA OLIVARES , R.D.H.	3/9/2021
H8186	MARCELA ORTIZ RAMIREZ , R.D.H.	3/9/2021
H8187	JESSICA CHARLOTTE SIPE , R.D.H.	3/9/2021
H8188	SEAN VINCENT VANSOOY , R.D.H.	3/12/2021
H8189	HILARY JANE IMHOF , R.D.H.	3/12/2021
H8190	JASMINE HODGERT , R.D.H.	4/2/2021
H8191	JONI N MCCULLY , R.D.H.	4/2/2021
H8192	SIERRA D BAUER , R.D.H.	4/2/2021
H8193	KELLY SHORT , R.D.H.	4/2/2021
H8194	MCCALL DYCHES LAUCK , R.D.H.	4/2/2021

DENTISTS

D11401	MADELINE R KELLEY , D.D.S.	2/11/2021
D11402	ELDON MATTHEW LAMB , D.D.S.	2/11/2021
D11403	TED A HUGHES , D.M.D.	2/11/2021
D11404	EFREN ALMEIDA , D.M.D.	2/11/2021
D11405	MATTHEW JOHN WILLIAMS , D.D.S.	3/9/2021
D11406	MARK A SCHLAM , D.M.D.	3/9/2021
D11407	PETRINA GEROGIANNI , D.D.S.	3/9/2021
D11408	ZACHARY D GLAUS , D.D.S.	3/9/2021
D11409	SUSAN CHOU , D.M.D.	3/9/2021
D11410	HONGSEOK AN ,	3/12/2021
D11411	RENELLE RENEE CONNER , D.D.S.	4/2/2021
D11412	IAN ROBERT DICKINSON , D.M.D.	4/2/2021
D11413	LEO CHOTI , D.D.S.	4/2/2021
D11414	KATRINA PE LO , D.M.D.	4/2/2021

DENTAL FACULTY

DF0050	PHILLIP THOMAS MARUCHA , D.M.D.	3/9/2021

LICENSE, PERMIT & CERTIFICATION

Request for Approval of a Local Anesthesia Course – University of Florida.

Vada Cook of the University of Florida is requesting that the Board approve the University of Florida's continuing education program for local anesthesia.

Relevant Rules:

OAR 818-035-0040 – Expanded Functions of Dental Hygienists
(1) Upon completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association or other course of instruction approved by the Board, a dental hygienist who completes a Board approved application shall be issued an endorsement to administer local anesthetic agents under the general supervision of a licensed dentist.

NYE Ingrid * OBD

From: Cook,Vada M <VCook@dental.ufl.edu>
Sent: Monday, March 8, 2021 5:34 AM
To: victoriagalanti; NYE Ingrid * OBD
Cc: UF Continuing Dental Education
Subject: RE: Need to send the Oregon Board of Dentistry the syllabus for Local Anesthesia for the Dental Hygienist
Attachments: UFCDE-Local_Anesthesia_Course Curriculum.6 10 20.pdf

Good Morning,

Attached, please find the course syllabus for our “Local Anesthesia for Today’s Dental Auxiliary” program.

If you have any questions or need any additional information, please let me know.

Best,
Vada

From: victoriagalanti <victoriagalanti@gmail.com>
Sent: Sunday, March 7, 2021 2:40 PM
To: Cook,Vada M <VCook@dental.ufl.edu>
Cc: UF Continuing Dental Education <ce@dental.ufl.edu>
Subject: Need to send the Oregon Board of Dentistry the syllabus for Local Anesthesia for the Dental Hygienist

[External Email]
HI Vada,
I was given your email address from Lori. She told me you were the person who can facilitate my request

I took The 60 contact hour CE course: Local Anesthesia for the Dental Hygienist"
I need the syllabus and all the course details send to the following email address

ingrid.nye@oregondentistry.org
She handles Licensure for the state and is a very kind person.
She stated the board will vote on it in April so time is of the essence for me

The Board will be looking to see if they can accept your course to get a Local Anesthesia License in Oregon

I am almost certain your course exceeds what is required

Due to Covid there are no courses here in Oregon given as a CE at the moment
They have had it in the actual dental hygiene curriculum for years

My daughter is ill and I had to move to Oregon
I have a license to practice here but no LA so its been prohibitive at best

Thank you in Advance
If you would be so kind , please send me an email that you received my request .
Victoria Galanti

NYE Ingrid * OBD

From: victoriagalanti <victoriagalanti@gmail.com>
Sent: Monday, March 8, 2021 8:05 AM
To: NYE Ingrid * OBD
Subject: Fwd: Need to send the Oregon Board of Dentistry the syllabus for Local Anesthesia for the Dental Hygienist
Attachments: UFCDE-Local_Anesthesia_Course Curriculum.6 10 20.pdf

Hi Ingrid
We spoke about the board reviewing the Local Anesthesia course that I took to see if it is acceptable for the State of Oregon's requirements
Please see attachment for the information for the Local Anesthesia course from the University of Gainesville continuing education Dept
Thank you
Victoria Galanti

---------- Forwarded message ---------
From: **Cook,Vada M** <VCook@dental.ufl.edu>
Date: Mon, Mar 8, 2021 at 5:33 AM
Subject: RE: Need to send the Oregon Board of Dentistry the syllabus for Local Anesthesia for the Dental Hygienist
To: victoriagalanti <victoriagalanti@gmail.com>, ingrid.nye@oregondentistry.org <ingrid.nye@oregondentistry.org>
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My daughter is ill and I had to move to Oregon

I have a license to practice here but no LA so its been prohibitive at best

Thank you in Advance

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Victoria Galanti

LOCAL ANESTHESIA TRAINING FOR TODAY'S DENTAL HYGIENISTS

Curriculum

Local Anesthesia for Dental Hygienists

CEUs: 60 contact hours. Participation

- 30 hr. didactic (5 hr. live and 25 hr. web-based and self-instruction)
- 30 hr. clinical (15 hr. live and 15 hr. observational)

Program Format – due to the nature of the program registrations will close two weeks prior to the course.

** Must attend the live weekend session, pass the written examination and finish all web-based, self-instruction and observational criteria to complete the program.*

- Live Weekend: Hands-on Participation Schedule
  - Friday 5 hr. didactic 1 pm – 6 pm
  - Saturday 7.5 hours clinical 8 am – 5 pm Networking Lunch
  - Sunday 7.5 hours clinical 8 am – 5 pm Networking Lunch

Course Fee: Lunch included

- Regular $1,449
- Early Bird $1,299 (Up to 1 month before course date)

Required Textbook (not included in fee) Local Anesthesia For Dental Professionals by Bassett, Di Marco and Naughton

Course Dates:
September 25-27, 2020
January 22-24, 2021
June 4-6, 2021
September 10-12, 2021

Location:
UF College of Dentistry
1395 Center Dr.
Gainesville, FL 32610

Register online at Local Anesthesia for Today's Dental Hygienist: Certification Training

For more information contact:

Continuing Dental Education Office
(352) 273-8480
ce@dental.ufl.edu

University of Florida College of Dentistry Curriculum:

Local Anesthesia Training for Dental Hygienists

Table of Contents:

Statute 466.017 (SB 1040)

(5) A dental hygienist under the direct supervision of a dentist may administer local anesthesia, including intraoral block anesthesia, soft tissue infiltration anesthesia, or both, to a nonsedated patient who is 18 years of age or older, if the following criteria are met:
(a) The dental hygienist has successfully completed a course in the administration of local anesthesia which is offered by a dental or dental hygiene program accredited by the Commission on Dental Accreditation of the American Dental Association or approved by the board. The course must include a minimum of 30 hours of didactic instruction and 30 hours of clinical experience, and instruction in:

1. Theory of pain control
2. Selection-of-pain-control modalities.
3. Anatomy.
4. Neurophysiology.
5. Pharmacology of local anesthetics.
6. Pharmacology of vasoconstrictors.
7. Psychological aspects of pain control.
8. Systematic complications.
9. Techniques of maxillary anesthesia.
10. Techniques of mandibular anesthesia.
11. Infection control.
12. Medical emergencies involving local anesthesia

(b) The dental hygienist presents evidence of current certification in basic or advanced cardiac life support. (c) The dental hygienist possesses a valid certificate issued under subsection (6).
(6) Any dental hygienist seeking a certificate to administer local anesthesia must apply to the department, remit an application fee, and submit proof of successful completion of a course in the administration of local anesthesia pursuant to subsection (5). The board shall certify, and the department shall issue a certificate to, any dental hygienist who fulfills the qualifications of subsection (5). The board shall establish a one-time application fee not to exceed $35. The certificate is not subject to renewal but is part of the dental hygienist's permanent record and must be prominently displayed at the location where the dental hygienist is authorized to administer local anesthesia.
The board shall adopt rules necessary to administer subsection (5) and this subsection.

Faculty

Dr. Samuel B Low Course Director, Department of Periodontics

Course Description:

Today's dental hygienist must be knowledgeable in all aspects of the hygiene profession including providing local anesthesia administration to provide comfort to the dental patient. Presented by the *ADA CERP recognized University of Florida Office of Continuing Dental Education and utilizing University of Florida faculty, this course provides the participant with the mechanics to create a positive patient environment with competent pain and anxiety management.

All aspects of local anesthesia are explored from pharmacology to anatomy and managing all dental patients requiring local anesthesia. Special emphasis is placed on administering anesthesia to a periodontal patient. Practice management aspects are provided with "pearls" to utilize quality local anesthesia

administration by the dental hygienist as a practice builder involving today's demanding patient.

As with any hands-on training course, the participant should realize that competency, and ultimately proficiency, in the administration of local anesthesia requires repeated administration and periodic self-reeducation.

***ADA CERP Recognized Provider**

Only providers that can meet ADA CERP standards and procedures are granted approval and are authorized to use the ADA CERP logo and recognition statement. Once approved, providers are held accountable for maintaining those same high standards through periodic reevaluation.

Pre-Requisites:

- Read and study textbook (listed under Required Materials) and Course Curriculum Guide
- Complete all online course assignments
- Complete online Bloodborne pathogen training
- Complete UFCD medical history and RX form (All participants are expected to practice as both a patient and an operator)
- Copy of completed UF HIPAA and Confidentiality Statement
- Copy of current license
- Copy of current CPR
- Copy of HepB verification

Course Goals:

The goals of this class are to assist the dental hygienist to become:

1) Knowledgeable in the use and administration of local anesthetics

2) Knowledgeable in the pharmacology, neurophysiology, neurochemistry and anatomy related to the administration of local anesthetics

3) Knowledgeable and competent in the physical and psychological evaluation of the patient prior to receiving local anesthetic or dental treatment

4) Knowledgeable in the side effects, complications and the management of those problems associated with local anesthetics

Course Objectives:

At the conclusion of the course, the participant will be trained in:

A. Scope of pain and anxiety control
1. Discuss the differences between the types of sedation / anesthesia
2. Discuss the pros and cons of each method of sedation / anesthesia
3. Describe the risks and benefits of each method of sedation / anesthesia
4. Summarize the requirements of state law regarding the administration of local anesthesia

5. Discuss the legal ramifications of administration of local anesthesia

B. Neurophysiology
1. Discuss the desirable properties of local anesthetics
2. Discuss the fundamentals of impulse generation and transmission
3. Discuss the mode and site of action of local anesthetics

C. Pharmacology of local anesthetics and vasoconstrictors
1. Discuss the pharmacokinetics of local anesthetics, including uptake, distribution, metabolism, and excretion
2. Discuss the systemic actions of local anesthetics on the following:
   a. Central nervous system
   b. Cardiovascular system
   c. Respiratory system
   d. Other miscellaneous actions
3. Describe the indications for using a vasoconstrictor in a local anesthetic solution. Consider the following:
   a. Mechanism of action
   b. Metabolism
   c. Maximum dosage
   d. Toxic effects
   e. Contraindications
4. Discuss the following information for lidocaine, mepivacaine and bupivacaine:
   a. Type of anesthetic, ester or amide
   b. Brand name(s)
   c. Onset and duration of action
   d. Metabolism, including uptake, redistribution, inactivation, and excretion
   e. Common concentrations used in dentistry
   f. Maximum dosage
5. Name the two general categories of topical anesthetics. Discuss benzocaine, lidocaine, and tetracaine topical anesthetics
6. Calculate the amount of anesthetic and vasoconstrictor contained in the various types of anesthetic solutions

D. A rmamentarium
1. Identify the components of the breech-loading aspirating syringes, needles, and carpules
2. Identify the problems that can occur with the syringes, needles and carpules
3. Discuss the component chemicals contained within the cartridge and their function
4. Recognize when local anesthetic is no longer safe to administer
5. Special consideration in patient with latex allergy

E. Physical and psychological evaluation
1. Discuss the evaluation of the patient prior to administration of local anesthesia or sedation, including the following:
   a. Medical history
   b. Physical evaluation
   c. Psychological evaluation
2. Recognition of signs and symptoms of anxiety

3. List the ASA classification
4. Demonstrate how to monitor the central nervous system, respiratory system and cardiovascular system for adverse reactions

F. Anatomic considerations, clinical application and supplemental injection techniques
1. Discuss the following types of administration of anesthetic:
   a. Maxillary anesthesia
   b. Mandibular anesthesia
   c. Gow-Gates
   d. Akinosi
   e. PDL
   f. Interosseous
   g. Electronic
   h. Controlled delivery devices

G. Local and systemic complications
1. Discuss the causes, problems, prevention and management of the following local complications:
   a. Needle breakage
   b. Pain on injection
   c. Persistent anesthesia: paresthesia
   d. Trismus
   e. Hematoma
   f. Infection
   g. Tissue sloughing
   i. Lip chewing
   j. Facial nerve paralysis
   k. Intravascular injection
2. Discuss the causes, problems, prevention and management of the following systemic complications:
   a. Local anesthetic overdose
   b. Epinephrine overdose
   c. Allergy
   d. Idiosyncratic reaction
   e. Side effects

Evaluation:

Cognitive Assessment: Students will be evaluated by a final written examination

Laboratory Preparation:

Review: Injection Videos in the document section, prior to your lab session.
- Read and study textbook (listed under Required Materials) and Course Curriculum Guide
- Complete all online course assignments

Learn and perform the following injection techniques on manikins and/or live patients:

a. ASA
b. MSA
c. PSA
d. Greater palatine
e. Infraorbital
f. Inferior alveolar
g. Lingual
h. Long buccal

Clinical Assessment: Demonstrate the proper injection technique for the assigned anesthesia assessment

Grade Weights:
Cumulative Final: 75%
Lab activities: S=Satisfactory

Remediation for this course will consist of a written assignment and then an oral examination with the course director. Students not receiving a "satisfactory" in the didactic or clinical session must remediate by participating in a remediation clinical session.

UF CDE curriculum:

Formal Training:

30 hr. Didactic (5 hr. live and 25 hr. web-based and self-instruction)

4 hrs. **Emergency Medical Procedures**

- Online "Treatment of Medical Emergencies"

A. Monitoring Vital Signs
B. Emergency Equipment and Preparedness
C. Recognition of Common Medical Emergencies and Treatment
D. Chest Pain /Cardiac Arrest
E. Allergy and Anaphylaxis
F. Hypotension
G. Syncopy
H. Basic Life Support
I. Seizure Management

2 hrs. **Scope of pain and anxiety control**

A. Discuss the differences between the types of sedation/anesthesia
B. Discuss the pros and cons of each method of sedation/anesthesia
C. Describe the risks and benefits of each method of sedation/anesthesia
D. Summarize the requirements of state law regarding the administration of local anesthesia
E. Discuss the legal ramifications of administration of local anesthesia

3 hrs. **Medical Assessment of Patient**

A. Medical History
B. Review of Systems
C. Pulmonary Evaluation
D. Cardiovascular Evaluation
E. Performing and Interpretation of Vital Signs
F. ASA Classification

G. Case-based Learning Session

3 hrs. **Management of Pain and Anxiety**

A. Physical and Psychological Evaluation
B. Non-pharmacologic reduction of pain and anxiety
C. Neurophysiology
D. Evaluation of Anesthetic Choice
E. Analgesic Agents – Topical Anesthetics

2 hrs. **Head and Neck Anatomy**

A. Muscles of Mastication
B. Muscles of Facial Expression
C. Facial Spaces
D. Trigeminal Nerve and Associated Vasculature

2 hrs. **Pharmacology of Local Anesthesia**

A. Mechanism of Action
B. Classification
C. Metabolism
D. Recommended and Maximum Doses
E. Drug Interactions and Side effects

2 hrs. **Pharmacology of Vasoconstrictors**

A. Mechanism of Action
B. Use with Local Anesthetics
C. Specific Agents
D. Toxicity
E. Recommended and Maximum Dosages
F. Contraindications

2 hrs. **Armamentarium–infection control**

A. The Syringe
B. The Needle
C. The Cartridge
D. Preparation of Armamentarium

8 hrs. **Techniques of Local Anesthesia**

A. Techniques of Maxillary Anesthesia
B. Techniques of Mandibular Anesthesia
    1. Basic Injection Techniques
    2. Anatomical Considerations
C. Manikin Practice Demonstration of:
    1. Infiltrations in Maxilla and Mandible
    2. Mandibular Nerve Block
    3. Mental Nerve Block
    4. Long Buccal Nerve Block
D. Manikin Practical
E. Local Anesthesia Considerations
F. Case-based Seminar

2 hrs. **Complications and Legal Considerations**

A. Local Complications
B. Systemic Complications
C. Legal Considerations

Written Examination

30 hr. Clinical Experience

The clinical course hours will be as follows:

1. 15 hours in the University of Florida dental clinics providing local anesthesia consisting of documentation for all maxillary and mandibular techniques (will include a practical examination to evaluate competency.)
2. 15 hours observing either in an educational institution or with a respective employer. (All observable procedures will be documented including technique, patient observations, and management.)

Clinical Assessment

Required Material:

***Required Textbook (not included in fee) Local Anesthesia for Dental Professionals**
By Bassett, Di Marco and Naughton

- Suggested vendors for purchasing textbook:
  Amazon.com
  Prentice Hall

Required Videos: (Online)

- University of Florida didactic local anesthesia videos
- Mandibular Anesthesia: Increasing the Success of Injection Techniques, Astra. (11 Videos; 23 minutes)
- Maxillary Anesthesia: Increasing the Success of Injection Techniques, Astra. (9 videos; 24 minutes)

Course hours per required areas of study:

2hrs D	1. Theory of pain control
2hrs D	2. Selection-of-pain-control modalities
2hrs D	3. Anatomy
2hrs D	4. Neurophysiology
2hrs D	5. Pharmacology of local anesthetics
2hrs D	6. Pharmacology of vasoconstrictors
2hrs D	7. Psychological aspects of pain control
2hrs D	8. Systematic complications
4hrs D/15hrs C	9. Techniques of maxillary anesthesia
4hrs D/15hrs C	10. Techniques of mandibular anesthesia
2hrs D	11. Infection control
4hrs D	12. Medical emergencies involving local anesthesia

Total: 30 hours Didactic and 30 hours Clinical