PUBLIC PACKET

OREGON BOARD OF DENTISTRY

BOARD MEETING
APRIL 26, 2024

Oregon
Tina Kotek, Governor

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

NOTICE OF REGULAR MEETING

PLACE: **BOARD OFFICE & VIRTUAL VIA ZOOM**

DATE: **April 26, 2024**

TIME: **8:00 a.m. – 3:30 p.m.**

Call to Order – Chip Dunn, President **8:00 a.m.**

OPEN SESSION (Zoom option available)
https://us02web.zoom.us/j/87554653197?pwd=c2pkZXZUTzNmbmUxbXR2S1QxcUFGUT09
Dial-In Phone #: 1-253-215-8782 ● Meeting ID: 875 5465 3197 ● Passcode: 352592

Review Agenda

1. Approval of February 23, 2024 Board Meeting Minutes

NEW BUSINESS

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

3. Committee and Liaison Reports
   - Director Prisby Email to Associations
   - Draft DAWSAC Meeting Minutes – 2.23.2024
   - Dr. Sheena Kansal served as a Dental Examiner in January and will share her experience

4 Executive Director's Report
   - Board Member and Staff Updates
   - OBD Budget Status Report
   - OBD 2025-2027 Budget – Revenue Projections
   - OBD 2025-2027 Budget Development Overview
   - Customer Service Survey
   - 2024 Dental License Renewal
   - Board and Staff Speaking Engagements
   - AADB & AADA Mid-Year Meetings
   - Tribal Summit
   - 2025 Proposed Board Meeting Dates
   - Newsletter

5. Unfinished Business and Rules
   - Memo - SOS Filing – 11 rule changes effective May 1, 2024

6. Correspondence
   - Dr. Spaniel: Rule Change Request regarding HPSP – brought back from Feb board meeting for further discussion
   - HPSP year end reports

Notes:
(1) 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.
(2) 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.

- Questions for the Oregon Board of Dentistry from Dr. Gary Marks Screening Dental X-rays
- 2012 FDA & ADA Dental Radiographic Examinations: Recommendations For Patient Selection and Limiting Radiation Exposure
- Updated Clarification on Radiographs

7. Other
   - Oregon Wellness Program – MOA
   - Oregon Wellness Program Annual Reports
   - Oregon Government Ethics Commission Update & HB 4117 (2024)
   - Memo – Election of OBD Officers
   - Tribes – Open Comment Period
   - Open Public Comment - Public comment is limited to matters on the public meeting agenda or otherwise relevant to matters that may come before the OBD. Comments will not be allowed that are longer than the time allotted by the President or are disruptive to the agency's conduct of its business.

8. Articles & Newsletters (No Action Necessary)
   - DANB Workgroup on Model Rules

Recognition for outgoing OBD President, Chip Dunn

EXECUTIVE SESSION **9:30 a.m.**

The Board will meet in Executive Session pursuant to ORS 192.345(4); ORS 192.660(2)(f)(h) and (I); 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

OPEN SESSION (Zoom option available) **3:00 p.m.**

https://us02web.zoom.us/j/87554653197?pwd=c2pkZXZUTzNmbmUxbXR2S1QxcUFGUT09

Dial-In Phone #: 1-253-215-8782 ● Meeting ID: 875 5465 3197 ● Passcode: 352592

Enforcement Actions (vote on cases reviewed in Executive Session)

LICENSURE AND EXAMINATION

16. Ratification of Licenses Issued
17. License and Examination Issues

ADJOURN **3:30 p.m.**

Notes:
(1) 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.
(2) 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

OREGON BOARD OF DENTISTRY
MINUTES
FEBRUARY 23, 2024

MEMBERS PRESENT:	Chip Dunn, President Jennifer Brixey, Vice President Alicia Riedman, R.D.H., E.P.P. Reza Sharifi, D.M.D. Jose Javier, D.D.S. Terrence Clark, D.M.D. Sharity Ludwig, R.D.H., E.P.P. Michelle Aldrich, D.M.D.
STAFF PRESENT:	Stephen Prisby, Executive Director Angela Smorra, D.M.D., Dental Director/ Chief Investigator Winthrop "Bernie" Carter, D.D.S., Dental Investigator Haley Robinson, Office Manager Kathleen McNeal, Office Specialist Shane Rubio, Investigator
ALSO PRESENT:	Lori Lindley, Sr. Assistant Attorney General
VISITORS PRESENT: VIA TELECONFERENCE*:	Mary Harrison, Oregon Dental Assistants Association; Ginny Jorgensen, Oregon Dental Assistants Association; Olesya Salathe, D.M.D., Oregon Dental Association (ODA); Brett Hamilton, ODA; Karen Hall, Oregon Dental Hygienist Association (ODHA); Katherine Landsberg, Dental Assisting National Board (DANB); Tony Garcia, DANB; Janelle Peterson, Colin Taggart, D.M.D., Julie Spaniel, D.D.S., Jon McElfresh, Bill Pfunder, Krisen Simmons, Jessica August, Kimberly Perlot

*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 9:16 a.m.

President Chip Dunn welcomed everyone to the meeting and had the Board Members, Lori Lindley, and Stephen Prisby introduce themselves.

NEW BUSINESS

Approval of December 15, 2023 Minutes

Dr. Sharifi moved and Dr. Javier seconded that the Board approve the minutes from the December 15, 2023 Board Meeting as amended. The motion passed unanimously.

Approval of February 9, 2024 Minutes

Dr. Sharifi moved and Ms. Riedman seconded that the Board approve the minutes from the February 9, 2024 Board Meeting as presented. The motion passed unanimously.

ASSOCIATION REPORTS

Oregon Dental Association (ODA)

Brett Hamilton, Director of Government Affairs reported that he and Dr. Taylor toured PCC and were working on recruiting and exploring their relationship together moving forward. The ODA was involved with the licensure compacts as well as legislature surrounding these issues. Mr. Hamilton encouraged everyone to read the December and February issues of JADA because there were great articles regarding guidelines and prescribing opioids for acute dental pain.

Oregon Dental Hygienists' Association (ODHA)

The ODHA congratulated Alicia Riedman upon completing her service as a member of the Oregon Board of Dentistry after almost 9 years on the Board.

The ODHA thanked the Oregon Dental Association for inviting our leadership to participate in their January 26 meeting that included a DDH Compact presentation from the Council of State Governments.

Two new dental hygiene education programs would be opening in Oregon this year. Concorde Career College in northeast Portland was granted initial accreditation status from CODA. Rogue Community College in southern Oregon hosted an accreditation site visit in January 2024 and they are waiting for their preliminary report from CODA.

As always, ODHA is excited to partner with the Oregon Dental Conference in April. They will have an exhibit table throughout the conference and will host an All-RDH Event April 6 from 11-12:30 with a motivational speaker presentation.

Lastly, the OREGON DENTAL HYGIENE CONFERENCE sponsored by the Oregon Dental Hygienists' Association conference is scheduled Nov 1 & 2 at the Salem Conference Center and they were excited about the speakers they have already engaged.

Oregon Dental Assistants Association (ODAA)

Mary Harrison reported that Dental Assistants Recognition Week is the first week of March. The ODAA will be at the Oregon Dental Conference, in addition to hosting a luncheon. Ms. Harrison also pointed to oregondentalassistants.com for resources regarding dental assistants in Oregon.

COMMITTEE AND LIAISON REPORTS

The OHA's Jill Boyd & Bill Pfunder presented information on the Health Care Provider Incentive Program and shared information on it. A slide deck was included in the meeting packet.

EXECUTIVE DIRECTOR'S REPORT

Board Member & Staff Updates

Mr. Prisby announced that Jennifer Brixey has indicated she will not seek another term on the OBD. She joined the Board on September 28, 2018 for a partial first term, and the current term ends on April 6, 2024. OBD staff appreciate and thanked Ms. Brixey for her service and support on the Board. Her lived experience, tribal background and consumer's point of view has been very valuable in OBD discussions and decisions.

Mr. Prisby reported that Dr. Jose Javier's service on the Board will conclude on April 1, 2024. He will have completed two full terms of service, initially joining the Board on June 1, 2016. OBD staff appreciate and thanked Dr. Javier for his service and support on the Board. His clinical experience in private practice, dental director of a FQHC and insight has been very valuable in OBD discussions and decisions.

Mr. Prisby announced that Alicia Riedman's, RDH, service on the Board will conclude on March 31, 2024. She first joined the Board on April 1, 2015 for a partial first term. She will have one of the longest service records of any board member (based on recent records), with almost 9 years of service on the Board. OBD staff appreciate and thanked Ms. Riedman for her years of service and support on the Board. Her FQHC dental outreach program experience, compassion for oral health care in children and long tenure on the Board has been very valuable in OBD discussions and decisions.

Mr. Prisby reflected that throughout their time on the Board they served as OBD President or Vice President at one time and chaired various OBD Committees. They committed their time and attention to regular board meetings, special board meetings, committee meetings, rulemaking hearings, workgroups, two Strategic Planning Sessions and helped steer the OBD through the most recent worldwide pandemic. Their replacements are going through the confirmation process (when this report was written) and we anticipate welcoming the three new board members at the April 26, 2024 Board Meeting.

Mr. Prisby discussed OBD Board Member assignments in upcoming year. Two of the professional Board Members serve as our Evaluators. They review the investigative case reports approximately 2 weeks before a board meeting with our attorney and investigators. In April when the Board elects a new President, the Evaluators would also transition as well.

Mr. Prisby reported that Dr. Michelle Aldrich, Dr. Terrence Clark and Sharity Ludwig, RDH joined the Board on the same day (June 10, 2022). One needs to fill the Junior Evaluator position for the Board from May 2024 to April 2025. During that time period, Dr. Sheena Kansal will serve as the Senior Evaluator for the Board.

Dr. Michelle Aldrich will assume the junior evaluator role from May 2024 – April 2025.

Mr. Prisby announced that the OBD welcomed back Shane Rubio to the Investigator position on January 16, 2024. He left the OBD in June 2023 to pursue another opportunity.

Mr. Prisby recognized Dr. Bernie Carter for five years of service with the OBD on February 1st. Dr. Carter previously served as our Dental Director/Chief Investigator, and is now working part time as the dental investigator.

Mr. Prisby reported that the OBD Licensing Manager, Samantha Plumlee's last day was February 16, 2024. She joined the OBD in March 2018 and made a positive impact on administrative work and served as licensing manager for the last 3 years. She was also a great resource for many OBD meetings, presentations and production of OBD Newsletters. The open position will be posted on the state's employment website and we will follow the state's rules and policies to recruit and hire her replacement.

OBD Budget Status Report

Mr. Prisby reported the latest budget report for the 2023 - 2025 Biennium. The report, which is from July 1, 2023 through, December 31, 2023 showed revenue of $912,506.27 and expenditures of $901,789.81.

Customer Service Survey

Mr. Prisby reviewed the survey results from July 1, 2023 – January 31, 2024. The results of the survey show that the OBD continued to receive positive ratings from the majority of those that submit a survey.

2024 Dental License Renewal

Mr. Prisby reported that the 2024 dental license renewal began in late January and will conclude on March 31 for those Oregon dentists whose license expires in 2024.

Board and Staff Speaking Engagements

Mr. Prisby stated that Samantha Plumlee gave a License Application virtual presentation to the graduating Dental Hygiene Students at OIT in Salem on Monday, February 5, 2024.

Mr. Prisby reported that Dr. Angela Smorra attended Sunset Oral Surgery Study Club in Portland on Thursday, February 8, 2024. She briefly reviewed pathways dental professionals have to become instructors for Radiological Proficiency, Pit & Fissure Sealants, Placing Subgingival Materials, or Soft Relines.

2024 Legislative Session & LC 98/HB 4071

Mr. Prisby stated that the 2024 Legislative Session began on February 5, 2024. LC 98 was circulated a few weeks ago and feedback was requested on it. It later in the session morphed into HB 4071 with many amendments and the versions was discussed. Other bills were referenced that have minimal impact on the OBD.

American Association of Dental Boards Mid-Year Meeting

Mr. Prisby reported that the AADB Mid-Year Meeting is scheduled for April 11 – 12, 2024 in Rosemont, Illinois. Any Board Members interested in attending should confirm with him so he could assist with logistics and approve travel authorization. Mr. Prisby would like to attend the meeting and asked for the Board to approve his request to attend it this spring.

Approval of Stephen Prisby Travel to AADB Mid-Year Meeting

Ms. Riedman moved and Dr. Javier seconded that the Board approve Mr. Prisby's travel to the AADB Mid-Year Meeting in Rosemont, Illinois. The motion passed unanimously.

Newsletter

Mr. Prisby announced that the OBD would produce a late spring newsletter with updates on new board members, rule changes, the Oregon Wellness Program and other important news for Licensees.

UNFINISHED BUSINESS AND RULES

Mr. Prisby reported that the Permanent Administrative Order for changes to Rule 818-001-0087 Fees, showed that the rule becomes effective on January 1, 2024.

The public packet for the OBD Public Rule Making Hearing that took place December 15, 2023 1 pm – 1 30 pm was included with the 11 recommended rule changes. It was noted that comments and feedback were open through January 19, 2024. No comments were received.

Approval of 11 Rule Changes

Dr. Clark moved and Dr. Sharifi seconded that the Board approve the 11 rule changes as presented to be effective May 1, 2024. The motion passed unanimously.

818-012-0005
Scope of Practice

(1) No dentist may perform any of the procedures listed below:
(a) Rhinoplasty;
(b) Blepharoplasty;
(c) Rhytidectomy;
(d) Submental liposuction;
(e) Laser resurfacing;
(f) Browlift, either open or endoscopic technique;
(g) Platysmal muscle plication;
(h) Otoplasty;
(i) Dermabrasion;
(j) Hair transplantation, not as an isolated procedure for male pattern baldness; and
(k) Harvesting bone extra orally for dental procedures, including oral and maxillofacial procedures.
(2) Unless the dentist:
(a) Has successfully completed a residency in Oral and Maxillofacial Surgery accredited by the American Dental Association, Commission on Dental Accreditation (CODA), or
(b) Holds privileges either:
(A) Issued by a credentialing committee of a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to perform these procedures in a hospital setting; or
(B) Issued by a credentialing committee for an ambulatory surgical center licensed by the State of Oregon and accredited by either the JCAHO or the Accreditation Association for Ambulatory Health Care (AAAHC).
(3) A dentist may utilize Botulinum Toxin Type A to treat conditions that are within the oral and maxillofacial region after completing a minimum of 10 hours in a hands on clinical course(s), in Botulinum Toxin Type A, and the provider is approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) or by the American Dental Association Continuing Education Recognition Program (ADA CERP). Alternatively, a dentist may meet the requirements of subsection (3) by successfully completing training in Botulinum Toxin Type A as part of a CODA accredited program.

(4) A dentist may utilize dermal fillers to treat conditions that are within the oral and maxillofacial region after completing a minimum of 10 hours in a hands on clinical course(s), in dermal fillers, and the provider is approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) or by the American Dental Association Continuing Education Recognition Program (ADA CERP). Alternatively, a dentist may meet the requirements of subsection (4) by successfully completing training in dermal fillers as part of a CODA accredited program.
(5) A dentist may place ~~endosseous~~ **dental** implants to replace natural teeth after completing a minimum of 56 hours of hands on clinical **dental implant** course(s), which includes treatment planning, appropriate case selection, potential complications and the surgical placement of the implants under direct supervision, and the provider is a Commission on Dental Accreditation (CODA) accredited ~~graduate~~ **postdoctoral** dental education program, or a provider that has been approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) or by the American Dental Association Continuing Education Recognition Program (ADA CERP).
(6) A dentist placing ~~endosseous~~ **dental** implants must complete at least seven (7) hours of continuing education related to the placement and or restoration of dental implants every licensure renewal period. (Effective January 1, 2024).

818-021-0060
Continuing Education — Dentists
(1) Each dentist must complete 40 hours of continuing education every two years. Continuing education (C.E.) must be directly related to clinical patient care or the practice of dental public health.
(2) Dentists must maintain records of successful completion of continuing education for at least four licensure years consistent with the licensee's licensure cycle. (A licensure year for dentists is April 1 through March 31.) The licensee, upon request by the Board, shall provide proof of successful completion of continuing education courses.
(3) Continuing education includes:
(a) Attendance at lectures, dental study groups, college post-graduate courses, or scientific sessions at conventions.
(b) Research, graduate study, teaching or preparation and presentation of scientific sessions. No more than 12 hours may be in teaching or scientific sessions. (Scientific sessions are defined as scientific presentations, table clinics, poster sessions and lectures.)
(c) Correspondence courses, videotapes, distance learning courses or similar self-study course, provided that the course provides a certificate of completion to the dentist. The certificate of completion should list the dentist’s name, course title, course completion date, course provider name, and continuing education hours completed.
(d) Continuing education credit can be given for volunteer pro bono dental services provided in the state of Oregon; community oral health instruction at a public health facility located in the state of Oregon; authorship of a publication, book, chapter of a book, article or paper published in a professional journal; participation on a state dental board, peer review, or quality of care review procedures; successful completion of the National Board Dental Examinations taken after initial licensure; a recognized specialty examination taken after initial licensure; or test development for clinical dental, dental hygiene or specialty examinations. No more than 6 hours of credit may be in these areas.
(4) At least three hours of continuing education must be related to medical emergencies in a dental office. No more than four hours of Practice Management and Patient Relations may be counted toward the C.E. requirement in any renewal period.

(5) At each renewal, all dentists licensed by the Oregon Board of Dentistry will complete a one-hour pain management course specific to Oregon provided by the Pain Management Commission of the Oregon Health Authority (Effective July 1, 2022).
(6) At least two (2) hours of continuing education must be related to infection control.
(7) At least two (2) hours of continuing education must be related to cultural competency (Effective January 1, 2021).
(8) A dentist placing ~~endosseous~~ **dental** implants must complete at least seven (7) hours of continuing education related to the placement **and/or restoration** of dental implants every licensure renewal period (Effective January 1, 2024).

OAR 818-026-0010
Definitions
As used in these rules:
(1) "Anesthesia Monitor" means a person trained in monitoring patients under sedation and capable of assisting with procedures, problems and emergency incidents that may occur as a result of the sedation or secondary to an unexpected medical complication.
(2) "Anxiolysis" means the diminution or elimination of anxiety.
(3) “General Anesthesia” means a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.
(4) “Deep Sedation” means a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.
(5) “Moderate Sedation” means a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.
(6) “Minimal Sedation” means minimally depressed level of consciousness, produced by non-intravenous **and/or non-intramuscular** pharmacological methods, that retains the patient’s ability to independently and continuously maintain an airway and respond normally to tactile stimulation and verbal command. When the intent is minimal sedation for adults, the appropriate initial dosing of a single non-intravenous **and/or non-intramuscular** pharmacological method is no more than the maximum recommended dose (MRD) of a drug that can be prescribed for unmonitored home use. Nitrous oxide/oxygen may be used in combination with a single non-intravenous **and/or non-intramuscular** pharmacological method in minimal sedation.
(7) “Nitrous Oxide Sedation” means an induced, controlled state of minimal sedation, produced solely by the inhalation of a combination of nitrous oxide and oxygen in which the patient retains the ability to independently and continuously maintain an airway and to respond purposefully to physical stimulation and to verbal command.
(8) “Maximum recommended dose” (MRD) means maximum Food and Drug Administration (FDA) recommended dose of a drug, as printed in FDA approved labeling for unmonitored use.
(9) “Incremental Dosing” means during minimal sedation, administration of multiple doses of a drug until a desired effect is reached, but not to exceed the maximum recommended dose (MRD).

(10) “Supplemental Dosing” means during minimal sedation, supplemental dosing is a single additional dose of the initial drug that is necessary for prolonged procedures. The supplemental dose should not exceed one-half of the initial dose and should not be administered until the dentist has determined the clinical half-life of the initial dosing has passed. The total aggregate dose must not exceed 1.5x the MRD on the day of treatment.
(11) “Enteral Route” means administration of medication via the gastrointestinal tract. Administration by mouth, sublingual (dissolving under the tongue), intranasal and rectal administration are included.
(12) “Parenteral Route” means administration of medication via a route other than enteral. Administration by intravenous, intramuscular, and subcutaneous routes are included.
(13) American Society of Anesthesiologists (ASA) Patient Physical Status Classification System.
(a) ASA I “A normal healthy patient”.
(b) ASA II “A patient with mild systemic disease”.
(c) ASA III “A patient with severe systemic disease”.
(d) ASA IV “A patient with severe systemic disease that is a constant threat to life”.
(e) ASA V “A moribund patient who is not expected to survive without the operation”.
(f) ASA VI “A declared brain-dead patient whose organs are being removed for donor purposes".
(14) “Recovery” means the patient is easily arousable and can independently and continuously maintain their airway with stable vital signs. Once this has occurred, the patient can be monitored by a qualified anesthesia monitor until discharge criteria is met.

OAR 818-026-0050
Minimal Sedation Permit
Minimal sedation and nitrous oxide sedation.
(1) The Board shall issue a Minimal Sedation Permit to an applicant who:
(a) Is a licensed dentist in Oregon;
(b) Maintains a current BLS for Healthcare Providers certificate or its equivalent; and
(c) Completion of a comprehensive training program consisting of at least 16 hours of training and satisfies the requirements of the current ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students at the time training was commenced or postgraduate instruction was completed, or the equivalent of that required in graduate training programs, in sedation, recognition and management of complications and emergency care; or
(d) In lieu of these requirements, the Board may accept equivalent training or experience in minimal sedation anesthesia.
(2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedures and during recovery:
(a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two individuals to freely move about the patient;
(b) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient’s airway, quickly alter the patient’s position in an emergency, and provide a firm platform for the administration of basic life support;
(c) A lighting system which permits evaluation of the patient’s skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;
(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;

(e) An oxygen delivery system with adequate full facemask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;
(f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system;
(g) Sphygmomanometer, stethoscope, pulse oximeter, and/or automatic blood pressure cuff; and
(h) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the drugs used, vasopressors, corticosteroids, bronchodilators, antihistamines, antihypertensives and anticonvulsants.
(3) Before inducing minimal sedation, a dentist permit holder who induces minimal sedation shall:
(a) Evaluate the patient and document, using the American Society of Anesthesiologists (ASA) Patient Physical Status Classifications, that the patient is an appropriate candidate for minimal sedation;
(b) Give written preoperative and postoperative instructions to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian;
(c) Certify that the patient is an appropriate candidate for minimal sedation; and
(d) Obtain written informed consent from the patient or patient's guardian for the anesthesia. The obtaining of the informed consent shall be documented in the patient's record.
(4) No permit holder shall have more than one person under minimal sedation **or nitrous oxide sedation** at the same time.
(5) While the patient is being treated under minimal sedation, an anesthesia monitor shall be present in the room in addition to the treatment provider. The anesthesia monitor may be the dental assistant. After training, a dental assistant, when directed by a dentist permit holder, may administer oral sedative agents or anxiolysis agents calculated and dispensed by a dentist permit holder under the direct supervision of a dentist permit holder.
(6) A patient under minimal sedation shall be visually monitored at all times, including recovery phase. The record must include documentation of all medications administered with dosages, time intervals and route of administration. The dentist permit holder or anesthesia monitor shall monitor and record the patient's condition.
(7) Persons serving as anesthesia monitors for minimal sedation in a dental office shall maintain current certification in BLS for Healthcare Providers Basic Life Support (BLS)/Cardio Pulmonary Resuscitation (CPR) training, or its equivalent, shall be trained and competent in monitoring patient vital signs, in the use of monitoring and emergency equipment appropriate for the level of sedation utilized. ("competent" means displaying special skill or knowledge derived from training and experience.)
(8) The patient shall be monitored as follows:
(a) Color of mucosa, skin or blood must be evaluated continually. Patients must have continuous monitoring using pulse oximetry. The patient's response to verbal stimuli, blood pressure, heart rate, pulse oximetry and respiration shall be monitored and documented every fifteen minutes, if they can reasonably be obtained.
(b) A discharge entry shall be made by the dentist permit holder in the patient's record indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.
(9) The dentist permit holder shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:
(a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;

(b) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;
(c) The patient can talk and respond coherently to verbal questioning;
(d) The patient can sit up unaided;
(e) The patient can ambulate with minimal assistance; and
(f) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.
(g) A dentist permit holder shall not release a patient who has undergone minimal sedation except to the care of a responsible third party.
(10) The permit holder shall make a discharge entry in the patient's record indicating the patient's condition upon discharge.
(11) Permit renewal. In order to renew a Minimal Sedation Permit, the permit holder must provide documentation of a current BLS for Healthcare Providers certificate or its equivalent. In addition, Minimal Sedation Permit holders must also complete four (4) hours of continuing education in one or more of the following areas every two years: sedation, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current BLS for Healthcare Providers certificate, or its equivalent, may not be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060.

OAR 818-035-0030
Additional Functions of Dental Hygienists
(1) In a ddition to functions set forth in ORS 679.010, a dental hygienist may perform the following functions under the general supervision of a licensed dentist:
(a) Make preliminary intra-oral and extra-oral examinations and record findings;
(b) Place periodontal dressings;
(c) Remove periodontal dressings or direct a dental assistant to remove periodontal dressings;
(d) Perform all functions delegable to dental assistants and expanded function dental assistants providing that the dental hygienist is appropriately trained;
(e) Administer and dispense antimicrobial solutions or other antimicrobial agents in the performance of dental hygiene functions.
(f) Prescribe, administer and dispense fluoride, fluoride varnish, antimicrobial solutions for mouth rinsing or other non-systemic antimicrobial agents.
(g) Use high-speed handpieces to polish restorations and to remove cement and adhesive material.
(h) Apply temporary soft relines to complete dentures for the purpose of tissue conditioning.
(i) Perform all aspects of teeth whitening procedures.
(2) A dental hygienist may perform the following functions at the locations and for the persons described in ORS 680.205(1) and (2) without the supervision of a dentist:
(a) Determine the need for and appropriateness of sealants or fluoride; and
(b) Apply sealants or fluoride.
(3) In addition to functions set forth in ORS 679.010, a dental hygienist may perform the following functions under the indirect supervision of a licensed dentist:
(a) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a dental hygienist may initiate an intravenous (IV) infusion line for a patient being prepared for IV medications, sedation, or general anesthesia under the indirect supervision of a dentist holding the appropriate anesthesia permit.
(b) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a dental hygienist may perform a phlebotomy blood draw under

the indirect supervision of a dentist. Products obtained through a phlebotomy blood draw may only be used by the dentist, to treat a condition that is within the scope of the practice of dentistry.

OAR 818-038-0021
Additional Functions of Dental Therapists
(1) In addition to functions set forth in ORS 679.010, a dental therapist may perform the following functions under the indirect supervision of a licensed dentist:
(a) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a dental therapist may initiate an intravenous (IV) infusion line for a patient being prepared for IV medications, sedation, or general anesthesia under the indirect supervision of a dentist holding the appropriate anesthesia permit.
(b) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a dental therapist may perform a phlebotomy blood draw under the indirect supervision of a dentist. Products obtained through a phlebotomy blood draw may only be used by the dentist, to treat a condition that is within the scope of the practice of dentistry.

OAR 818-042-0020
Dentist, Dental Therapist and Dental Hygienist Responsibility
(1) A dentist is responsible for assuring that a dental assistant has been properly trained, has demonstrated proficiency, and is supervised in all the duties the assistant performs in the dental office. Unless otherwise specified, dental assistants shall work under indirect supervision in the dental office.
(2) A dental hygienist who works under general supervision may supervise dental assistants in the dental office if the dental assistants are rendering assistance to the dental hygienist in providing dental hygiene services and the dentist is not in the office to provide indirect supervision. A dental hygienist with an Expanded Practice Permit may hire and supervise dental assistants who will render assistance to the dental hygienist in providing dental hygiene services.
(3) A dental therapist who works under general supervision may supervise dental assistants in the dental office if the dental assistants are rendering assistance to the dental therapist in providing dental therapy services.
(4) The supervising licensee is responsible for assuring that all required licenses, permits or certificates are current and posted in a conspicuous place.
(5) Dental assistants who are in compliance with written training and screening protocols adopted by the Board may perform oral health screenings under general supervision.
(6) Dental assistants may take physical impressions and digital scans.

OAR 818-042-0100
Expanded Functions — Orthodontic Assistant (EFODA)
(1) An EFODA may perform the following duties while under the indirect supervision of a licensed dentist:
(a) Remove orthodontic bands and brackets and attachments with removal of the bonding material and cement. An ultrasonic scaler, hand scaler or slow speed handpiece may be used. Use of a high speed handpiece is prohibited;
(b) Select or try for the fit of orthodontic bands;
(c) Recement loose orthodontic bands;
(d) Place and remove orthodontic separators;

(e) Prepare teeth for bonding or placement of orthodontic appliances and select, pre-position and cure orthodontic brackets, attachments and/ or retainers after their position has been approved by the supervising licensed dentist;
(f) Fit and adjust headgear;
(g) Remove fixed orthodontic appliances;
(h) Remove and replace orthodontic wires. Place and ligate archwires. Place elastic ligatures or chains as directed; **and**
(i) Cut arch wires.~~; and~~
~~(j) Take impressions for study models or temporary oral devices such as, but not limited to, space maintainers, orthodontic retainers and occlusal guards.~~
(2) An EFODA may perform the following duties while under the general supervision of a licensed dentist:
(a) An expanded function orthodontic assistant may remove any portion of an orthodontic appliance causing a patient discomfort and in the process may replace ligatures and/ or separators if the dentist is not available, providing that the patient is rescheduled for follow-up care by a licensed dentist as soon as is reasonably appropriate.
(b) An EFODA may recement orthodontic bands if the dentist is not available and the patient is in discomfort, providing that the patient is rescheduled for follow-up care by a licensed dentist as soon as is reasonably appropriate.

OAR 818-042-0114
Additional Functions of Expanded Function Preventive Dental Assistants (EFPDA)
~~(1)~~ Upon successful completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association, or other course of instruction approved by the Board, a certified Expanded Function Preventive Dental Assistant may perform the following functions under the indirect supervision of a licensee providing that the procedure is checked by the licensee prior to the patient being dismissed:
~~(2)~~ **(1)** Apply pit and fissure sealants provided the patient is examined before the sealants are placed. The sealants must be placed within 45 days of the procedure being authorized by a licensee.

OAR 818-042-0115
Expanded Functions — Certified Anesthesia Dental Assistant
(1) A dentist holding the appropriate anesthesia permit may verbally authorize a Certified Anesthesia Dental Assistant, who possesses a Certified Anesthesia Dental Assistant certificate from the Oregon Board of Dentistry to:
(a) Administer medications into an existing intravenous (IV) line of a patient under sedation or anesthesia under direct visual supervision.
(b) Administer emergency medications to a patient in order to assist the licensee in an emergent situation under direct visual supervision.
(c) Perform phlebotomy for dental procedures.
(2) A dentist holding the appropriate anesthesia permit may verbally authorize a Certified Anesthesia Dental Assistant to dispense to a patient, oral medications that have been prepared by the dentist and given to the anesthesia dental assistant by the supervising dentist for oral administration to a patient under Indirect Supervision.

OAR 818-042-0117
Initiation of IV Line and Phlebotomy Blood Draw

(1) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a Certified Anesthesia Dental Assistant may initiate an intravenous (IV) infusion line for a patient being prepared for IV medications, sedation, or general anesthesia under the Indirect Supervision of a dentist holding the appropriate anesthesia permit.
(2) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a Certified Anesthesia Dental Assistant may perform a phlebotomy blood draw under the Indirect Supervision of a dentist. Products obtained through a phlebotomy blood draw may only be used by the dentist, to treat a condition that is within the scope of the practice of dentistry.

The OCHCI Guidance for compliance with GFE Requirements was discussed briefly. The document was in the meeting packet.

OTHER

Items were in the board meeting packet for informational purposes.

- OHA HWRP Updates – Slide deck
- OHA Proposed new SOGI Questions on Surveys
- OHA HWRP Data Collection
- OHA Medicaid Advisory Committee Open Position - Oral Health Professional
- Smile Direct Club articles, case background and FAQ
- Corporate Transparency Act ADA FAQ
- Tribes – Comment Period (none received)

ARTICLES AND NEWS

- CRDTS Winter 2024 Report

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 11:32 a.m.

CONSENT AGENDA

2024-0057, 2024-0060, 2024-0080, 2024-0068, 2024-0019, 2024-0073, 2024-0079, 2024-0082, 2024-0075, 2022-0125

Ms. Brixey 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

2023-0189, 2024-0006, 2024-0037, 2023-0180, 2023-0165

Ms. Brixey moved and Dr. Sharifi seconded that the Board close the matters with a finding of No Further Action or No Violation. The motion passed unanimously.

2023-0097
Dr. Sharifi moved and Ms. Riedman seconded that the Board close the matter with a Letter of Concern reminding the licensee to assure she completes all required continuing education hours, including those related to infection control within the required renewal period. The motion passed unanimously.

2023-0199
Ms. Riedman moved and Dr. Javier seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure he (1) collects varied clinical data, and diagnostic test results to assist in the diagnosis of odontogenic dental pain, and (2) he document all radiographic findings in the patient record. The motion passed unanimously.

2023-0101
Dr. Javier moved and Ms. Riedman seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure she maintains a current BLS for Health Care Providers certificate or its equivalent while holding an active Oregon dental hygiene license. The motion passed unanimously.

2024-0050
Dr. Aldrich moved and Dr. Javier seconded that the Board close the matter with a strongly worded letter of concern reminding licensee to assure (1) she responds to the Board within 10 days of a written request for information; and (2) she completes all required continuing education hours, including those related to Cultural Competency and Pain Management, within the required license renewal period. The motion passed unanimously.

2023-0103
Dr. Clark moved and Dr. Javier seconded that the Board close the matter with a Letter of Concern reminding licensee to maintain records of successful completion of continuing education for at least four licensure years consistent with the licensee's licensure cycle. The motion passed unanimously.

2023-0104
Dr. Clark moved and Ms. Riedman seconded that the Board close the matter with a Letter of Concern reminding licensee to maintain records of successful completion of continuing education for at least four licensure years consistent with the licensee's licensure cycle. The motion passed unanimously.

2024-0061
Dr. Sharifi moved and Ms. Riedman seconded that the Board close the matter with a Letter of Concern reminding the licensee to assure that when he provides anxiolysis via a single oral agent he does not submit CDT codes to insurance companies that might imply he provided minimal or moderate sedation. The level of anesthesia is determined by the anesthesia providers documentation of the anesthetic effects upon the central nervous system. He is reminded the progression from anxiolysis to sedation is a continuum, and the types, dosages, and routes of administration of drugs administered to a patient determine what result can reasonably be expected from those drugs in those dosages and routes administered in a patient of that physical and psychological status. The motion passed unanimously

2023-0146
Ms. Riedman moved and Dr. Javier seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure (1) his patients understand the risks involved with leaving an implant body under a fixed partial denture; (2) patients are aware the rescue and recovery involved with the removal of these dental implants may require destruction of the fixed partial denture; and (3) he provides referrals to additional dental specialists who may assist with the comprehensive treatment of patients with complex interdisciplinary needs. The motion passed unanimously.

2024-0024
Dr. Aldrich moved and Dr. Javier seconded that the Board close the matter with a Letter of Concern reminding licensee that only the American Dental Association's course titled "Recognition and Management of Complications during Minimal and Moderate Sedation" can be substituted for ACLS, and he should assure to always maintains a current ACLS certificate with his enteral moderate sedation permit. The motion passed unanimously.

2024-0049
Dr. Aldrich moved and Dr. Javier seconded that the Board close the matter with a Letter of Concern reminding licensee to assure he completes all required continuing education hours, including those related to infection control, within the required renewal period. The motion passed unanimously.

2024-0013
Ms. Ludwig moved and Ms. Brixey seconded that the Board close the matter with a Letter of Concern reminding licensee to assure that he vigilantly, and with due diligence monitor and complete 100% of his required continuing education for each licensure period, and that he retain all completed CE certificates for at least two licensure periods (4 years).The motion passed unanimously.

2022-0124
Dr. Clark moved and Dr. Sharifi seconded that the Board close the matter with a Letter of Concern reminding licensee to assure that Licensee renews his license within the renewal period.
Dr. Sharifi, Dr. Clark, Dr. Javier, and Ms. Brixey voted aye.
Mr. Dunn, Dr. Aldrich, Ms. Riedman and Ms. Ludwig voted no.
The motion died.

Dr. Aldrich moved and Ms. Ludwig seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order.
Mr. Dunn, Dr. Aldrich, Ms. Riedman and Ms. Ludwig voted aye.
Dr. Sharifi, Dr. Clark, Dr. Javier, and Ms. Brixey voted no.
The motion died.

Ms. Ludwig moved and Dr. Aldrich seconded that the Board move case 2022-0124 to the April 2024 Board meeting for further discussion. The motion passed unanimously.

2023-0198
Dr. Sharifi moved and Ms. Brixey seconded that the Board close the matter with a Letter of Concern reminding licensee to assure that (1) he maintains proof of completing all required continuing education hours, including those related to "Changing the Conversation about Pain;"

(2) he maintains records showing that the heat sterilizing devices are tested each calendar week in which scheduled patients are treated; (3) his patient exams include an evaluation of the teeth, jaws, bite, gums, and oral tissues to check growth and development when indicated; and (4) utilize appropriate CDT billing codes if an examination cannot be completed on a patient. The motion passed unanimously.

2024-0032
Ms. Riedman moved and Dr. Javier seconded that the Board close the matter with a Letter of Concern reminding licensee to assure that for periodontal data collection he documents gingival margins, and indirectly as recession, estimate levels of alveolar bone loss, document probings as probing depths not as pockets; preoperatively, whether or not teeth are symptomatic, perform periapical diagnostic radiographic images of teeth needing root canal treatment and cast restorations. The motion passed unanimously.

2024-0031
Dr. Javier moved and Ms. Riedman seconded that the Board close the matter with a Letter of Concern reminding licensee to assure that he maintains the proper sedation permit prior to administering nitrous oxide. The motion passed unanimously.

PREVIOUS CASES REQUIRING BOARD ACTION

GUTIERREZ, MARCO A. D.D.S. 2023-0127
Dr. Aldrich moved and Dr. Javier seconded that the Board deny Licensee's request to reduce the civil penalty, and affirm the Board's October 27, 2023 decision. The motion passed unanimously.

LEE, CHRIS Y.J. D.M.D. 2023-0208
Ms. Ludwig moved and Ms. Riedman seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand, a $6,000.00 civil penalty, by single payment, in the form of a cashier's, bank, or official check made payable to the Oregon Board of Dentistry and delivered to the Board offices within 90 days of the effective date of the Order, submit documentation to the Board verifying completion of eight hours of Board approved continuing education in the area of infection control within 60 days, and complete quarterly submission of spore testing results for a period of one year from the effective date of the Order. The motion passed unanimously.

NELSON, BRIAN HALE, D.M.D. 2023-0095
Dr. Clark moved and Dr. Sharifi seconded that the Board deny the licensee's request to close the case without taking any further action, and affirm the Board's October 27, 2023 decision. The motion passed unanimously.

Request for approval of Nonresident Permit – Charles Lee, D.D.S.
Dr. Sharifi moved and Ms. Brixey seconded that the Board approve the nonresident permit of Charles Lee D.D.S. The motion passed unanimously.

Request for approval of Nonresident Permit – Michael Yeh, D.D.S.
Ms. Riedman moved and Dr. Javier seconded that the Board approve the nonresident permit of Michael Yeh D.D.S. The motion passed unanimously.

Request for reinstatement of Dental License – Kevin Kryder, D.D.S.
Dr. Javier moved and Ms. Riedman seconded that the Board reinstate the dental license of Kevin Kryder, D.D.S. The motion passed unanimously.

Request for release of case summary for 2023-0092
Dr. Aldrich moved and Dr. Javier seconded that the Board release the case summary for 2023-0092.The motion passed unanimously.

Above Dental
Ms. Ludwig moved and Dr. Sharifi seconded that the Board grant an extension to Above Dental to continue operating the dental practice until December 31, 2024. The motion passed unanimously.

Request for approval of Soft Reline Course Revisions – Bonnie Marshall
Dr. Sharifi moved and Ms. Riedman seconded that the Board approve the proposed Soft Reline Course Revisions for Bonnie Marshall. The motion passed unanimously.

Request for approval of Soft Reline Course – Brianna Burks
Dr. Sharifi moved and Dr. Javier seconded that the Board approve the proposed Soft Reline Course for Brianna Burks. The motion passed unanimously.

Request for approval of IV Therapy Course - OAGD
Dr. Sharifi moved and Dr. Javier seconded that the Board approve the Comprehensive Training in Parenteral Moderate Sedation course as a board approved IV/Phlebotomy course put forth by the OAGD. The motion passed unanimously.

RATIFICATION OF LICENSES

Dr. Clark moved and Ms. Brixey seconded that the Board ratify the licenses presented in tab 16. The motion passed unanimously.

ADJOURNMENT

The meeting was adjourned at 2:52 p.m. Mr. Dunn stated that the next Board Meeting would take place on April 26, 2024.

_____
Charles ‘Chip’ Dunn
President

ASSOCIATION REPORTS

COMMITTEE REPORTS

OBD Committees

PRISBY Stephen * OBD <Stephen.PRISBY@obd.oregon.gov>

Thu 3/28/2024 11:13 AM

To:Brett Hamilton <bhamilton@oregondental.org>;Karen Hall <hallkarenmarie@gmail.com>;'mary2805@aol.com' <mary2805@aol.com>
Cc:ROBINSON Haley * OBD <Haley.ROBINSON@obd.oregon.gov>

Hello,

Please feel free to pass this info on to interested parties that plan on or are interested in serving on any OBD Committee.

- Next Committee Meeting is DAWSAC via Zoom Wed., May 15 from 6 pm - 7 pm.
- No other Committee meetings scheduled as of now.
- No compensation for participating.
- All Meetings are public meetings with minutes and recordings of the proceedings.
- No training, they get the meeting packet approximately 10 days before the meeting to review and be ready to discuss the agenda topics.
- We encourage all committee members to share freely and candidly their opinions on the agenda topics, you are going to make recommendations to the OBD on what to do on a particular matter.
- **Most** Committee meetings are:
    - 60 minutes
    - Conducted weeknight evenings at 6 pm
    - Zoom & Teleconference option (not planning to be in person)
- Sometimes Committee meetings are scheduled in conjunction with the board meeting.

At Every April Board meeting our Board elects a new President, then we review all the board member committee assignments at that time. Our Board President designates an OBD Board Member to Chair each Committee. I work with them to schedule date of a specific committee meeting and the specific agendas. The OBD lines this up for a 12-month period, roughly May 2024 - April 2025. Then in April 2026, we do it again, and in 2027, 2028, etc....

The Associations (ODA, ODHA, ODAA) choose who they want to be on each OBD Committee, to represent their Association.

Since the Dental Therapists do not have their own Oregon Assocation yet, I have emailed all 20 licensed Dental Therapists information about the OBD's Committees and their interest in serving on an OBD Commitee. It is important that the OBD Committees have representation for all three types of Licensees and all three professional associations. We value and need your feedback!

Please direct any Qs to me please.

Thank you,
Stephen

Stephen Prisby
Executive Director
Oregon Board of Dentistry
1500 SW 1st Avenue, Suite 770
Portland, OR 97201
Telephone: 971-673-3200
www.oregon.gov/dentistry

should this fail to transmit correctly. Please destroy incorrectly transmitted documents immediately.


Please consider the environment before printing this e-mail

"The Mission of the OBD is to promote quality oral health care and protect all communities in the State of Oregon by equitably and ethically regulating dental professionals."

OREGON BOARD OF DENTISTRY
DENTAL ASSISTANT WORKFORCE SHORTAGE ADVISORY COMMITTEE MEETING MINUTES
(DAWSAC) Draft
February 23, 2024

MEMBERS PRESENT:	Terrence Clark, D.M.D., Co-Chair Aarati Kalluri, D.D.S. Co-Chair Olesya Salathe, D.M.D. - ODA Rep. Laura Vanderwerf, R.D.H. - ODHA Rep. Ginny Jorgensen - ODAA Rep. Jill Lomax Lynn Murray Terri Dean Alexandria "Alex" Case Jessica "Jessie" Andrews Alyssa Kobylinsky
STAFF PRESENT:	Stephen Prisby, Executive Director Angela Smorra, D.M.D., Dental Director/Chief Investigator Winthrop "Bernie" Carter, D.D.S., Dental Investigator Haley Robinson, Office Manager Kathleen McNeal, Office Specialist
ALSO PRESENT:	Lori Lindley, Sr. Assistant Attorney General
VISITORS PRESENT: IN PERSON & VIA TELECONFERENCE*	Mary Harrison, ODAA; Michelle Aldrich, D.M.D.; Brett Hamilton - ODA Katherine Landsberg – DANB, Sarah Kowalski, Cali Roa, D.M.D., Amanda Nash, Laura Vanderwerf, Linda Kihs

*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 Chair at 8:01 am at the Board office at 1500 SW 1st Ave., Suite 770, Portland, Oregon.

Chair Terrence Clark, D.M.D. welcomed everyone to the meeting and had the Members, Lori Lindley, and Stephen Prisby introduce themselves.

Self-Introductions of Committee Members
Committee members introduced themselves and shared information about their history and current positions in the dental assisting field.

Approval of October 27, 2023 Minutes
Dr. Clark moved and Dr. Kalluri seconded that the Board approve the minutes from the October 27, 2023 Board Meeting as presented. The motion passed unanimously.

Dental Assistants Performing Local Anesthesia
The committee discussed that the request for dental assistants to perform local anesthesia is on the agenda for the next regularly scheduled Licensing, Standards, and Competency Committee Meeting.

Review HB 3223 and Identified goals of the DAWSAC Committee

DAWSAC packet introduced

Dental assisting trends we saw in 2023 – DANB Article
The committee discussed common trends seen with dental assistants and potential reasons that they moved on or stayed with the profession. Salary ranges were discussed, as well as capturing more information through required surveys. Limitations of surveys were acknowledged, as most dental assisting certifications do not expire so there is little opportunity to capture data from the majority of dental assistants.

Review Comments for the February 23, 2024 DAWSAC Meeting
The topic of retaining dental assistants was discussed as well as a national survey that captured some of the data from dental assistants. Katherine Landsberg reported that DANB was utilizing a survey to capture some of the retention data for dental assistants. A renewal for dental assistant certificates was discussed as an option to better capture important data.

Dr. Salathe proposed adding questions to the legislatively mandated OHA Workforce Survey regarding dental assistant employment. Mr. Prisby stated that the Board of Dentistry did not have influence on the types of questions asked in the survey. Dr. Salathe reported that she would reach out the ODA regarding these survey questions.

The committee requested data from DANB regarding the number of Certified Dental Assistants (CDA) in each state and the renewal data, since that level of certification requires a renewal. The interest was when/if the CDA stopped renewing their certification in an attempt to pinpoint when we lose dental assistants in the workforce. In Oregon, dental assistants are not required to have a CDA so that was a limitation on potential state-specific data.

1. Retention Rate Analysis: The committee looked into the retention rates of dental assistants over the years, focusing on ADA statistics and state-by-state data. They identified a disparity in retention rates and discussed the need for more detailed information, particularly how to track it. ADA statistic was used and was 4 years avg retention.

2. Oregon Certification and Renewal: Questions arose regarding a possible renewal process for Oregon certification. Specifically, the committee discussed whether there should be a renewal fee and how to track renewal status effectively.

3. Dentist Renewal and Workforce Questions: The committee delved into questions about the dental workforce, including the duration of employment for dental assistants and whether dentists had prior experience as assistants. They also examined wage data across different cities, noting a range from $25 to $32 per hour. Discrepancies in reported wages and the overall compensation package were highlighted for further investigation. Discussion was focused on getting a good baseline on wages and benefit packages across the state. Steven confirmed that they cannot add questions regarding wages to the dentist renewal application due to OHA guiding that. Perhaps ODA could include that in

surveys?

4. CDA/RDA Requirements Across States: Discussion centered on the requirements for Certified Dental Assistants (CDAs) and Registered Dental Assistants (RDAs) across various states. Everyone agreed that Oregon was a more progressive state with many pathways to certification. Minnesota potentially being the only state more advanced than us.

5. Marketing and Recruitment Strategies: The committee explored marketing and recruitment strategies for dental assisting programs. Challenges such as reduced marketing budgets and unpaid instructor hours were raised, prompting a call for additional state resources to support these efforts.

6. Innovative Training Programs: Members shared information about innovative training programs, including a private program in Medford and a new on-the-job training initiative at OHSU. Credentialing

7. Promotion of the Dental Assisting Profession: Ideas were proposed to promote the dental assisting profession through podcasts, social media, and high school career programs. The committee discussed engaging current members in outreach efforts.

8. Funding and Collaboration: Discussion focused on requesting funding from the state and seeking contributions from the Oregon Dental Association (ODA) and other relevant associations. Collaboration with other organizations was emphasized to strengthen workforce development initiatives.

PDSF DA Scholarship Steps Flyer

ADA Health Policy Institute Study

OBD Approved Radiology Course Approved Instructors List

Oregon Dental Assistant Employment Information

State Comparisons of Dental Practices, DA duties

Dental School DA programs
Different types of dental assisting education pathways were discussed. Many outreach/marketing programs were eliminated due to budget cuts. The committee agreed that better communication to high school students that dental assisting can be a career choice was important. It was generally agreed that marketing and outreach of programs for oral health careers needs more focused and dedicated resources.

3 Ways to Increase Dental Team Longevity

Open Discussion on the following issues:

- Research information and data from the states listed on the comparison table to show differences in the number of job openings from state to state.

- How ODA and ODAA can create a recruitment tool(s) to use across the state at high schools, job fairs, DA programs, etc.
- How many healthcare and other certificate exams are offered in languages other than English?

ADJOURNMENT

The meeting was adjourned at 9:02 a.m. Chair Clark stated that the next DAWSAC meeting would take place on May 15, 2024 at 6pm via Zoom.

EXECUTIVE DIRECTOR'S REPORT

EXECUTIVE DIRECTOR'S REPORT
April 26, 2024

Board Member & Staff Updates

The Governor's three recommendations to the Board were approved by the Senate on February 12, 2024. These three individuals are replacing Jose Javier, DDS, Alicia Riedman, RDH and Jennifer Brixey who were recognized for their board service at the February Board Meeting.

Kristen Simmons, RDH, term of service is April 1, 2024 to March 31, 2028.
Olesya Salathe, DMD, term of service is April 2, 2024 to April 1, 2028.
Ginny Jorgensen term of service is April 7, 2024 to April 6, 2028.

Kristen Simmons, RDH, is an assistant professor at Pacific University School of Dental Hygiene Studies. In 2020, she completed her doctoral degree in Education and Leadership from Pacific University. Kristen is actively involved in various initiatives aimed at improving the quality of oral healthcare. She enjoys working with the constantly evolving oral healthcare system to emphasize the importance of quality measurement, which can lead to better oral health outcomes.

Olesya Z. Salathe, DMD, completed her undergraduate studies at George Fox University before pursuing her graduate degree at OHSU. Since 2010, Dr. Salathe has been serving her community through private practice, with offices located in Molalla and West Linn. Beyond her practice, Dr. Salathe is actively engaged in leadership roles at the county, state, and national levels within Clackamas, Oregon, and the American Dental Association (ADA). Her commitment to advancing dentistry extends beyond the clinic, as she strives to shape the future of oral healthcare through advocacy and innovation. Outside of her professional endeavors, Dr. Salathe finds joy in her role as a mother to two teenagers. She and her husband reside on a 20-acre ranch, where they cherish the beauty of rural life.

Virginia (Ginny) Jorgensen is a native Oregonian who was born and raised in Northeast Portland. She raised two daughters in Gladstone and now resides in Wilsonville. Her siblings, daughters and grandchildren all live in the Portland metro area. As a dental assistant in general and orthodontic practices Ginny learned about patient advocacy and the importance of dental health. Her desire to help patients have a positive experience during dental treatment guided her toward becoming a Certified Dental Assistant, an Oregon Expanded Functions Dental Assistant and a dental assisting educator. Ginny believes that all Oregon Citizens should receive safe, quality dental care from trained, responsible dental health care workers. She is actively involved in the Oregon Dental Assistant Association, a professional organization that focuses on education, community involvement and patient advocacy.

The three new Board Members attended new board member orientation at the OBD on April 19 and ongoing support will continue on throughout their terms of service of course.

Name	Date Initial Service	Term Ends	Eligible for another term
Charles "Chip" Dunn	May-17	March-25	NO
Reza Sharifi, DMD	May-19	May-27	NO
Aarati Kalluri, DDS	March-21	March-25	YES

Sheena Kansal, DDS	April-21	April-25	YES
Terrence Clark, DMD	June-22	April-26	YES
Michelle Aldrich, DMD	June-22	April-26	YES
Sharity Ludwig, RDH	June-22	April-26	YES
Kristen Simmons, RDH	April-24	April-28	YES
Olesya Salathe, DMD	April-24	April-28	YES
Ginny Jorgensen	April-24	April-28	YES

On March 1, 2024, I appointed Kathleen McNeal as our new Licensing Manager. We are so happy she has stepped up to this important and mission critical position for the OBD. Kathleen joined the OBD in November 2021 as our Office Specialist. She regularly stepped forward to take on additional duties in supporting the Board. She is a graduate in Asian Studies from the University of Oregon. She is a positive resource and is excited to take on all the important and time sensitive work in processing license applications, permits, renewals and helping assist our 8000 plus Licensees and consumers on a myriad of issues.

We welcomed Dawn Dreasher, as a temporary employee on March 1, 2024. The OBD has significant and time sensitive administrative work to complete and we were fortunate to be able to bring on a smart and qualified person to assist us.

It is an exceptionally busy time of the year for OBD Staff with a number of license application presentations along with two OHSU School of Dentistry presentations scheduled as well. The dental license renewal period recently closed, there are three new board members to welcome & onboard, and the OBD is still not fully staffed. A recent investigator recruitment concluded and I should have an update at this board meeting. The Governor and DAS have added additional duties and reporting requirements on all agencies including Executive Director 360-degree performance review, DEI initiatives, budget development and robust turnover among other state agency staff that intersect with the OBD's work.

OBD Budget Status Report

Attached is the budget report for the 2023 - 2025 Biennium. This report, which is from July 1, 2023 through February 29, 2024, shows revenue of $1,329,517.76 and expenditures of $1,198,510.67. **Attachment #1**

OBD 2025 – 2027 Revenue Projection

The 2025- 2027 budget is in its initial planning and development stages and the revenue projection and supporting documentation was submitted to Department of Administrative Services & Legislative Fiscal Office per budget development instructions. **Attachment #2**

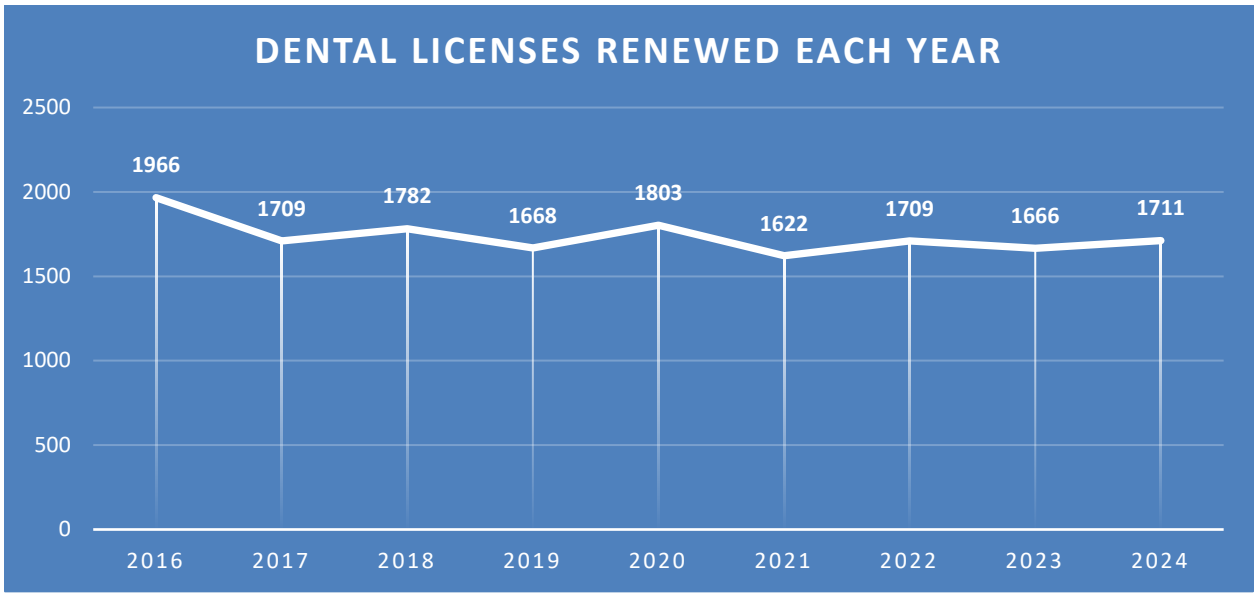
OBD 2025 - 2027 Budget Development Overview

This information is provided to the Board Members to assist in an understanding of the 2025 – 2027 budget development. There are three new Board Members and all Board members need to have a solid overview of operations and potential cost issues leading up to the development of the next budget. **Attachment #3**

Customer Service Survey
Attached are the most recent customer service survey results for the period, from July 1, 2023 through March 31, 2024. The results of the survey show that the OBD continues to receive positive feedback from those that choose to submit a survey. **Attachment #4**

2024 Dental License Renewal
The 2024 Dental License renewal period ended on March 31, 2024. A majority of the dentists renewing their licenses had no issues, and were generally pleasant when interacting with staff. 2024 Dental license renewal: 1711 renewed, 204 expired, 22 retired and 3 deceased.

Previous years of dental license renewal data:



Board and Staff Speaking Engagements
Kathleen McNeal, Licensing Manager, gave a license application virtual presentation to the dental hygiene students at OIT- Klamath Falls on Wednesday, March 6, 2024.

The Oregon Dental Conference was held at the Oregon Convention Center in Portland, April 4 - 6, 2024. The OBD staffed a resource table outside the Exhibit Hall to answer questions and encourage safe oral health practice amongst the attendees. OBD staff gave two presentations at the conference. I want to thank all OBD staff who worked the table at various times.

Haley Robinson and I gave a presentation on Thursday, April 4, 2024, covering an overview of the Board, operations, budget, rulemaking, enforcement, CE and FAQs. A PDF is shared to provide an overview of the Board Updates presentation. It is modified for the audience, whether dental students, dental hygiene students, study club or for time constraints. **Attachment #5**

Dr. Angela Smorra and Dr. Bernie Carter and gave a presentation on Thursday, April 4, 2024, covering an overview of the Board's investigation process, common complaints, CE and FAQs. We thank the Oregon Dental Association for inviting us to present again at their well-attended conference.

AADB & AADA Mid-Year Meetings

The American Association of Dental Boards (AADB) 2023 Mid-Year Meeting was held April 11 & 12, 2024 in Rosemont, Illinois. Lori Lindley attended and led the Attorneys' Round Table. I attended and will have a report at this meeting. The American Association of Dental Administrators (AADA) 2023 Mid-Year Meeting was scheduled for April 23, 2024 as a virtual meeting. **Attachment #6**

Save the Date - Tribal Summit

Attached is the Save the Date notice for the annual Tribal-State Government-to-Government Summit to be held on July 24. It will be generously Co-Hosted by the Cow Creek Band of Umpqua Tribe of Indians. I am the OBD's designated Native American Affairs Coordinator and plan to attend this summit. **Attachment #7**

2025 Proposed Board Meeting Dates

Attached is a draft of the proposed board meeting dates for 2025. These dates follow the Board's regular annual schedule of holding them every other month. The Board may consider adopting these dates for next year's meetings so that all can plan accordingly.
Attachment #8 ACTION REQUESTED

Newsletter

The next OBD Newsletter is scheduled to be available in May and it will have important news and updates for our Licensees.

Agency 834

			Appn Year	2025		
				Monthly Activity	Biennium to Date	Budget
Fund	Budget Obj	Budget Obj Title				
3400	1000	REVENUES		382,966.64	1,329,517.76	3,972,405.00
	2500	TRANSFER OUT		0.00	4,998.15	267,000.00
	3000	PERSONAL SERVICES		89,332.28	728,968.55	2,273,180.00
	4000	SERVICES AND SUPPLIES		66,191.87	469,542.12	1,968,770.00
3400 Total				**538,490.79**	**2,533,026.58**	**8,481,355.00**
Grand Total				**538,490.79**	**2,533,026.58**	**8,481,355.00**

Agency	834
Agency Title	BOARD OF DENTISTRY
Appn Year	2025
Rpt Fiscal Mm	08
Rpt Fiscal Mm Name	FEBRUARY 2024
Load Date GI	3/15/2024

Fund	D23 Fund Title	D10 Budget Obj	Budget Obj	ORBITS (D10 Compt Srce Grp)	D10 Compt Srce Grp Ttl	Monthly Activity	Biennium to Date	Budget
3400	BOARD OF DENTISTRY	1000	REVENUES	0205	OTHER BUSINESS LICENSES	357,858.00	1,141,723.00	3,495,149.00
				0210	OTHER NONBUSINESS LICENSES AND FEES	2,050.00	6,200.00	14,900.00
				0410	CHARGES FOR SERVICES	2,507.50	9,775.00	148,355.00
				0505	FINES AND FORFEITS	15,750.00	132,580.70	240,000.00
				0605	INTEREST AND INVESTMENTS	4,416.32	36,560.60	60,000.00
				0975	OTHER REVENUE	384.82	2,678.46	14,001.00
			REVENUES Total			**382,966.64**	**1,329,517.76**	**3,972,405.00**
		2500	TRANSFER OUT	2443	TRANSFER OUT TO OREGON HEALTH AUTHORITY	0.00	4,998.15	267,000.00
			TRANSFER OUT Total			**0.00**	**4,998.15**	**267,000.00**
		3000	PERSONAL SERVICES	3110	CLASS/UNCLASS SALARY & PER DIEM	53,078.96	466,118.92	1,403,771.00
				3115	BOARD MEMBER STIPENDS	5,146.00	21,951.00	46,900.00
				3160	TEMPORARY APPOINTMENTS	0.00	0.00	4,585.00
				3170	OVERTIME PAYMENTS	0.00	605.69	6,669.00
				3180	SHIFT DIFFERENTIAL	0.00	1.00	0.00
				3190	ALL OTHER DIFFERENTIAL	629.69	4,845.31	41,510.00
				3210	ERB ASSESSMENT	13.14	107.31	404.00
				3220	PUBLIC EMPLOYES' RETIREMENT SYSTEM	10,157.42	87,877.90	255,636.00

Agency	834
Agency Title	BOARD OF DENTISTRY
Appn Year	2025
Rpt Fiscal Mm	08
Rpt Fiscal Mm Name	FEBRUARY 2024
Load Date GI	3/15/2024

Fund	D23 Fund Title	D10 Budget Obj	Budget Obj	ORBITS (D10 Compt Srce Grp)	D10 Compt Srce Grp Ttl	Monthly Activity	Biennium to Date	Budget
3400	BOARD OF DENTISTRY	3000	PERSONAL SERVICES	3221	PENSION BOND CONTRIBUTION	2,305.68	23,802.25	80,296.00
				3230	SOCIAL SECURITY TAX	4,088.36	37,104.06	116,198.00
				3241	PAID FAMILY MEDICAL LEAVE INSURANCE	213.73	1,737.51	5,391.00
				3250	WORKERS' COMPENSATION ASSESSMENT	9.47	85.90	351.00
				3260	MASS TRANSIT	322.25	2,804.27	9,521.00
				3270	FLEXIBLE BENEFITS	13,367.58	81,927.43	301,948.00
			PERSONAL SERVICES Total			**89,332.28**	**728,968.55**	**2,273,180.00**
		4000	SERVICES AND SUPPLIES	4100	INSTATE TRAVEL	2,186.20	5,901.52	55,194.00
				4125	OUT-OF-STATE TRAVEL	0.00	0.00	8,220.00
				4150	EMPLOYEE TRAINING	0.00	6,297.15	58,929.00
				4175	OFFICE EXPENSES	1,038.47	6,823.91	99,149.00
				4200	TELECOMM/TECH SVC AND SUPPLIES	382.34	4,747.47	27,088.00
				4225	STATE GOVERNMENT SERVICE CHARGES	64.20	45,754.63	94,114.00
				4250	DATA PROCESSING	2,685.39	41,528.91	163,405.00
				4275	PUBLICITY & PUBLICATIONS	65.76	554.30	16,145.00
				4300	PROFESSIONAL SERVICES	8,183.00	135,824.46	458,367.00
				4315	IT PROFESSIONAL SERVICES	0.00	0.00	161,038.00
				4325	ATTORNEY GENERAL LEGAL FEES	8,402.90	75,639.08	338,907.00
				4375	EMPLOYEE RECRUITMENT AND DEVELOPMENT	0.00	120.00	766.00
				4400	DUES AND SUBSCRIPTIONS	128.90	1,171.80	11,331.00
				4425	LEASE PAYMENTS & TAXES	8,191.40	65,054.02	206,576.00
				4475	FACILITIES MAINTENANCE	0.00	0.00	634.00

Agency	834
Agency Title	BOARD OF DENTISTRY
Appn Year	2025
Rpt Fiscal Mm	08
Rpt Fiscal Mm Name	FEBRUARY 2024
Load Date GI	3/15/2024

Fund	D23 Fund Title	D10 Budget Obj	Budget Obj	ORBITS (D10 Compt Srce Grp)	D10 Compt Srce Grp Ttl	Monthly Activity	Biennium to Date	Budget
3400	BOARD OF DENTISTRY	4000	SERVICES AND SUPPLIES	4575	AGENCY PROGRAM RELATED SVCS & SUPP	1,680.82	11,619.02	142,660.00
				4650	OTHER SERVICES AND SUPPLIES	10,983.49	41,878.45	94,383.00
				4700	EXPENDABLE PROPERTY $250-$5000	0.00	0.00	6,343.00
				4715	IT EXPENDABLE PROPERTY	22,199.00	26,627.40	25,521.00
			SERVICES AND SUPPLIES Total			**66,191.87**	**469,542.12**	**1,968,770.00**

DAFR9210 Agency 834 - month end

Oregon
Tina Kotek, Governor

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

TO: DAS/LFO Analysts, OMB Budget Personnel & Interested Parties

FROM: Stephen Prisby, OBD Executive Director

DATE: March 29, 2024

SUBJECT: Oregon Board of Dentistry 2025 - 2027 Revenue Forecast

The Oregon Board of Dentistry (OBD) was created by an Act of the Legislature in 1887. The authority and responsibilities of the Board are contained in Oregon Revised Statutes Chapter 679 (Dentists and Dental Therapists), Chapter 680.010 to 680.205 (Dental Hygienists), and Oregon Administrative Rules, Chapter 818. These statutes charge the OBD with the responsibility to regulate the practice of dentistry, dental therapy and dental hygiene, and also enforce all provisions in statute as well. The OBD has 7.5 Full Time Equivalent staff members and 10 volunteer Board Members.

The Mission of the OBD is to promote quality oral health care and protect all communities in the state of Oregon by equitably and ethically regulating dental professionals.

SOURCES OF REVENUE

The Board of Dentistry's funding is 100% Other Funds generated primarily from fees paid by Licensees and applicants for new licenses, license renewals and various permits. A small portion (generally less than six percent) of the Board's revenue is from miscellaneous revenues generated from civil penalties, the sale of documents, late fees, interest and dental assistant certifications fees.

PROGRAM FUNDED

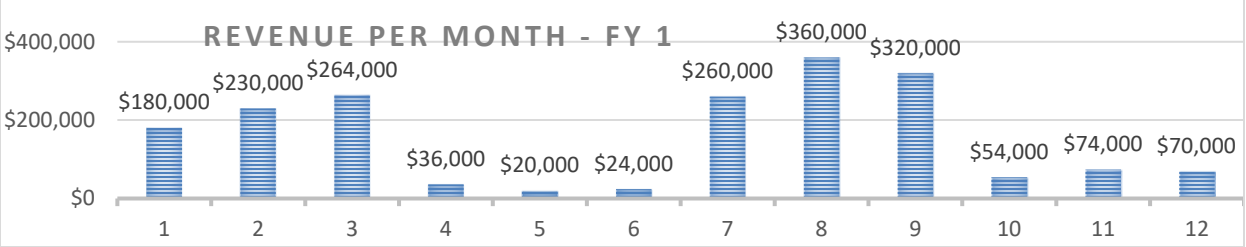
The Oregon Revised Statutes directs that all money received by the Board be used only for the administration and enforcement of ORS 676.850 and 680.010 to 680.205 and all referenced in Chapter 679.

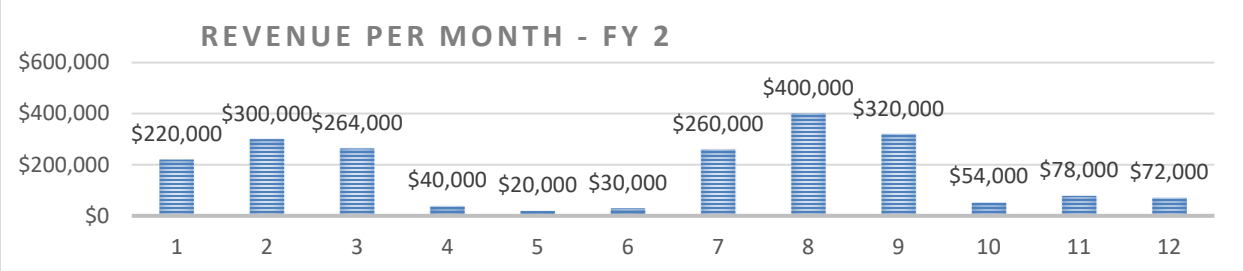
BACKGROUND FOR THE 2025-2027 REVENUE ESTIMATES

Licenses regulated by the Board are issued to expire and be renewed every year in two distinct timeframes. The result is that our biennial revenue is primarily received at different times during each biennium. Half of the dentists renew spring each year and half our dental hygienists and dental therapists renew in the fall each year. The agency aims for a minimum beginning balance of a minimum of three months of operating expenses at the beginning of every biennium.

Revenue stream- uneven every year due to Licensees renewing in spring & fall

Every year one half of our dentists renew their 2-year license between Jan – March 31. Every year one half of our dental hygienists and dental therapists renew their 2-year license between July – Sept 30. Example of the uneven revenue typically received per Fiscal Year (FY) shown below. The OBD began licensing dental therapists in November 2022 and we forecast that it will have a minimal impact on revenue in the current biennium or in the 2025 - 2027 biennium.





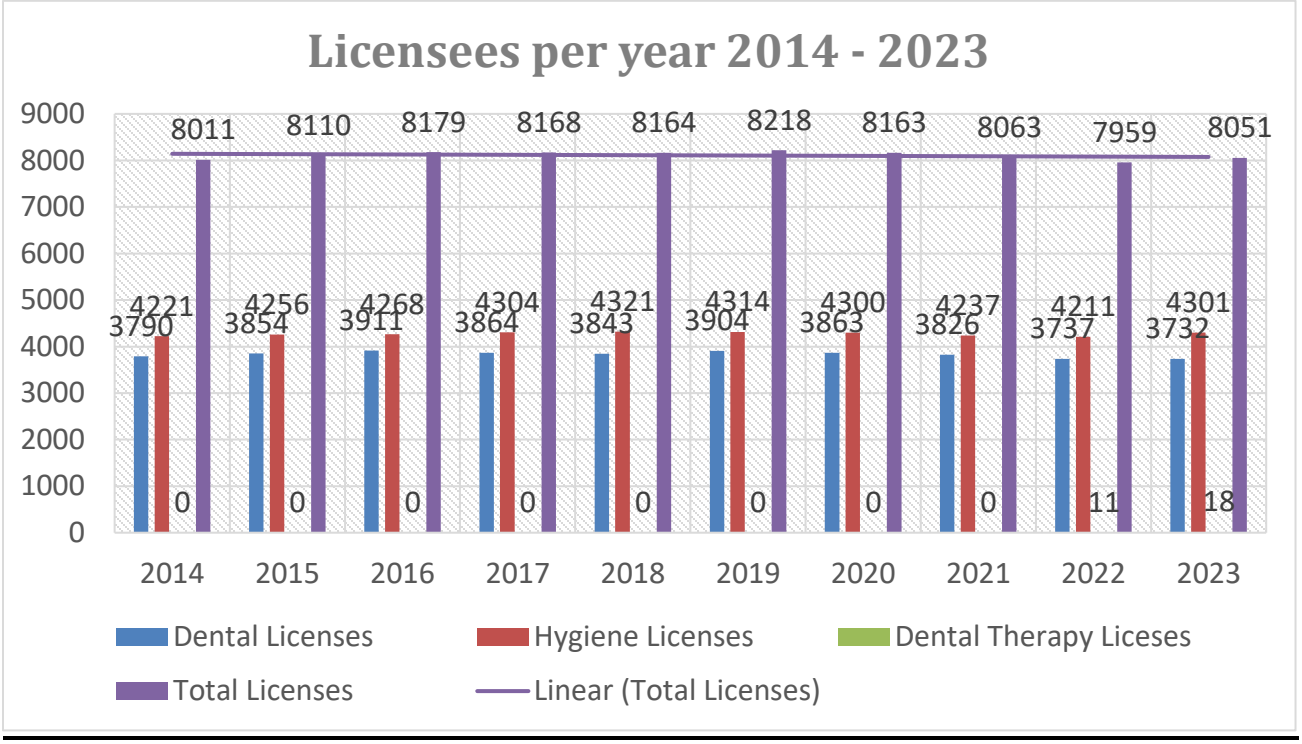
Revenue Estimates

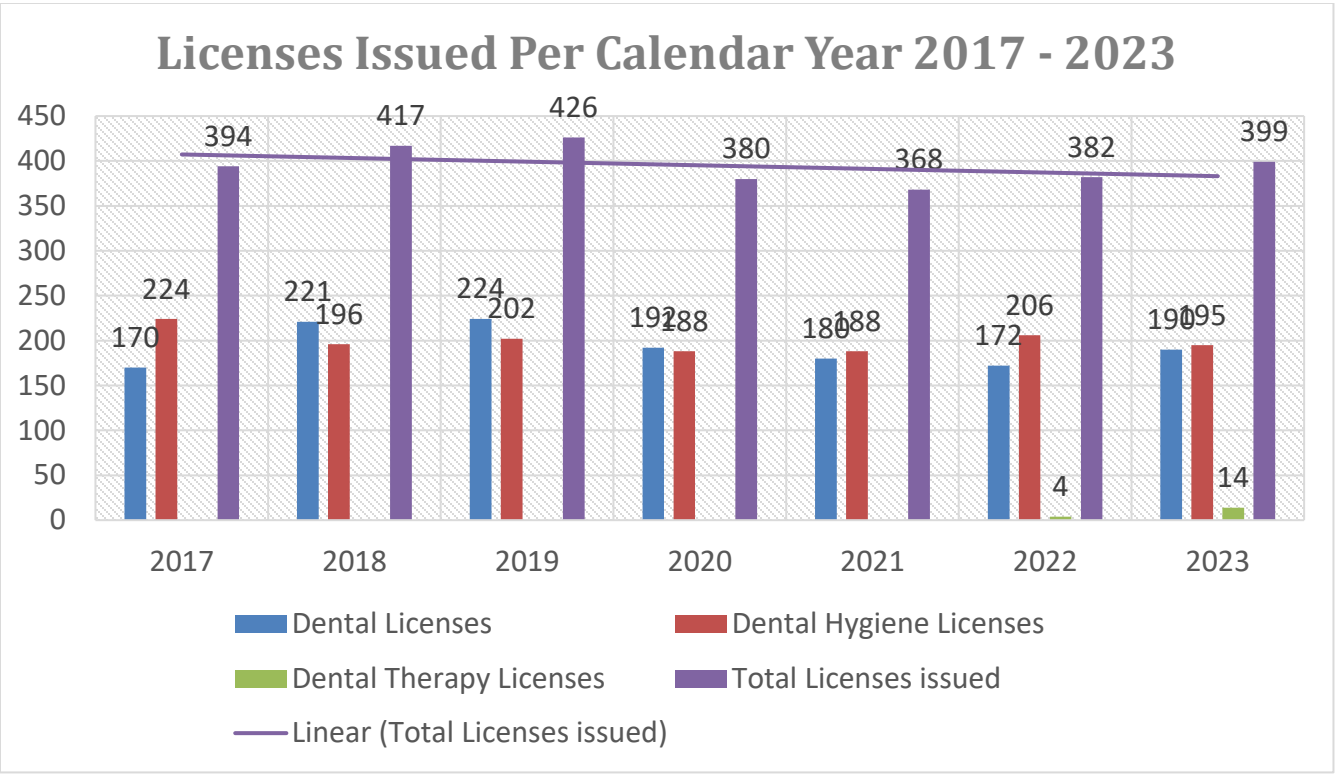
At this point, I am projecting revenue for the 2025-27 biennium to be approximately 10% higher than the 2023-25 budget biennium. The main driver for this revenue increase is the fee increases that were approved by the Legislature in the OBD's 2023-25 budget, and effective July 1, 2023. The revenue growth will not be due to any significant increase in the number of Licensees in Oregon during the 2025-27 biennium. These estimates are based on the current fees, without any increases for 2025-27, though in the future projections those may need to be considered and included.

Note – An excel spreadsheet is being provided with all revenue and fee data to support this memo.

Revenue	FY 19-21 Actual	FY 21-23 Actual	FY 23-25 ESTIMATE	FY 25-27 ESTIMATE
OTHER BUSINESS LICENSES	3,197,000	3,096,000	3,400,000	3,765,000
OTHER NONBUSINESS LIC & FEES	14,900	22,200	14,000	14,000
CHARGES FOR SERVICES	25,100	25,600	146,000	146,000
FINES AND FORFEITS	243,000	191,000	240,000	240,000
INTEREST AND INVESTMENTS	49,000	49,000	60,000	60,000
OTHER REVENUE	14,700	7,000	9,000	9,000
TOTAL	3,543,700	3,390,000	3,869,000	4,265,000

Numbers have been rounded.


Licensees per year 2014 - 2023
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
8011
8110
8179
8168
8164
8218
8163
8063
7959
8051
3790
4221
0
3854
4256
0
3911
4268
0
3864
4304
0
3843
4321
0
3904
4314
0
3863
4300
0
3826
4237
0
3737
4211
11
3732
4301
18
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
Dental Licenses
Hygiene Licenses
Dental Therapy Liceses
Total Licenses
Linear (Total Licenses)

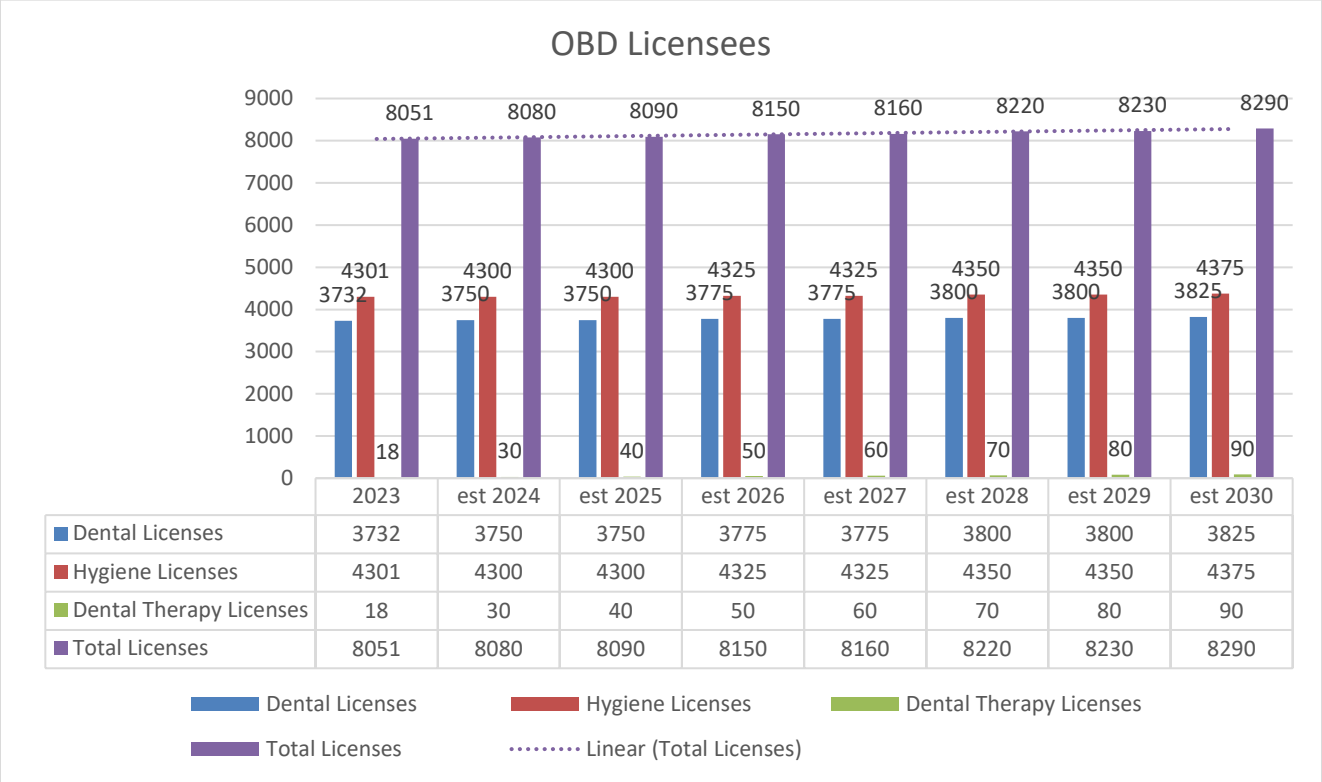

Licenses Issued Per Calendar Year 2017 - 2023
450
400
350
300
250
200
150
100
50
0
394
417
426
380
368
382
399
224
170
221
196
224
202
192
188
180
188
172
206
4
190
195
14
2017
2018
2019
2020
2021
2022
2023
Dental Licenses
Dental Hygiene Licenses
Dental Therapy Licenses
Total Licenses issued
Linear (Total Licenses issued)

PROJECTIONS going up to 2030

A slight trend upward in licensees projected due to:

- Dental Therapy Programs being implemented and more widely recognized in the United States
- New dental hygiene and dental schools being built which will expand workforce
- Many oral healthcare workforce initiatives at state and national level to expand workforce
- Other initiatives to support retention and wellness of oral healthcare workforce
    - ❖ An important issues which could impact projections is a dental/dental hygiene license compact. It is unclear if that could increase Oregon license base (revenue), but more likely it could decrease license base. Licensees might logically choose the least expensive route for initial licensure and forego maintaining licensure in multiple states.

Calendar Year	2023	est 2024	est 2025	est 2026	est 2027	est 2028	est 2029	est 2030
Dental Licenses	3732	3750	3750	3775	3775	3800	3800	3825
Hygiene Licenses	4301	4300	4300	4325	4325	4350	4350	4375
Dental Therapy Licenses	18	30	40	50	60	70	80	90
Total Licenses	**8051**	**8080**	**8090**	**8150**	**8160**	**8220**	**8230**	**8290**



Estimated Beginning Balance for 2025 - 2027

The 2025 - 2027 beginning ending balance was set at $563,777.99, when the 2023 - 2025 budget was finalized. Based on updated information the beginning balance at this point in time is estimated to be $600,000. The slight increase is mainly attributed to vacancy savings with staff turnover and the time to fill those unfilled positions in which no salary was paid for those positions.

Summary

The OBD like all state agencies is charged with being a good steward of its resources and also to plan for upcoming challenges. The OBD is also directed to fulfill its mission and all its statutory requirements. The OBD is funded by a finite number of Licensees and this is not growing in any substantial way. There will be revisions and changes to the revenue projections as more information becomes available.

Revenue	FY 19-21 Act	FY 21-23 Act	FY 23-25 EST	FY 25-27 EST	FY 27-29 EST
LICENSE & RENEWALS	3,197,055	3,096,266	3,400,000	3,765,000	3,765,000
NONBUSINESS LIC & FEES	14,900	22,230	14,000	14,000	14,000
CHARGES FOR SERVICES	25,105.50	25,635	146,000	146,000	146,000
FINES AND FORFEITS	243,135.82	191,788.52	240,000	240,000	240,000
INTEREST	49,214.63	49,114.59	60,000	60,000	60,000
OTHER REVENUE	14,678.06	6,852.01	9,000	9,000	9,000
TOTAL	**$3,529,189**	**$3,391,886**	**$3,869,000**	**$4,265,000**	**$4,265,000**

Fee Increase Effective July 1, 2023 – Estimated $365,150 increase in revenue
Raise Dental License Application fee by $100 - 490 expected applicants = $49,000 additional revenue
Raise Dental 2-year license fee by $50 - 3800 licensees = $190,000 additional revenue
Raise Dental Hygiene Application fee by $30 - 510 expected applicants = $15,300 additional revenue

Raise Dental Hygiene 2-year license fee by $25 - 4300 licensees = $107,500 additional revenue
Raise Dental Therapist Application fee by $30 on 70 applicants = $2,100 additional revenue
Raise Dental Therapist 2-year license fee by $25 on 50 licensees = $1,250 additional revenue

Fee schedule for 2023-2025 & 2025-2027 (March 29, 2024)

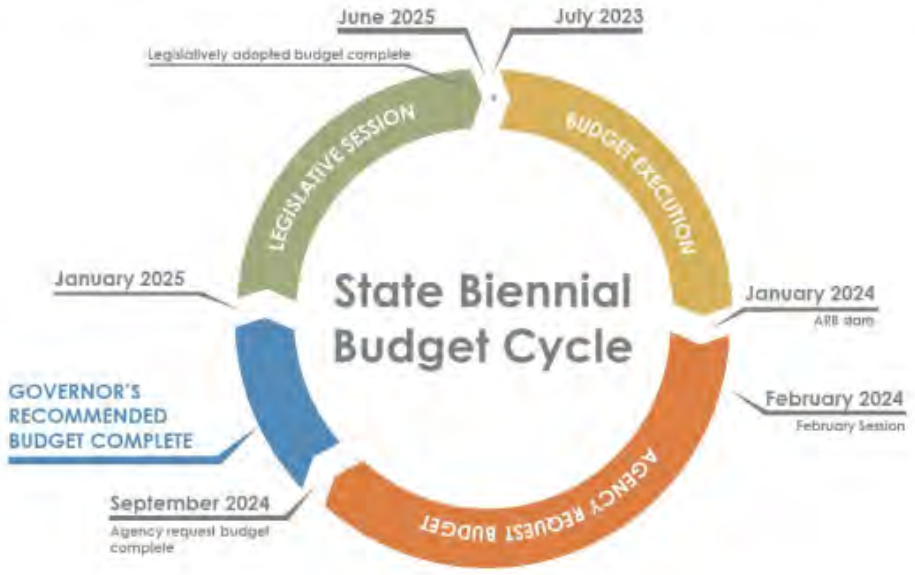
OBD Fee Category	Amount	Object Code
Licensure fee – Dentist /Specialty	$436	2101
Faculty - License fee	$385	2101
Application fee - Licensure by Examination - Dentist	$445	2111
Application fee - LOWFE – Dentist	$890	2112
Faculty – Application fee	$405	2111
Dental/Specialty Renewal fee	$436	2104
Licensure Fee – Dental Therapy	$255	2106
Application fee – Licensure by Examination – Dental Therapy	$210	2108
Application fee – LOWFE – Dental Therapy	$820	2109
Dental Therapy Renewal fee	$251	2107
Licensure by Examination fee – Dental Hygiene	$251	2103
Application fee – Licensure by Examination - Dental Hygiene	$210	2113
Application fee – LOWFE – Dental Hygiene	$820	2114
Dental Hygiene Renewal fee	$251	2105
Expanded Practice Permit – Dental Hygiene	$75	2142
Restorative Functions - Hygiene	$50	2143
Anesthesia Permit – Nitrous Oxide	$40	2131
Anesthesia Permit – Minimal	$75	2132
Anesthesia Permit – Deep Sedation	$75	2133
Anesthesia Permit – General Anesthesia	$140	2134
Anesthesia Permit – Moderate	$75	2135
Instructor Permit	$40	2141
Delinquent fees and Reinstatement	$50, $100, $150, $250, $500	1290
Subscription to Minutes	$60	1701
Verification of Licensure	$2.50 each	1702
Certificate of Standing	$20	1703
Data Processing Orders	Varies	1704
Public Records	Varies	1705
Prescription Monitoring Program	$50	1706
OHWI Data Collection	$4	1707
Miscellaneous Revenue	Varies	1774
Civil Penalties	Varies	2470
Merchant Card - Credit Card Service Fees	$3.50	408
Reimbursement for Board Member Attendance (Trainings, etc.)	Varies	1811
DANB Checks	Varies	2115

Information for Board discussion regarding the development and planning of the OBD's 2025-2027 Budget

This information is for general discussion and consideration by the Board Members and Executive Director. There are three new Board Members and all need to have a solid overview of operations and potential cost issues leading up to the development of the next budget. The OBD has finite resources (people, revenue and time). This document is intended to inform the Board on important operations and budgetary issues. This document will be reviewed at the April 26, 2024 Board Meeting. This is meant to be informative and helpful to the Board in the development of the OBD's 2025-2027 Budget.

PHASES OF THE BUDGET PROCESS

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



Brief Overview

The Oregon Board of Dentistry (OBD) is an Other Funds agency. Basically the OBD's source of funding is limited. Applications for licensure and current license base are the OBD's main revenue sources (96%). The Oregon Revised Statutes directs that all money received by the Board be used only for the administration and enforcement of ORS 676.850 and 680.010 to 680.205 and all referenced in Chapter 679.

The March 2024 Revenue Memo has more detail on this and is in this Board Meeting packet (4/26/2024).

Data shows sources of most revenue and anticipated revenue is stagnant.

Licenses Issued per year																
Per year	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	*est 2024*	*est 2025*	*est 2026*	*est 2027*	*est 2028*	*est 2029*
Dental Licenses	168	183	196	170	221	224	192	180	172	190	*190*	*190*	*195*	*195*	*200*	*200*
Dental Hygiene Licenses	210	221	239	224	196	202	188	188	206	195	*195*	*195*	*200*	*200*	*205*	*205*
Dental Therapy Licenses									4	14	*20*	*30*	*40*	*50*	*60*	*70*
Total Licenses issued	378	404	435	394	417	426	380	368	382	399	*405*	*415*	*435*	*445*	*465*	*475*

Calendar Year	2023	est 2024	est 2025	est 2026	est 2027	est 2028	est 2029	est 2030
Dental Licenses	3732	3750	3750	3775	3775	3800	3800	3825
Hygiene Licenses	4301	4300	4300	4325	4325	4350	4350	4375
Dental Therapy Licenses	18	30	40	50	60	70	80	90
Total Licenses	**8051**	**8080**	**8090**	**8150**	**8160**	**8220**	**8230**	**8290**

Revenue Issues

- License base has plateaued
- The last fee increases were approved by the Legislature on July 1, 2023.
- What impact would a licensure compact have on the OBD's revenues? I believe it could decrease revenue for the OBD, and increase operating costs. It will add another layer of bureaucracy to be part of any license compact.

Select Major Cost Drivers

- **STAFF – $2,700,000**
- **DOJ – $336,000**
- **RENT - $207,000**
- **DAS - $94,000**
- **OMB transition to DAS - $100,000**
- **HPSP - $138,000**
- **OWP - $80,000**

Staff

In the current 2023-2025 OBD Budget Biennium the OBD has 7.5 Full Time Employee/Equivalents (FTE). One Full Time Dental Investigator position was reduced from FTE to 1/2 time (.5 FTE) effective Jan 2024. This transition was made to save the OBD money and align investigator staffing level to the case load. It would be challenging to reduce staff level any further to maintain current service level.

Total complaints and investigations each year can ebb and flow. The total amount of work at the OBD increases every year. One source of additional work is the Legislature. Our legislature passes important laws every legislative session to benefit Oregonians. Recent examples include dental therapy becoming a new type of Licensee and all the rules and processes to license and regulate them. Also, recent legislation requiring the OBD to convene a standing dental assistant workforce shortage advisory committee required to meet four times a year. Other examples include requiring cultural competency continuing education and mandating spore testing as well. The Governor's expectations of agency leaders and the executive branch logically changes with new leadership.

DAS also increases agency workload in different ways. The onboarding process for new board members and staff members has become more robust and bureaucratic. Reporting requirements and transitions to Workday, Oregon Buys, InLumon, DAS Payroll, etc…are some recent examples as well.

Impact of the generous Cost of Living Adjustments (COLA) on a hypothetical employee. Jane Doe earns $50,000 per year at Step 5. Assume every December on her work anniversary she advances another Step. Each year most state employees advance another Step up the salary ladder on their work anniversary date up to 9 Steps.

Jan 2023 - $50,000 a year salary
Dec 2023 - $52,500 – she earns her Step increase of 5%
Jan 2024 - $55,912 (6.5% COLA most state employees automatically receive)
Dec 2024 - $58,708 – she earns her Step increase of 5%
Jan 2025 - $62,553 (6.55% COLA most state employees automatically receive)
Dec 2025 - $65,681 – she earns her Step increase of 5%

In 3 years Jane Doe's salary will have increased 31%. This has an impact on the OBD and throughout all state government budgets.

A small staff does not have additional resources to fall back on like a larger state agency. When staff are out for vacations or for unexpected issues like sick leave, it

forces the agency to prioritize work and unfortunately other work can be delayed. Extended periods of leave to utilize Paid Leave Oregon can be a real challenge to a small agency in fulfilling its mission and delivering world class customer service.

Here is what we have done to adapt to our work and the changing landscape of work within a state agency:

- Streamline
- Prioritize
- Eliminate
- Educate
- Empower
- Evaluate

DOJ - Legal Support

The OBD is assigned an attorney. The attorney's fees are nonnegotiable and currently it is $275/hour. In the current budget biennium the OBD has allocated $339,000 for DOJ support.

Rent

The OBD's Lease expenditure for the current biennium is $207,000. However the Lease agreement allows certain add on/pass through fees from the landlord. This lease was negotiated by DAS on behalf of the OBD. Last month we paid over $10,000. I reached out to DAS in March to ask that they attempt to renegotiate the terms to reduce our costs. An update on this will be provided when this is being discussed on 4/26.

DAS

The Department of Administrative Services (DAS) charges all state agencies a menu of charges to support state government. These are nonnegotiable and have been increasing every biennium. The 2023-25 rates are 28% higher than the 2021-23 biennium. ($73,273 in 2021-23)

STATE GOVERNMENT SERVICE CHARGES
Dentistry, Board of -- 83400

Description	2023-25 LAB Amount
Central Government Service Charges	$9,817
COBID - Certification Office for Business Inclusion and Diversity	$646
DAS - Chief Financial Office	$5,000
DAS - Chief Human Resource Office	$7,941
DAS - Chief Operating Office	$2,088
DAS - Chief Operating Office - Office of Public Records Advocate	
DAS - Enterprise Goods & Services-Liability (Auto & General)	$8,563
DAS - Enterprise Goods & Services-Property (Auto & General)	$688
DAS - Enterprise Goods & Services-Workers Compensation	$822
DAS - Enterprise Information Services (EIS)	$5,000
DAS - Enterprise Goods & Services-Procurement Services	$1,202
DAS - Enterprise Goods & Services-Workday Payroll System	$3,493
DAS - Enterprise Asset Management & Real Estate Services	$647

DAS - Enterprise Asset Management-Surplus Property Base	$85
DAS - Enterprise Information Services -Microsoft 365	$18,901
DAS - Enterprise Information Services-Data Center Services (DCS)	$12,402
Oregon Government Ethics	$280
Oregon Law Library	$651
Oregon State Library	$932
Secretary of State - Administrative Rules	
Secretary of State - Archives Compact Shelving	$130
Secretary of State - Archives & Records Management	$2,833
Secretary of State - Archives Records Center	$8,041
Secretary of State - Audits	$3,770
Office of Public Records Advocate	$182
Total	$94,114

OMB transition to DAS

The Legislature directed the OBD in a budget note in its 2023-2025 Budget to look at the feasibility of DAS taking over all financial and accounting support functions from the Oregon Medical Board. The OBD and OMB offices are in the same building in downtown Portland. The OBD is on floor 7 and the OMB on floor 6. Once the OBD moved into its current building in Dec 2013 and settled in, then discussions between OBD and OMB leadership led to an Inter-Agency Agreement (IAA) being formalized. The IAA evolved to cover accounting, budgeting, human resource and payroll support. The OMB has dedicated staff in each area and was able to incorporate the OBD's work and needs within its own. The OBD's fee paid per the IAA to the OMB was updated (11/2023) excluding payroll support and is approximately $2,260 per month. The transition on July 1, 2025 to DAS handling those functions for the OBD will cost the OBD $4,166 per month. That is an 84% increase if you were curious and does not cover payroll support, which will be an additional charge too.

Budget Notes

Transition to the Department of Administrative Services Shared Financial Services

The Oregon Board of Dentistry, in consultation with the Department of Administrative Services Chief Financial Office and Oregon Medical Board, shall review the most cost effective and programmatically efficient approach to transition its budget and accounting services from the Oregon Medical Board to the Department of Administrative Services (DAS), Shared Financial Services (SFS) beginning in the 2025-27 biennium. The agency shall submit a report to the Interim Joint Committee on Ways and Means or Emergency Board before January 2024 on its findings and include for consideration a plan to complete the transition in the most cost effective and efficient way, including the workload impact on both the Oregon Medical Board and DAS SFS.

OBD Financial Services Costs

	2023-2025 Biennium		2025-2027 Biennium
Time Period	7/23-11/23	12/23-6/25	7/25-6/27
Financial Services Monthly Fee	$913	$1,350	$4,166
Biennium Total Cost	$30, 215		$99,984

Health Professionals' Services Program (HPSP)

The Legislature via ORS 679.190 (2009) allows health licensing boards to establish an impaired health professional program. It is not mandatory that the OBD be part of this. The OBD along with the Medical, Pharmacy and Nursing boards are the only Oregon health boards participating in this program adhering to the statutes and rules allowing this for its licensees.

Based on the current monthly cost to OBD. The estimated 2025 – 2027 Expense (at current rates) would be $138,120. Most Health Licensing Boards in Oregon do not have this option (HPSP) and function and carry on their missions. The Nursing Board is currently NOT enrolling any of their Licensees into the HPSP. They also are NOT allowing anyone to self-refer into the HPSP. (Verified 3/26/2024)

Alternatives and discussions are occurring with the Governor's office and other health licensing boards.

			Monthly Cost*:	**$76,547**	
			Weighted:	50%	50%
			Weighted Cost:	$38,274	$38,274
	Board's Eligible Licensees	Board's Participating Licensees	Fee for Board's Eligible Licensees	Fee for Board's Participating Licensees	**Board Total Fee**
Board of Nursing	56,916	20	$23,694	$8,143	**$31,837**
Medical Board	22,683	60	$9,443	$24,430	**$33,873**
Board of Pharmacy	4,386	8	$1,826	$3,257	**$5,083**
Board of Dentistry	7,955	6	$3,312	$2,443	**$5,755**
TOTALS	**91,940**	**94**	**$38,275**	**$38,273**	**$76,548.00**

The OBD is in a situation unlike Medical, Pharmacy and Nursing, in that our License base has plateaued while theirs have grown in recent years. The Nursing and Pharmacy Boards in the 2024 Legislative Session requested and received approval for additional staff to support increase in applicants for licenses, support admin functions, and to handle increased investigative caseload as well.

The Oregon Wellness Program (OWP)

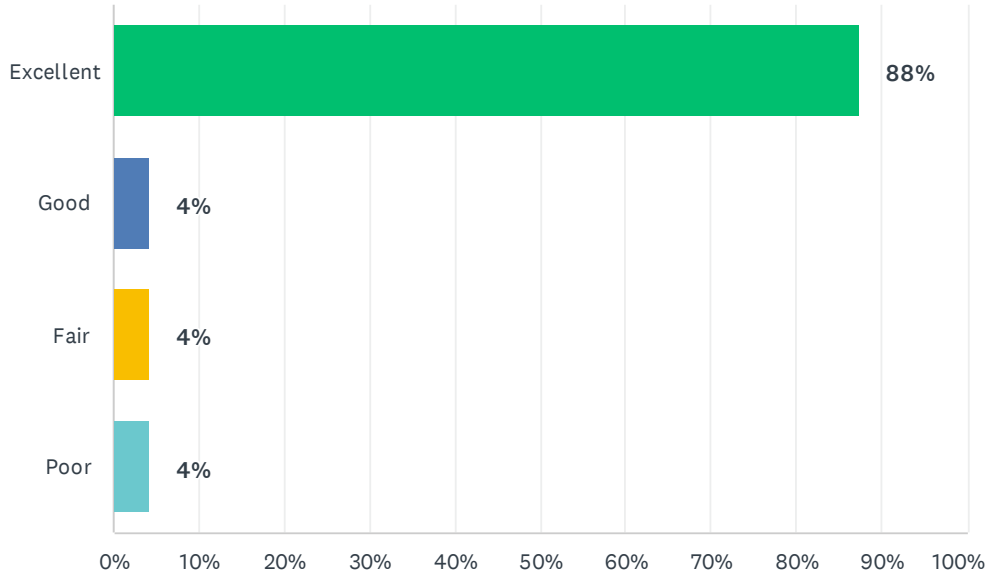
In the current budget biennium, the OBD supported and $80,000 was approved to fund the OWP to support our Licensees. The OWP is receiving funding from other health boards and sources, not just the OBD. This funding was not passed on to current licensees and is absorbed from the current budget.

The purpose of the OWP is to ensure health care professionals within the state of Oregon have access to mental health support that is non-reported, urgently available, and complimentary. OWP contracts with licensed and credentialed mental health providers, who each have a minimum of five years professional experience providing services to health care professionals. The program was founded in 2018 to support the well-being of Oregon healthcare professionals through education, research of the issue of burnout, as well as by delivering counseling and related services via in-person and telemedicine appointments. OWP affiliated providers offer:

- Up to eight complimentary sessions per calendar year
- Appointments within three business days and no “paper trail” or reporting to boards or insurance companies.

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

Answered: 24 Skipped: 0

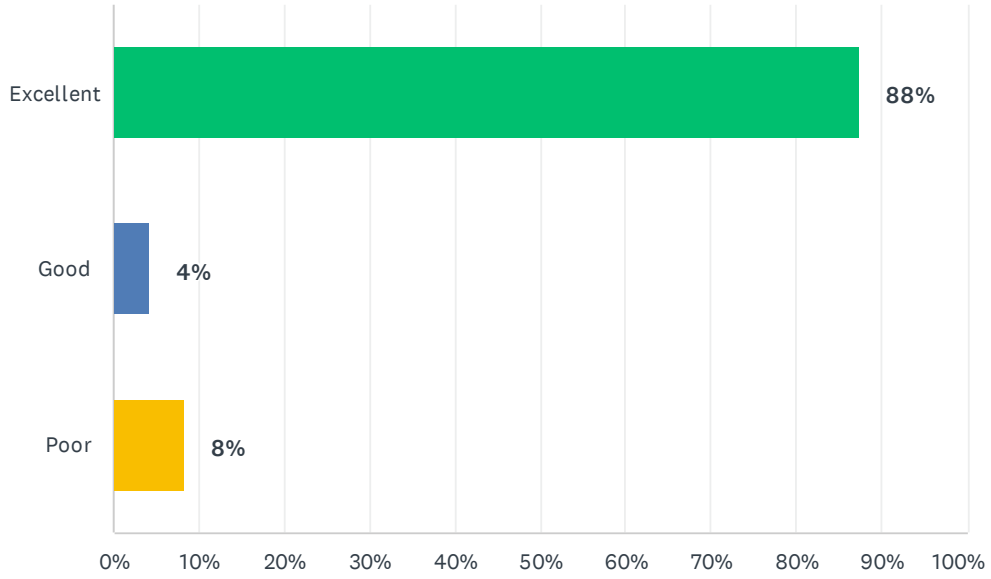


ANSWER CHOICES	RESPONSES	
Excellent	88%	21
Good	4%	1
Fair	4%	1
Poor	4%	1
TOTAL		24

Attachment #4

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

Answered: 24 Skipped: 0

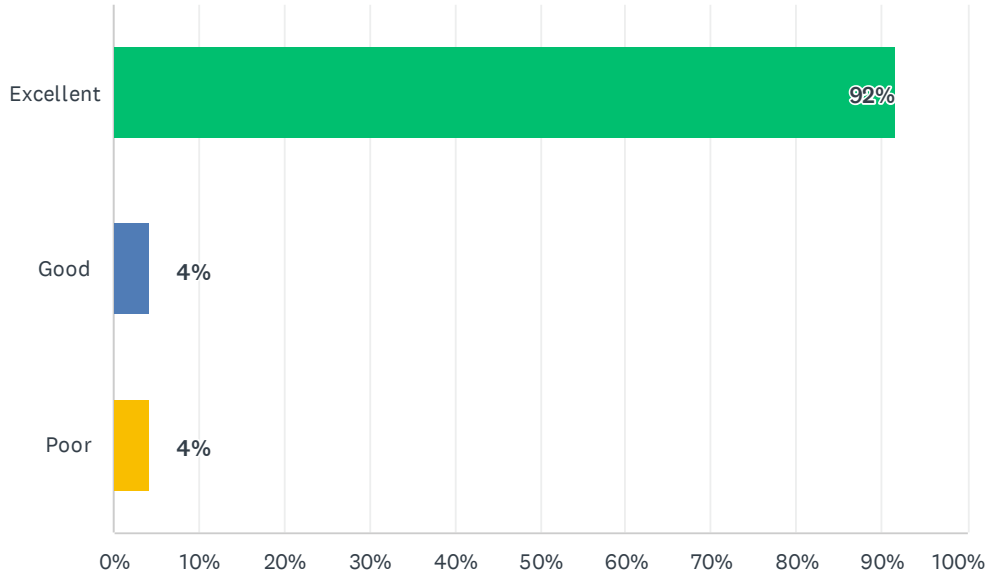


ANSWER CHOICES	RESPONSES	
Excellent	88%	21
Good	4%	1
Poor	8%	2
TOTAL		24

Attachment #4

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

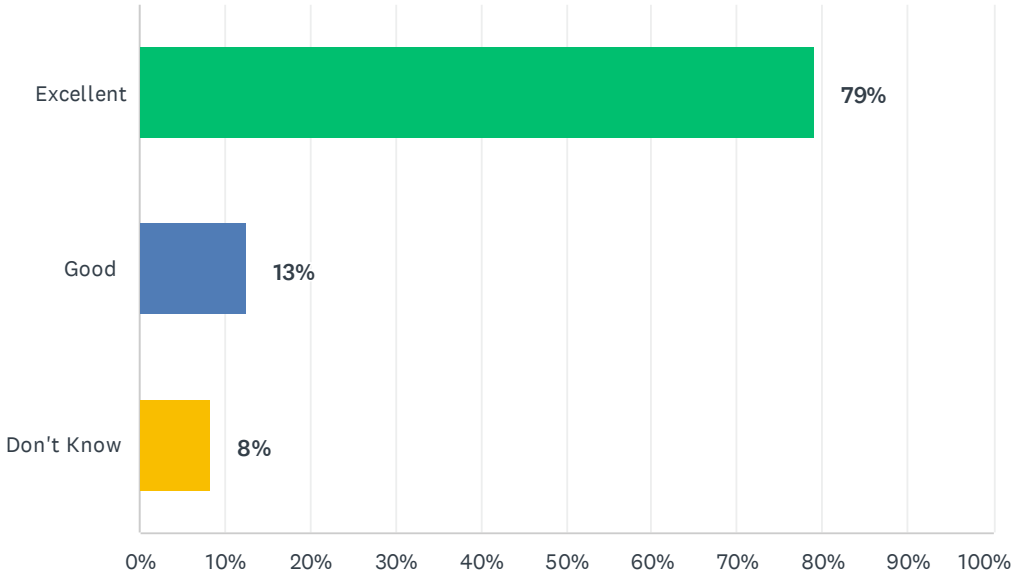
Answered: 24 Skipped: 0



ANSWER CHOICES	RESPONSES	
Excellent	92%	22
Good	4%	1
Poor	4%	1
TOTAL		24

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

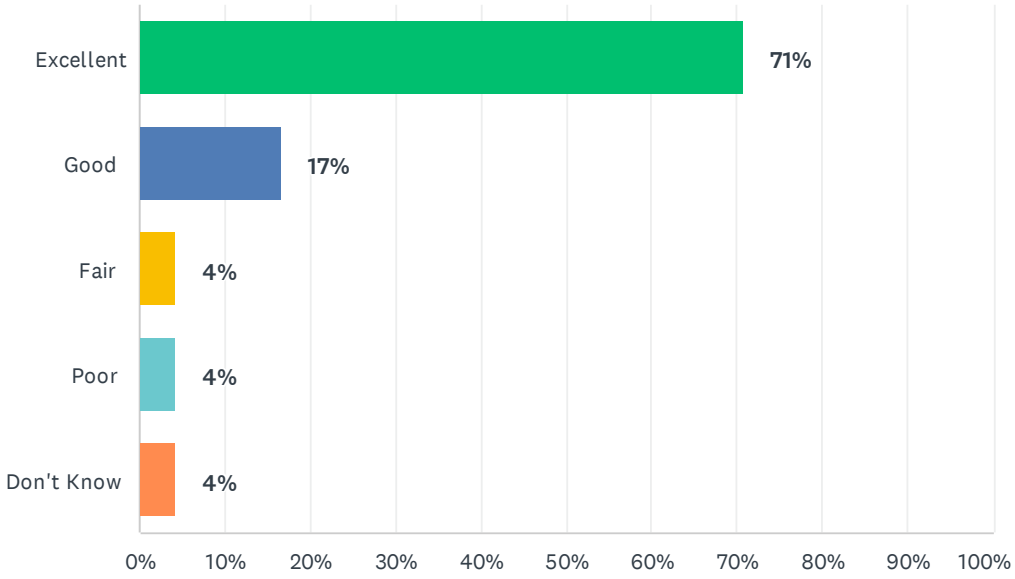
Answered: 24 Skipped: 0



ANSWER CHOICES	RESPONSES	
Excellent	79%	19
Good	13%	3
Don't Know	8%	2
TOTAL		24

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

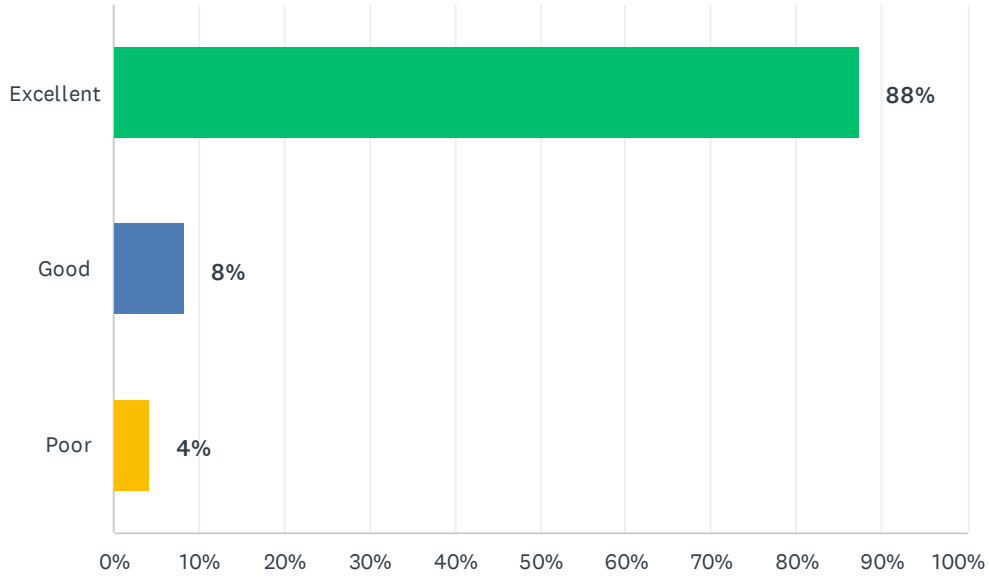
Answered: 24 Skipped: 0



ANSWER CHOICES	RESPONSES	
Excellent	71%	17
Good	17%	4
Fair	4%	1
Poor	4%	1
Don't Know	4%	1
TOTAL		24

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

Answered: 24 Skipped: 0



ANSWER CHOICES	RESPONSES	
Excellent	88%	21
Good	8%	2
Poor	4%	1
TOTAL		24

Attachment #4

OREGON BOARD OF DENTISTRY

Today's Presentation

Stephen Prisby, Executive Director
Haley Robinson, Office Manager

- **Board Updates – Resources**
- **Oregon Wellness Program available to All Licensees**
- **Dental Therapists – New Licensee**
- **Dental Implant Rule changes effective January 2024**
- **FYI – License Renewal & Reminders**
- **Statistics**
- **Complaints & Investigation Process**
- **CE Reminders**
- **FAQs**

OREGON BOARD OF DENTISTRY

History & Mission Statement:

The Board of Dentistry was created by an act of the Legislature in 1887.

The oldest health licensing board in Oregon.

The mission of the Oregon Board of Dentistry is to promote quality oral health care and protect all communities in the State of Oregon by equitably and ethically regulating dental professionals.

OREGON BOARD OF DENTISTRY

FUNDING

The activities of the Board are funded from license application, renewal, and permit fees paid by licensees, as well as dental assistants for certifications.

The OBD's 2023-2025 Budget is approximately $4.2 million.

Less than 4% of our funding is derived from civil penalties paid by licensees who were disciplined.

OREGON BOARD OF DENTISTRY

Ten Members serve on the Board:

- Six Dentists
- Two Dental Hygienists
- Two Public Members

All are appointed by the Governor and confirmed by the Senate. A term is four years in length. They can serve two terms.

OREGON BOARD OF DENTISTRY

In April 2024, 3 board members term out & we welcome 3 new ones

Kristen Simmons, RDH, term of service is April 1, 2024 to March 31, 2028

Dr. Olesya Salathe term of service is April 2, 2024 to April 1, 2028

Ginny Jorgensen term of service is April 7, 2024 to April 6, 2028

OREGON BOARD OF DENTISTRY

Board Staff

Stephen Prisby
Executive Director

Haley Robinson
Office Manager

Kathleen McNeal
Licensing Manager

Temporary Employee

Dawn Dreasher Admin Support

OREGON BOARD OF DENTISTRY

Board Staff

Angela Smorra, D.M.D.
Dental Director/Chief Investigator

Bernie Carter, D.D.S.
Dental Investigator

Shane Rubio
Investigator

We have a vacant Investigator position

OREGON BOARD OF DENTISTRY

Board accomplishes its mission by:

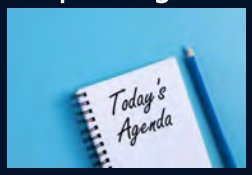
- Reviewing & setting education standards
- Requiring continuing education of all licensees
- Investigating complaints and enforcing the provisions of the Dental Practice Act
- Communicating Board policies and other pertinent information to all licensees on a regular basis
- Providing clear interpretation of Board statutes and rules to licensees and members of the public
- Acting as a resource to dental consumers in determining the adequacy of their dental treatment
- Working with other health care licensing boards, professional associations and the educational system to develop partnerships for forging a viable health care delivery system

OREGON BOARD OF DENTISTRY

Upcoming Board Meetings

The meetings are always open to the public. Information should be submitted to the executive director 12 days before a Board Meeting, to be considered for that meeting's agenda. All Board Meetings are available through a zoom or teleconference option. The recordings are posted on the OBD website a few days after each meeting.

Upcoming scheduled Board Meetings (every other month):



April 26, 2024
June 14, 2024
August 23, 2024
October 25, 2024
December 13, 2024

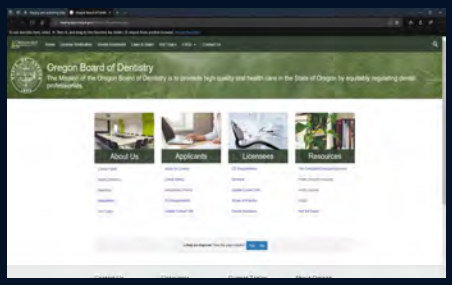
OREGON BOARD OF DENTISTRY

The Board has standing Committees and may create new ones

- Administrative Workgroup
- Anesthesia
- Communications
- Dental Hygiene
- Enforcement & Discipline
- Licensing, Standards & Competency
- Dental Therapy Rules Oversight
- Rules Oversight
- Dental Assistant Workforce Shortage Advisory

OREGON BOARD OF DENTISTRY

Visit our Website



- Answers to frequently asked questions
- Downloadable forms
- Board meeting agendas
- Board meeting minutes
- Dental Practice Act

- Newsletters & Strategic Plan

www.oregon.gov/Dentistry

OREGON BOARD OF DENTISTRY

Newsletters

The Newsletters have important and useful information

- Overview of rule changes
- Board Member Bios
- Investigators' Concerns
- Meeting Dates
- FAQs & more

OREGON BOARD OF DENTISTRY

OBD 2022 – 2025 Strategic Plan & Goals

AGENCY GOALS for 2023 - 2025 include:

- Implement 2022 - 2025 Strategic Plan Initiatives
  - **Licensure Evolution**
    - Develop and implement rules based on legislative changes
    - Successfully implement Dental Therapy Rules
  - **Dental Practice Accountability**
    - Ensure Licensee dictates clinical care provided to patients
    - Assert OBD jurisdiction over dental practices regardless of ownership model
  - **Community Interaction and Equity**
    - Increase ease of access to OBD services and information
    - Ensure equity exists in investigation outcomes
  - **Workplace Environment**
    - Increase workplace flexibility through hybrid work models
    - Increase workplace satisfaction
  - **Technology & Processes**
    - Improve investigation management and archived files
    - Improve resource efficiencies
- Advance the Governor's priorities for state agencies
  - Increased accountability and prioritize customer service
  - Improving access to the OBD's services and information
  - Removing barriers that prevent people from getting assistance

OREGON BOARD OF DENTISTRY

Oregon Wellness Program (OWP) Effective August 2023

All Licensees may utilize the OWP

Promoting wellness for healthcare professions in Oregon through coordinated counseling services, education, and research

Over 35,000 licensees covered Physicians Physician Assistants Podiatrists Acupuncturists Nurse Practitioners **Dentists Dental Hygienists & Dental Therapists**

- **Confidential – NO interaction with the Board of Dentistry**
- **NO Insurance involved**
- **FREE**
- **Support for you dealing with stress, burnout, work-life balance, sad news and difficult people….**

The OWP is serviced by 34 MHPs • Mental health professionals - PhD, PsyD, Psychiatrist, PMHNP, LPC, or LCSW • Licensed in Oregon and offer telehealth care to extend geographic availability • Experienced providing care to healthcare colleagues

OREGON BOARD OF DENTISTRY

DENTAL THERAPY

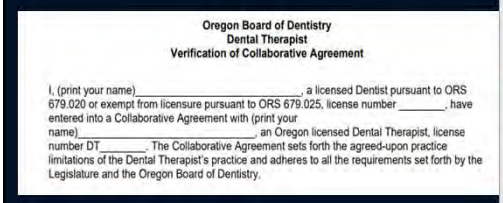
- HB 2528(2021) was signed by Governor Kate Brown in July 2021. It authorizes the OBD to regulate and license Dental Therapists.
- The bill is 13 pages long.

- The OBD went through extensive meetings and rules were put in place effective July 1, 2022.
- The first license was not issued until Nov 1, 2022 and there are only 4 DT. There are also 13 others licensed as a DT and DH.

OREGON BOARD OF DENTISTRY

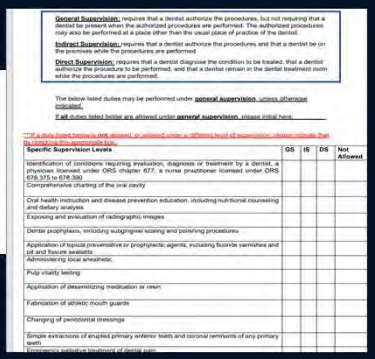
DENTAL THERAPY

- A dental therapist MUST have a collaborative agreement with a licensed Oregon Dentist to practice in Oregon. This 7 page document must be on file with the Board, submitted annually and when any parameters change.



Oregon Board of Dentistry
Dental Therapist
Verification of Collaborative Agreement

I, (print your name)_____, a licensed Dentist pursuant to ORS 679.020 or exempt from licensure pursuant to ORS 679.025, license number _____, have entered into a Collaborative Agreement with (print your name)_____, an Oregon licensed Dental Therapist, license number DT_____. The Collaborative Agreement sets forth the agreed-upon practice limitations of the Dental Therapist's practice and adheres to all the requirements set forth by the Legislature and the Oregon Board of Dentistry.



General Supervision: requires that a dentist authorize the procedures, but not requiring that a dentist be present when the authorized procedures are performed. The authorized procedures may also be performed at a place other than the usual place of practice of the dentist.

Indirect Supervision: requires that a dentist authorize the procedures and that a dentist be on the premises while the procedures are performed.

Direct Supervision: requires that a dentist diagnose the condition to be treated, that a dentist authorize the procedure to be performed, and that a dentist remain in the dental treatment room while the procedures are performed.

The below listed duties may be performed under **general supervision**, unless otherwise indicated.

If **all** duties listed below are allowed under **general supervision**, please initial here: _____

**If a duty listed below is not allowed, or allowed under a different level of supervision, please indicate that by checking the appropriate box.

Specific Supervision Levels	GS	IS	DS	Not Allowed
Identification of conditions requiring evaluation, diagnosis or treatment by a dentist, a physician licensed under ORS chapter 677, a nurse practitioner licensed under ORS 678.375 to 678.390				
Comprehensive charting of the oral cavity				
Oral health instruction and disease prevention education, including nutritional counseling and dietary analysis				
Exposing and evaluation of radiographic images				
Dental prophylaxis, including subgingival scaling and polishing procedures				
Application of topical preventative or prophylactic agents, including fluoride varnishes and pit and fissure sealants				
Administering local anesthetic				
Pulp vitality testing				
Application of desensitizing medication or resin				
Fabrication of athletic mouth guards				
Changing of periodontal dressings				
Simple extractions of erupted primary anterior teeth and coronal remnants of any primary teeth				
Emergency palliative treatment of dental pain				

OREGON BOARD OF DENTISTRY

DENTAL IMPLANT RULE CHANGES

OAR 818-012-0005 Scope of Practice

(4) A dentist may place endosseous implants to replace natural teeth after completing a minimum of **56 hours of hands on clinical course(s), which includes treatment planning, appropriate case selection, potential complications and the surgical placement of the implants** under direct supervision, and the provider is approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE), by the American Dental Association Continuing Education Recognition Program (ADA CERP) or by a Commission on Dental Accreditation (CODA) approved graduate dental education program.

(5) A dentist placing endosseous implants must complete at least seven **(7) hours of continuing education related to the placement and or restoration of dental implants every licensure renewal period (Effective January 1, 2024).**

OREGON BOARD OF DENTISTRY

DENTAL IMPLANT RULE CHANGES

I obtained my Oregon dental license on, or after, January 1, 2024. Am I required to take 56 hours of hands on clinical implant course(s) prior to placing dental implants?

Yes. Once you have completed the 56 hours of hands on clinical course(s), or if you have already completed the required training hours, the OBD recommends that you obtain a letter of verification, signed by your training director, certifying that you have completed the required training as stated in the rule. The OBD recommends that you maintain easily accessible copies of that documentation throughout your career in Oregon.

I have placed a great number of implants over the years with a high success rate. Can I be "Grandmothered" into placing implants without taking 56 hours of hands on clinical courses?

No, there is not currently a portion of the rules that allows this. In order to place implants after January 1, 2024, you will need to meet the 56 hour requirement in 818-012-0005(4)

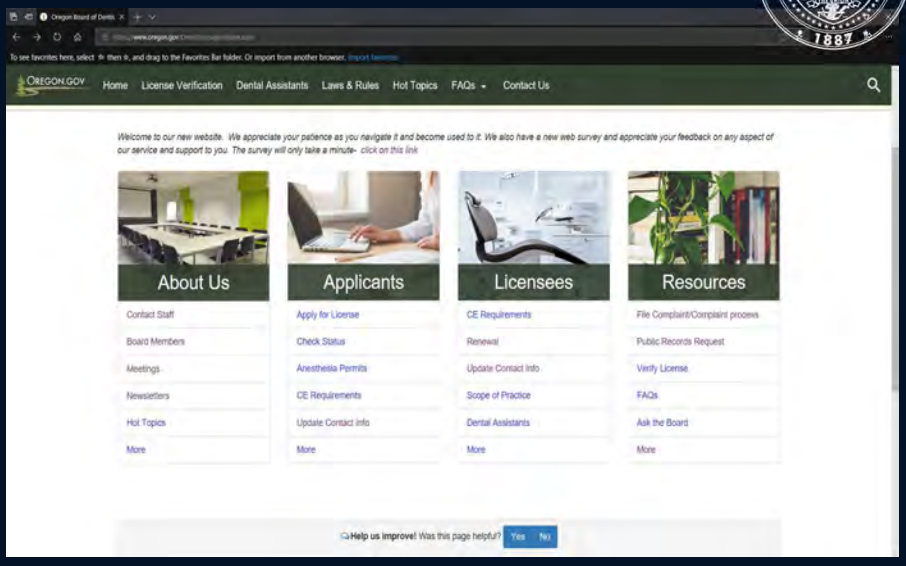
OREGON BOARD OF DENTISTRY

One License Renewal reminder postcard is sent and all investigations are initiated via the US mail.

Failure to respond to the Board within 10 days. ORS 679.170

Every Licensee shall advise the board within 30 days of any change of address. ORS 679.120

OREGON BOARD OF DENTISTRY



OREGON BOARD OF DENTISTRY

Rule Changes Effective Jan 1, 2020

HB 2011 (2019) requires Cultural Competency CE
The Board will require 2 hours of this CE, beginning in 2021
You still only need your 40, 36 or 24 hours for a 2 – year licensure period. The 2 hours of cultural competency CE will be calculated within your total hour requirement

"Cultural competency continuing education is a life-long process of examining values and beliefs while developing and applying an inclusive approach to healthcare practice in a manner that recognizes the context and complexities of provider-patient interactions and preserves the dignity of individuals, families and communities.

Continuing education in cultural competency should teach attitudes, knowledge and skills to care effectively for patients form diverse cultures, groups and communities."

OREGON BOARD OF DENTISTRY

Anesthesia Rule Reminders

818-026-0020 **A licensee must ensure a written emergency response protocol is in place for all patients undergoing nitrous oxide, minimal sedation, moderate sedation, deep sedation or general anesthesia.**

818-026-0020(4) **A licensee that does not hold a Moderate, Deep Sedation or General Anesthesia Permit may not administer, for purpose of anxiolysis or sedation, Benzodiazepines or narcotics in children under 6 years of age.**

818-026-0030 **A dentist with no anesthesia permit, may utilize a single oral agent to achieve anxiolysis.**

There have been over 130 rule changes made in the Dental Practice Act since 2018

OREGON BOARD OF DENTISTRY

Public Rulemaking

The Board is regularly reviewing and updating rules in the Dental Practice Act. Board Committees review and make recommendations to the Board. The Board then votes to hold public rulemaking hearings before changing any rules.

Email blasts are sent out periodically and documents which detail all rule changes up for consideration. Board meeting agendas/materials also cover the proposed rule changes.

Public Rulemaking Hearings are conducted and comment may always be submitted by email.

On the OBD webpage front page and laws & rules tab are the most recent updates and rule changes to the Dental Practice Act.

OREGON BOARD OF DENTISTRY

OREGON BOARD OF DENTISTRY
PUBLIC RULE MAKING HEARING
December 15 at 1 pm – 1:30 p.m.* to be conducted via Zoom

Comments and feedback may be submitted until January 19, 2024 at 4 p.m. to information@obd.oregon.gov

***The public meeting will end early if no one is present or plans to submit comments on the rule changes proposed.**

1. **818-012-0005 Scope of Practice**
2. **818-021-0060 Continuing Education — Dentists**
3. **OAR 818-026-0010 Definitions**
4. **OAR 818-026-0050 Minimal Sedation Permit**
5. **OAR 818-026-0055 Dental Hygiene, Dental Therapy, and Dental Assistant Procedures Performed Under Nitrous Oxide or Minimal Sedation**
6. **OAR 818-038-00XX Additional Functions of Dental Therapists – proposed New rule**
7. **OAR 818-042-0020 Dentist, Dental Therapist and Dental Hygienist Responsibility**
8. **OAR 818-042-0100 Expanded Functions — Orthodontic Assistant (EFODA)**
9. **OAR 818-042-0114 Additional Functions of Expanded Function Preventive Dental Assistants (EFPDA)**
10. **OAR 818-042-0115 Expanded Functions — Certified Anesthesia Dental Assistant**
11. **OAR 818-042-0117 Initiation of IV Line and Phlebotomy Blood Draw**

OREGON BOARD OF DENTISTRY

Public Rulemaking

The public comment period on the proposed rule changes was open until January 19, 2024 and no comments were submitted by anyone.

The Board Members voted on the proposed rule changes at the February 23, 2024 Board Meeting. These latest rule changes are effective May 1, 2024.

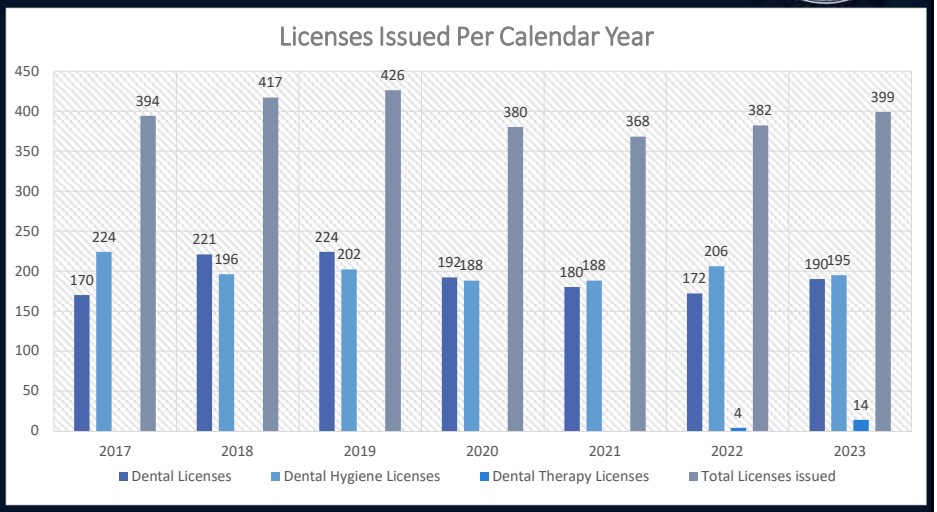
The 11 rule changes will be referenced on the OBD website, cited in the next newsletter and staff can get information to you as well.

OREGON BOARD OF DENTISTRY

OREGON BOARD OF DENTISTRY

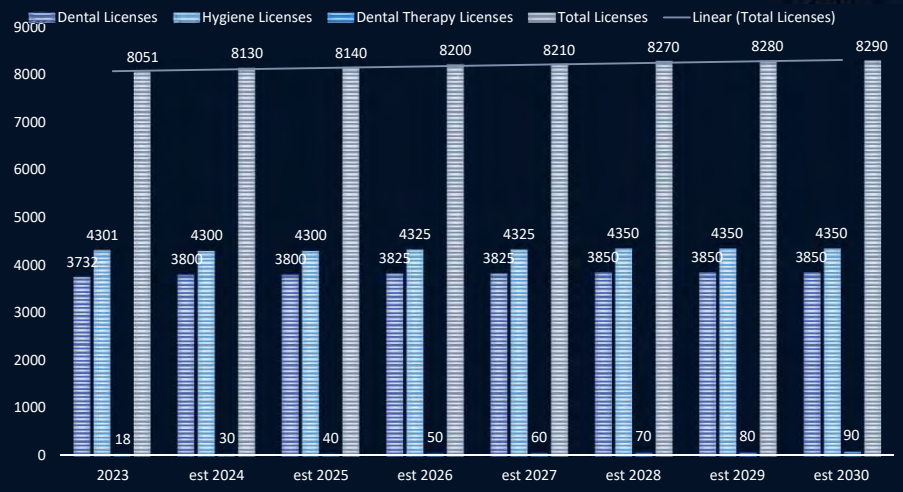
As of January 1, 2024. There were 3732 dentists, 4301 dental hygienists and 18 dental therapists.

OREGON BOARD OF DENTISTRY



OREGON BOARD OF DENTISTRY

Licensee Estimates up to 2030



OREGON BOARD OF DENTISTRY

Important Reminders

- Dental License Renewal
- Register with the PDMP
- Dental Hygiene License Renewal
- Dental Therapy License Renewal
- Continuing Education
- Current BLS for Healthcare Provider
- Sterilizer Monitoring Records
- **Update your email and mailing addresses as we are reducing our use and reliance on US postal Service, but US mail is still utilized.**

OREGON BOARD OF DENTISTRY

Now let's shift gears and discuss enforcement and investigations.

OREGON BOARD OF DENTISTRY

PRIMARY ACTIVITIES

Enforcement

The Board investigates complaints submitted alleging misconduct or unacceptable patient care by licensees of the Board. Details of complaints are confidential and not available as public information.

If a licensee has been disciplined by the Board, the details of the disciplinary action (but not of the investigation) become public. The number of complaints fluctuates in a given year, but the average over the past 7 years has been 218 per year.

In an average year about 13% - 18% result in disciplinary action being taken.

OREGON BOARD OF DENTISTRY

PRIMARY ACTIVITIES
Enforcement

Reporting Obligations

Per ORS 676.150(3), a licensee who is convicted of a misdemeanor or felony or who is arrested for a felony crime shall report the conviction or arrest to the Board within 10 days after the conviction or arrest.

OREGON BOARD OF DENTISTRY

Health Professionals' Services Program (HPSP)

- The Board has a legislatively mandated non-disciplinary, confidential diversion program to help licensees with substance abuse disorders and mental health issues
- Confidential, even Board members are unaware of who enters into program
- Typically up of 5 years of monitoring, must be in compliance & meet requirements of the program
- Board gets updates from staff diversion coordinator on progress, and informed if action needed

OREGON BOARD OF DENTISTRY

Complaints - Some Common Issues

- Communication break down
- Implant Complications
- Anesthesia Complications
- Sterilizer Monitoring deficiencies
- Continuing Education deficiencies
- Dentists complaining about each other
- Documentation Errors/None
- Radiographs/Records not being released to patient/other providers
- Failure to respond to the Board within 10 days (ORS 679.170)

OREGON BOARD OF DENTISTRY

The Processing of Complaints

Receipt of complaint. Screening/Determination to investigate.

Letter from the OBD requesting:

- Original chart (including patient ledger)
- Narrative describing care provided
- Digital copy of films if appropriate
- Continuing Education records
- Amalgam separator records
- Sterilizer monitoring records
- Proof of current BLS Healthcare certificate
- Verification and date that you have signed up with the PDMP if you have a DEA Registration

If you receive a letter from us regarding an investigation, please respond to us and we advise you contact your malpractice carrier ASAP.

OREGON BOARD OF DENTISTRY

The Investigation Process

- ✓ Case assignment
- ✓ Investigation and review of materials
- ✓ Draft report
- ✓ Request for interview
- ✓ Interview
- ✓ Supplement to report
- ✓ Recommendation from Protocols
- ✓ Evaluators review and recommendation
- ✓ Reviewed by the Board at regular meeting
- ✓ Board votes in public session on each case

OREGON BOARD OF DENTISTRY

The Board has developed disciplinary protocols to address a number of reoccurring violations and to be fair and equitable when disciplining Licensees.

- Completion of CE
- Maintaining Health Care BLS/CPR
- Maintaining ACLS/PALS
- Sterilizer Monitoring
- Working without a license
- Failure to respond to the Board within 10 days

  - Specific penalties
  - Uniform discipline
  - Prescribed timeframes to complete remediation efforts, pay fines or complete CE

OREGON BOARD OF DENTISTRY

ORS 679.140 gives us broad discretion to:

- Suspend judgement
- Place a licensee on probation
- Suspend a licensee to practice
- Revoke a license
- Place limitations on licensee
- Refuse to renew a licensee
- Accept the resignation of a licensee
- Assess a civil penalty
- Reprimand a licensee
- Impose any other disciplinary action the board in its discretion finds proper, including assessment of the costs of the disciplinary proceedings as a civil penalty

The Board may impose a civil penalty of up to $5,000 for each violation. The Board may continue with any investigation for a period not to exceed four years from the date of the expiration, suspension, revocation, retirement or surrender of the license.

OREGON BOARD OF DENTISTRY

The Board typically is monitoring 40 – 60 Licensees a year for compliance with board orders.

Caseload per Fiscal Year	2017	2018	2019	2020	2021	2022	2023
Formal Investigations Opened	199	272	281	216	195	150	213
Cases Completed and Closed	248	260	315	286	205	154	170
Cases resulting in discipline	57	89	85	47	24	22	28
Some cases had multiple respondents							

OREGON BOARD OF DENTISTRY

The Board actions in closer detail show outcomes, and note only Discipline outcomes are public actions.

Board Action - FY	2019	2020	2021	2022	2023
Cases Opened	281	216	195	150	213
Cases Closed	315	286	205	154	170
No Violation	59	56	46	60	71
No Further Action	104	110	75	41	40
Letter of Concern	79	88	60	38	31
Discipline	99	47	24	22	28
Total	341	301	205	161	170
There may be more actions than cases because some cases have more than one respondent					

OREGON BOARD OF DENTISTRY

- DOCUMENTATION

&

- COMMUNICATION

OREGON BOARD OF DENTISTRY

CONTINUING EDUCATION - REQUIREMENTS

The Basic Requirements:

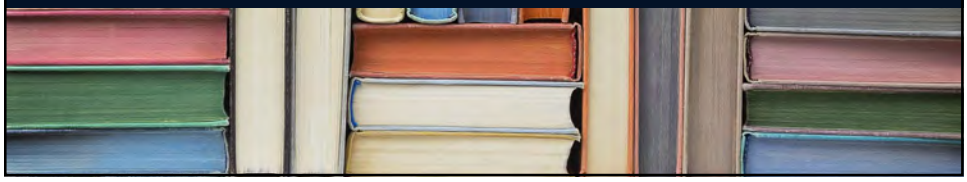
- Must be *directly related to clinical dentistry/dental hygiene or dental public health*.
- Two hours must be specific to *infection control*.
- Three hours must be specific to *medical emergencies*.
- Two hours must be specific to *cultural competence* – ***effective Jan. 1, 2021***.
- One hour of pain management required at every renewal for dentists and dental therapists.

OREGON BOARD OF DENTISTRY

CONTINUING EDUCATION - REQUIREMENTS

The Basic Requirements (Continued):

- For dentists, volunteer pro bono dental services completed in Oregon may be counted as CE (up to six hours).
- Research, graduate study, teaching, or preparation and presentation of scientific sessions may be counted as CE (up to six hours for hygienists; up to twelve hours for dentists).
- Must maintain proof of completion of CE hours for four years.



OREGON BOARD OF DENTISTRY

CONTINUING EDUCATION – REQUIREMENTS DENTISTS OAR 818-021-0060

(1) Each dentist must complete 40 hours of continuing education every two years. Continuing education (C.E.) must be directly related to clinical patient care or the practice of dental public health.

(2) Dentists must maintain records of successful completion of continuing education for at least four licensure years consistent with the licensee's licensure cycle. (A licensure year for dentists is April 1 through March 31.) The licensee, upon request by the Board, shall provide proof of successful completion of continuing education courses.

(3) Continuing education includes:

(a) Attendance at lectures, dental study groups, college post-graduate courses, or scientific sessions at conventions.

(b) Research, graduate study, teaching or preparation and presentation of scientific sessions. No more than 12 hours may be in teaching or scientific sessions. (Scientific sessions are defined as scientific presentations, table clinics, poster sessions and lectures.)

OREGON BOARD OF DENTISTRY

CONTINUING EDUCATION – REQUIREMENTS DENTISTS

(c) Correspondence courses, videotapes, distance learning courses or similar self-study course, provided that the course provides a certificate of completion to the dentist. The certificate of completion should list the dentist's name, course title, course completion date, course provider name, and continuing education hours completed.

(d) Continuing education credit can be given for volunteer pro bono dental services provided in the state of Oregon; community oral health instruction at a public health facility located in the state of Oregon; authorship of a publication, book, chapter of a book, article or paper published in a professional journal; participation on a state dental board, peer review, or quality of care review procedures; successful completion of the National Board Dental Examinations taken after initial licensure; a recognized specialty examination taken after initial licensure; or test development for clinical dental, dental hygiene or specialty examinations. No more than 6 hours of credit may be in these areas.

OREGON BOARD OF DENTISTRY

CONTINUING EDUCATION – REQUIREMENTS DENTISTS

(4) At least three hours of continuing education must be related to medical emergencies in a dental office. No more than four hours of Practice Management and Patient Relations may be counted toward the C.E. requirement in any renewal period.

(5) At each renewal, all dentists licensed by the Oregon Board of Dentistry will complete a one-hour pain management course specific to Oregon provided by the Pain Management Commission of the Oregon Health Authority (Effective July 1, 2022).

(6) At least two (2) hours of continuing education must be related to infection control.

(7) At least two (2) hours of continuing education must be related to cultural competency (Effective January 1, 2021).

(8) A dentist placing endosseous implants must complete at least seven (7) hours of continuing education related to the placement of dental implants every licensure renewal period (Effective January 1, 2024).

OREGON BOARD OF DENTISTRY

CONTINUING EDUCATION – REQUIREMENTS DENTAL HYGIENISTS OAR 818-021-0070

(1) Each dental hygienist must complete 24 hours of continuing education every two years. An Expanded Practice Permit Dental Hygienist shall complete a total of 36 hours of continuing education every two years. Continuing education (C.E.) must be directly related to clinical patient care or the practice of dental public health.

(2) Dental hygienists must maintain records of successful completion of continuing education for at least four licensure years consistent with the licensee's licensure cycle. (A licensure year for dental hygienists is October 1 through September 30.) The licensee, upon request by the Board, shall provide proof of successful completion of continuing education courses.

(3) Continuing education includes:

(a) Attendance at lectures, dental study groups, college post-graduate courses, or scientific sessions at conventions.

(b) Research, graduate study, teaching or preparation and presentation of scientific sessions. No more than six hours may be in teaching or scientific sessions. (Scientific sessions are defined as scientific presentations, table clinics, poster sessions and lectures.)

OREGON BOARD OF DENTISTRY

CONTINUING EDUCATION – REQUIREMENTS DENTAL HYGIENISTS

(c) Correspondence courses, videotapes, distance learning courses or similar self-study course, provided that the course provides a certificate of completion to the dental hygienist. The certificate of completion should list the dental hygienist's name, course title, course completion date, course provider name, and continuing education hours completed.

(d) Continuing education credit can be given for volunteer pro bono dental hygiene services provided in the state of Oregon; community oral health instruction at a public health facility located in the state of Oregon; authorship of a publication, book, chapter of a book, article or paper published in a professional journal; participation on a state dental board, peer review, or quality of care review procedures; successful completion of the National Board Dental Hygiene Examination, taken after initial licensure; or test development for clinical dental hygiene examinations. No more than 6 hours of credit may be in these areas.

OREGON BOARD OF DENTISTRY

CONTINUING EDUCATION – REQUIREMENTS DENTAL HYGIENISTS

(4) At least three hours of continuing education must be related to medical emergencies in a dental office. No more than two hours of Practice Management and Patient Relations may be counted toward the C.E. requirement in any renewal period.

(5) Dental hygienists who hold a Nitrous Oxide Permit must meet the requirements contained in OAR 818-026-0040(11) for renewal of the Nitrous Oxide Permit.

(6) At least two (2) hours of continuing education must be related to infection control.

(7) At least two (2) hours of continuing education must be related to cultural competency (Effective January 1, 2021).

OREGON BOARD OF DENTISTRY

CONTINUING EDUCATION – REQUIREMENTS DENTAL THERAPISTS OAR 818-021-0076

(1) Each dental therapist must complete 36 hours of continuing education every two years. Continuing education (C.E.) must be directly related to clinical patient care or the practice of dental public health.

(2) Dental therapists must maintain records of successful completion of continuing education for at least four licensure years consistent with the licensee's licensure cycle. (A licensure year for dental therapists is October 1 through September 30.) The licensee, upon request by the Board, shall provide proof of successful completion of continuing education courses.

(3) Continuing education includes:

(a) Attendance at lectures, dental study groups, college post-graduate courses, or scientific sessions at conventions.

(b) Research, graduate study, teaching or preparation and presentation of scientific sessions. No more than six hours may be in teaching or scientific sessions. (Scientific sessions are defined as scientific presentations, table clinics, poster sessions and lectures.)

OREGON BOARD OF DENTISTRY

CONTINUING EDUCATION – REQUIREMENTS DENTAL THERAPISTS

(c) Correspondence courses, videotapes, distance learning courses or similar self-study course, provided that the course provides a certificate of completion to the dental therapist. The certificate of completion should list the dental therapist's name, course title, course completion date, course provider name, and continuing education hours completed.

(d) Continuing education credit can be given for volunteer pro bono dental therapy services provided in the state of Oregon; community oral health instruction at a public health facility located in the state of Oregon; authorship of a publication, book, chapter of a book, article or paper published in a professional journal; participation on a state dental board, peer review, or quality of care review procedures; successful completion of the National Board Dental Therapy Examination, taken after initial licensure; or test development for clinical dental therapy examinations. No more than 6 hours of credit may be in these areas.

OREGON BOARD OF DENTISTRY

CONTINUING EDUCATION – REQUIREMENTS DENTAL THERAPISTS

(4) At least three hours of continuing education must be related to medical emergencies in a dental office. No more than two hours of Practice Management and Patient Relations may be counted toward the C.E. requirement in any renewal period.

(5) At least two (2) hours of continuing education must be related to infection control.

(6) At least two (2) hours of continuing education must be related to cultural competency.

(7) At least one (1) hour of continuing education must be related to pain management.

Dental Therapists who are also Dental Hygienists do not need to complete additional CE for both licenses. The 36 hours of CE will cover both licenses.

OREGON BOARD OF DENTISTRY

CONTINUING EDUCATION - AUDIT

- The OBD audits a number of our licensees in any given renewal cycle. This has been Board Policy since 1999.
- Waiting until the last two weeks prior to the expiration date to contact the Board that you won't have your CE completed is not a good idea. Failure to complete your CE on time could result in the Board taking disciplinary action.
- CE Logs can be download from our website.

OREGON BOARD OF DENTISTRY

FREQUENTLY ASKED QUESTIONS

- Can a licensee use Nitrous on a patient that has taken a Zanax, Valium, other sedative, or benzodiazepine?

That is a clinical decision that the supervising dentist must make by determining their level of sedation permit and what level of sedation the patient would be under.

- Can a Registered Dental Hygienist administer Botox or dermal fillers?

No, only Oregon licensed dentists who have completed a Board-approved course in accordance with OAR 818-012-0005(3) can administer Botox and dermal fillers.

- Do I have to inform the Board when I change my information?

Yes, you are required to update your information with the Board within 30 days of a change of address (either home or primary business location).

OREGON BOARD OF DENTISTRY

FREQUENTLY ASKED QUESTIONS

- Can a Registered Dental Hygienist or dental assistant perform teeth whitening without a dentist supervising?

Teeth whitening can be performed under general supervision

- Can I perform teledentistry?

OAR 818-001-0002:"Teledentistry" is defined as the use of information technology and telecommunications to facilitate the providing of dental primary care, consultation, education, and public awareness in the same manner as telehealth and telemedicine.

- Do I have to have to expose radiographs for every patient?

The decision when to take or not to take radiographs is the responsibility of an Oregon licensee and is based on factors including the patient's oral health, patient's age, the risk for disease and any sign or symptoms of oral disease that a patient may be experiencing.

The Board does not have a time requirement for how often radiographs or X-rays are to be taken.

OREGON BOARD OF DENTISTRY

FREQUENTLY ASKED QUESTIONS

- Do I have to report a serious complication or injury to the Board?

Yes, in accordance with OAR 818-026-0120, If a death, any serious complication or any injury occurs which may have resulted from the administration of any central nervous system anesthesia or sedation, the licensee performing the dental procedure must submit a written detailed report to the Board within **five days of the incident**

- Can I administer Nitrous Oxide if the doctor is not in the office?

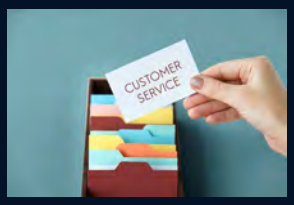
No, an RDH with an active Nitrous Oxide permit can only administer Nitrous under indirect supervision. "Indirect Supervision" means supervision requiring that a dentist authorize the procedures and that a dentist be on the premises while the procedures are performed.

OREGON BOARD OF DENTISTRY

Reminders

- Dentists must register with the PDMP, if you have a DEA Registration
- Dentists must comply with dental implant rules if placing implants – effective 1/1/2024
- Current BLS for Healthcare Provider – **at all times** even if not practicing or in an administrative role
- Sterilizer Monitoring Records –Dentists and Dental Hygienists with EPP when applicable
- All Licensees can utilize the Oregon Wellness Program
- **Please Update your email and mailing addresses as we are reducing our use and reliance on US postal Service, but US mail is still utilized for one renewal notice and in investigations.**

OREGON BOARD OF DENTISTRY



- The Board is a resource.
- The Board is accessible.
- The Board appreciates feedback from our Licensees, consumers and other interested parties.
- The best way to contact the Board is by email:

information@obd.oregon.gov

OREGON BOARD OF DENTISTRY

We are here to serve you and all Oregonians.

information@obd.oregon.gov

2024 Mid-Year Meeting Program

All times are Central Time

Thursday, April 11th

5:00 p.m. - 6:00 p.m. — **Registration - FIRST FLOOR LOBBY**

Friday, April 12th (1:00 pm - 6:15 pm)

11:00 a.m. - 6:15 p.m. — **Registration - FIRST FLOOR LOBBY**

12:00 p.m. - 6:15 p.m. — **AADB Attorney Round Table Meeting - OTHELLA (2nd floor)**
This closed session is for Attorneys who represent State/Territory Dental Boards.

1:00 p.m. - 1:15 p.m. — **AADB President's Opening Remarks**
Dale Chamberlain, DDS
AADB President
Recognition of the AADB Board of Directors
Name Change
Updates

1:15 p.m. - 1:20 p.m. — **Executive Director's Welcome & Report**
Kimber Cobb, RDH
AADB Executive Director

1:20 p.m. - 1:30 p.m. — **DentalACE Update**
John Stamper
DentalACE Managing Partner

1:30 p.m. - 2:30 p.m. — **DANB Presentation**
Katherine Landsberg
Director, Government Relations
Frank Maggio, DDS

2:30 p.m. - 3:30 p.m. — **AADB Dental & Dental Hygiene Compact Update**
Arthur Chen-Shu Jee, DMD
AADB Vice President

3:30 p.m. - 3:45 p.m. — **Exhibits & Networking Break**

3:45 p.m. - 4:45 p.m. — **Botox And Fillers In Dental Practice – A Clinical Overview**
Louis Malcmacher, DDS, MAGD, American Academy of Facial Esthetics

4:45 p.m. - 4:50 p.m. — **Transition Break**

4:50 p.m. - 5:50 p.m. — **Spa Dentistry: Model Regulations & limitations/prohibitions**
Louis Malcmacher, DDS, MAGD, American Academy of Facial Esthetics
Bobby J. Carmen, DDS, MAGD, AADB Secretary
Mr. Jeff Puckett, Deputy Director, Oklahoma Board of Dentistry

5:50 p.m. - 6:15 p.m. — **Q&A Session**

6:30 p.m. - 8:00 p.m.	**Presidential Reception - cash bar - MEZZANINE FOYER** *Please join President Dale Chamberlain, DDS, the AADB Board of Directors, the AADB team, and invited speakers for light hors d'oeuvres and drinks.*

Saturday, April 13th (8:00 am - 1:00 pm)

8:00 a.m. - 1:00 p.m.	**AADB Attorney Round Table Meeting - OTHELLA (2nd floor)** *This closed session is for Attorneys who represent State/Territory Dental Boards.*
8:00 a.m. - 10:00 a.m.	**Registration - FIRST FLOOR LOBBY**
8:00 a.m. - 9:00 a.m.	**Hot Breakfast Buffet**
8:30 a.m. - 9:30 a.m.	**AADB Member Hygienist Caucus Meeting - DUET (2nd floor)** Diane Klemann, RDH AADB Dental Hygiene Board Member *This closed session is for AADB member hygienists*
8:30 a.m. - 9:30 a.m.	**AADB Member Investigator Caucus Meeting - WINCHESTER (2nd floor)** W. Blake Strickland Executive Director - Board of Dental Examiners of Alabama
8:30 a.m. - 9:30 a.m.	**AADB Member Administrator Caucus Meeting - LEANDER (2nd floor)** Dr. Arthur 'Rusty' Hickham Louisiana State Dental Board AADB Administrator Member
9:30 a.m. - 10:15 a.m.	**Regional Caucus Meetings** *North Caucus* - **WINCHESTER (2nd floor)** *South Caucus* - **DUET (2nd floor)** *East Caucus* - **LEANDER (2nd floor)** *West Caucus* - ***CHICAGO PEACE*** **(2nd floor)**
10:15 a.m. - 10:30 a.m.	**Exhibits & Networking Break**
10:30 a.m. - 10:45 a.m.	**Sponsorship Recognition**
10:45 a.m. - 11:45 a.m.	**Attorney Roundtable** Lori Lindley, AAG Senior Assistant Attorney General Oregon Board of Dentistry
11:45 a.m. - 12:15 p.m.	**Caucus Reports** **North:** Frank Maggio, DDS, AADB Caucus Chair **South**: Melodie Jones, DMD, AADB Caucus Chair **East**: Maxine Feinberg, DDS, AADB Caucus Chair **West**: Casey Nichols, J.D., AADB Caucus Chair
12:15 p.m. - 1:00 p.m.	**AADB State Dental Board Forum: State/Jurisdictions Board Issues** Frank Maggio, DDS AADB Member and Moderator
1:00 p.m.	**Adjournment**

Caucuses by State

North

Illinois
Indiana
Iowa
Michigan
Minnesota
Missouri
Nebraska
North Dakota
Ohio
South Dakota
Wisconsin

South

Alabama
Arkansas
Florida
Georgia
Kentucky
Louisiana
Mississippi
North Carolina
Puerto Rico
South Carolina
Tennessee
Virginia
Virgin Islands

East

Connecticut
Delaware
District of Columbia
Maine
Maryland
Massachusetts
New Hampshire
New Jersey
New York
Pennsylvania
Rhode Island
Vermont
West Virginia

West

Alaska
Arizona
California
Colorado
Hawaii
Idaho
Kansas
Montana
Nevada
New Mexico
Oklahoma
Oregon
Texas
Utah
Washington
Wyoming

Save the Date

Annual Summit:
July 24, 2024

Informal Reception:
July 23, 2024

Tribal-State Government-to-Government

Annual Summit

Mark your calendars! Registration opens soon.
More details to follow.

Co-Hosted by the Cow Creek Band of Umpqua Tribe of Indians
Seven Feathers Casino Resort
146 Chief Miwaleta Lane
Canyonville OR 97417

Attachment #7

OREGON BOARD OF DENTISTRY
2025
MEETING DATES

EVALUATORS	BOARD
February 14, 2025	February 28, 2025
April 11, 2025	April 25, 2025
May 30, 2025	June 13, 2025
August 8, 2025	August 22, 2025
October 10, 2025	October 24, 2025
November 26, 2025	December 12, 2025

UNFINISHED BUSINESS & RULES

Oregon
Tina Kotek, Governor

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

DATE: April 10, 2024

TO: OBD Board Members

FROM: OBD Executive Director Stephen Prisby

SUBJECT: Rule Changes effective May 1, 2024

At its February 23, 2024 Board Meeting the Board voted to make the most recent rule changes effective May 1, 2024.

The Secretary of State filing is attached to confirm that the rule changes were successfully filed. The rule changes can be accessed on the OBD website, are referenced in the next OBD Newsletter and staff can assist anyone who has questions about them as well.

OFFICE OF THE SECRETARY OF STATE
LAVONNE GRIFFIN-VALADE
SECRETARY OF STATE

CHERYL MYERS
DEPUTY SECRETARY OF STATE
AND TRIBAL LIAISON

ARCHIVES DIVISION
STEPHANIE CLARK
DIRECTOR

800 SUMMER STREET NE
SALEM, OR 97310
503-373-0701

PERMANENT ADMINISTRATIVE ORDER

FILED
03/08/2024 12:57 PM
ARCHIVES DIVISION
SECRETARY OF STATE
& LEGISLATIVE COUNSEL

OBD 1-2024
CHAPTER 818
OREGON BOARD OF DENTISTRY

FILING CAPTION: The Board is amending 10 rules and adopting 1 new rule.

EFFECTIVE DATE: 05/01/2024

AGENCY APPROVED DATE: 02/23/2024

CONTACT: Stephen Prisby
971-673-3200
stephen.prisby@state.or.us

1500 SW 1st Ave
Suite #770
Portland,OR 97201

Filed By:
Stephen Prisby
Rules Coordinator

RULES:
818-012-0005, 818-021-0060, 818-026-0010, 818-026-0050, 818-035-0030, 818-038-0022, 818-042-0020, 818-042-0100, 818-042-0114, 818-042-0115, 818-042-0117

AMEND: 818-012-0005

RULE TITLE: Scope of Practice

NOTICE FILED DATE: 11/09/2023

RULE SUMMARY: The rule is being amended to clarify that any type of dental implant is subject to the rule and the CE requirement as well.

RULE TEXT:
(1) No dentist may perform any of the procedures listed below:
(a) Rhinoplasty;
(b) Blepharoplasty;
(c) Rhytidectomy;
(d) Submental liposuction;
(e) Laser resurfacing;
(f) Browlift, either open or endoscopic technique;
(g) Platysmal muscle plication;
(h) Otoplasty;
(i) Dermabrasion;
(j) Hair transplantation, not as an isolated procedure for male pattern baldness; and
(k) Harvesting bone extra orally for dental procedures, including oral and maxillofacial procedures.
(2) Unless the dentist:
(a) Has successfully completed a residency in Oral and Maxillofacial Surgery accredited by the American Dental Association, Commission on Dental Accreditation (CODA), or
(b) Holds privileges either:
(A) Issued by a credentialing committee of a hospital accredited by the Joint Commission on Accreditation of Healthcare

Organizations (JCAHO) to perform these procedures in a hospital setting; or
(B) Issued by a credentialing committee for an ambulatory surgical center licensed by the State of Oregon and accredited by either the JCAHO or the Accreditation Association for Ambulatory Health Care (AAAHC).
(3) A dentist may utilize Botulinum Toxin Type A to treat conditions that are within the oral and maxillofacial region after completing a minimum of 10 hours in a hands on clinical course(s), in Botulinum Toxin Type A, and the provider is approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) or by the American Dental Association Continuing Education Recognition Program (ADA CERP). Alternatively, a dentist may meet the requirements of subsection (3) by successfully completing training in Botulinum Toxin Type A as part of a CODA accredited program.
(4) A dentist may utilize dermal fillers to treat conditions that are within the oral and maxillofacial region after completing a minimum of 10 hours in a hands on clinical course(s), in dermal fillers, and the provider is approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) or by the American Dental Association Continuing Education Recognition Program (ADA CERP). Alternatively, a dentist may meet the requirements of subsection (4) by successfully completing training in dermal fillers as part of a CODA accredited program.
(5) A dentist may place dental implants to replace natural teeth after completing a minimum of 56 hours of hands on clinical dental implant course(s), which includes treatment planning, appropriate case selection, potential complications and the surgical placement of the implants under direct supervision, and the provider is a Commission on Dental Accreditation (CODA) accredited postdoctoral dental education program, or a provider that has been approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) or by the American Dental Association Continuing Education Recognition Program (ADA CERP).
(6) A dentist placing dental implants must complete at least seven (7) hours of continuing education related to the placement and or restoration of dental implants every licensure renewal period. (Effective January 1, 2024).

STATUTORY/OTHER AUTHORITY: ORS 679, 680

STATUTES/OTHER IMPLEMENTED: ORS 679.010(2), 679.140(1)(c), 679.140(2), 679.170(6), 680.100

AMEND: 818-021-0060

RULE TITLE: Continuing Education — Dentists

NOTICE FILED DATE: 11/09/2023

RULE SUMMARY: The rule is being amended to clarify that any type of dental implant and restoration is added to the continuing education rule reference , regarding dental implants.

RULE TEXT:

(1) Each dentist must complete 40 hours of continuing education every two years. Continuing education (C.E.) must be directly related to clinical patient care or the practice of dental public health.

(2) Dentists must maintain records of successful completion of continuing education for at least four licensure years consistent with the licensee's licensure cycle. (A licensure year for dentists is April 1 through March 31.) The licensee, upon request by the Board, shall provide proof of successful completion of continuing education courses.

(3) Continuing education includes:

(a) Attendance at lectures, dental study groups, college post-graduate courses, or scientific sessions at conventions.

(b) Research, graduate study, teaching or preparation and presentation of scientific sessions. No more than 12 hours may be in teaching or scientific sessions. (Scientific sessions are defined as scientific presentations, table clinics, poster sessions and lectures.)

(c) Correspondence courses, videotapes, distance learning courses or similar self-study course, provided that the course provides a certificate of completion to the dentist. The certificate of completion should list the dentist’s name, course title, course completion date, course provider name, and continuing education hours completed.

(d) Continuing education credit can be given for volunteer pro bono dental services provided in the state of Oregon; community oral health instruction at a public health facility located in the state of Oregon; authorship of a publication, book, chapter of a book, article or paper published in a professional journal; participation on a state dental board, peer review, or quality of care review procedures; successful completion of the National Board Dental Examinations taken after initial licensure; a recognized specialty examination taken after initial licensure; or test development for clinical dental, dental hygiene or specialty examinations. No more than 6 hours of credit may be in these areas.

(4) At least three hours of continuing education must be related to medical emergencies in a dental office. No more than four hours of Practice Management and Patient Relations may be counted toward the C.E. requirement in any renewal period.

(5) At each renewal, all dentists licensed by the Oregon Board of Dentistry will complete a one-hour pain management course specific to Oregon provided by the Pain Management Commission of the Oregon Health Authority (Effective July 1, 2022).

(6) At least two (2) hours of continuing education must be related to infection control.

(7) At least two (2) hours of continuing education must be related to cultural competency (Effective January 1, 2021).

(8) A dentist placing dental implants must complete at least seven (7) hours of continuing education related to the placement and/or restoration of dental implants every licensure renewal period (Effective January 1, 2024).

STATUTORY/OTHER AUTHORITY: ORS 679

STATUTES/OTHER IMPLEMENTED: ORS 679.250(9)

AMEND: 818-026-0010

RULE TITLE: Definitions

NOTICE FILED DATE: 11/09/2023

RULE SUMMARY: The rule is being amended to include reference to non-intramuscular under minimal sedation and also define "recovery" in the rule.

RULE TEXT:

As used in these rules:

(1) "Anesthesia Monitor" means a person trained in monitoring patients under sedation and capable of assisting with procedures, problems and emergency incidents that may occur as a result of the sedation or secondary to an unexpected medical complication.

(2) "Anxiolysis" means the diminution or elimination of anxiety.

(3) “General Anesthesia” means a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

(4) “Deep Sedation” means a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

(5) “Moderate Sedation” means a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

(6) “Minimal Sedation” means minimally depressed level of consciousness, produced by non-intravenous and/or non-intramuscular pharmacological methods, that retains the patient’s ability to independently and continuously maintain an airway and respond normally to tactile stimulation and verbal command. When the intent is minimal sedation for adults, the appropriate initial dosing of a single non-intravenous and/or non-intramuscular pharmacological method is no more than the maximum recommended dose (MRD) of a drug that can be prescribed for unmonitored home use. Nitrous oxide/oxygen may be used in combination with a single non-intravenous and/or non-intramuscular pharmacological method in minimal sedation.

(7) “Nitrous Oxide Sedation” means an induced, controlled state of minimal sedation, produced solely by the inhalation of a combination of nitrous oxide and oxygen in which the patient retains the ability to independently and continuously maintain an airway and to respond purposefully to physical stimulation and to verbal command.

(8) “Maximum recommended dose” (MRD) means maximum Food and Drug Administration (FDA) recommended dose of a drug, as printed in FDA approved labeling for unmonitored use.

(9) “Incremental Dosing” means during minimal sedation, administration of multiple doses of a drug until a desired effect is reached, but not to exceed the maximum recommended dose (MRD).

(10) “Supplemental Dosing” means during minimal sedation, supplemental dosing is a single additional dose of the initial drug that is necessary for prolonged procedures. The supplemental dose should not exceed one-half of the initial dose and should not be administered until the dentist has determined the clinical half-life of the initial dosing has passed. The total aggregate dose must not exceed 1.5x the MRD on the day of treatment.

(11) “Enteral Route” means administration of medication via the gastrointestinal tract. Administration by mouth, sublingual (dissolving under the tongue), intranasal and rectal administration are included.

(12) “Parenteral Route” means administration of medication via a route other than enteral. Administration by intravenous, intramuscular, and subcutaneous routes are included.

(13) American Society of Anesthesiologists (ASA) Patient Physical Status Classification System.

(a) ASA I “A normal healthy patient”.
(b) ASA II “A patient with mild systemic disease”.
(c) ASA III “A patient with severe systemic disease”.
(d) ASA IV “A patient with severe systemic disease that is a constant threat to life”.
(e) ASA V “A moribund patient who is not expected to survive without the operation”.
(f) ASA VI “A declared brain-dead patient whose organs are being removed for donor purposes".
(14) “Recovery” means the patient is easily arousable and can independently and continuously maintain their airway with stable vital signs. Once this has occurred, the patient can be monitored by a qualified anesthesia monitor until discharge criteria is met.

STATUTORY/OTHER AUTHORITY: ORS 679

STATUTES/OTHER IMPLEMENTED: ORS 679.250(7), 679.250(10)

AMEND: 818-026-0050

RULE TITLE: Minimal Sedation Permit

NOTICE FILED DATE: 11/09/2023

RULE SUMMARY: The rule is being amended to add that no permit holder shall have more than one person under nitrous oxide sedation at the same time as well. This is consistent with all other levels of sedation and permit types.

RULE TEXT:

Minimal sedation and nitrous oxide sedation.

(1) The Board shall issue a Minimal Sedation Permit to an applicant who:

(a) Is a licensed dentist in Oregon;

(b) Maintains a current BLS for Healthcare Providers certificate or its equivalent; and

(c) Completion of a comprehensive training program consisting of at least 16 hours of training and satisfies the requirements of the current ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students at the time training was commenced or postgraduate instruction was completed, or the equivalent of that required in graduate training programs, in sedation, recognition and management of complications and emergency care; or

(d) In lieu of these requirements, the Board may accept equivalent training or experience in minimal sedation anesthesia.

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

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

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

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

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

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

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

(g) Sphygmomanometer, stethoscope, pulse oximeter, and/or automatic blood pressure cuff; and

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

(3) Before inducing minimal sedation, a dentist permit holder who induces minimal sedation shall:

(a) Evaluate the patient and document, using the American Society of Anesthesiologists (ASA) Patient Physical Status Classifications, that the patient is an appropriate candidate for minimal sedation;

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

(c) Certify that the patient is an appropriate candidate for minimal sedation; and

(d) Obtain written informed consent from the patient or patient's guardian for the anesthesia. The obtaining of the informed consent shall be documented in the patient's record.

(4) No permit holder shall have more than one person under minimal sedation or nitrous oxide sedation at the same time.

(5) While the patient is being treated under minimal sedation, an anesthesia monitor shall be present in the room in addition to the treatment provider. The anesthesia monitor may be the dental assistant. After training, a dental

assistant, when directed by a dentist permit holder, may administer oral sedative agents or anxiolysis agents calculated and dispensed by a dentist permit holder under the direct supervision of a dentist permit holder.
(6) A patient under minimal sedation shall be visually monitored at all times, including recovery phase. The record must include documentation of all medications administered with dosages, time intervals and route of administration. The dentist permit holder or anesthesia monitor shall monitor and record the patient's condition.
(7) Persons serving as anesthesia monitors for minimal sedation in a dental office shall maintain current certification in BLS for Healthcare Providers Basic Life Support (BLS)/Cardio Pulmonary Resuscitation (CPR) training, or its equivalent, shall be trained and competent in monitoring patient vital signs, in the use of monitoring and emergency equipment appropriate for the level of sedation utilized. ("competent" means displaying special skill or knowledge derived from training and experience.)
(8) The patient shall be monitored as follows:
(a) Color of mucosa, skin or blood must be evaluated continually. Patients must have continuous monitoring using pulse oximetry. The patient's response to verbal stimuli, blood pressure, heart rate, pulse oximetry and respiration shall be monitored and documented every fifteen minutes, if they can reasonably be obtained.
(b) A discharge entry shall be made by the dentist permit holder in the patient's record indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.
(9) The dentist permit holder shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:
(a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;
(b) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;
(c) The patient can talk and respond coherently to verbal questioning;
(d) The patient can sit up unaided;
(e) The patient can ambulate with minimal assistance; and
(f) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.
(g) A dentist permit holder shall not release a patient who has undergone minimal sedation except to the care of a responsible third party.
(10) The permit holder shall make a discharge entry in the patient's record indicating the patient's condition upon discharge.
(11) Permit renewal. In order to renew a Minimal Sedation Permit, the permit holder must provide documentation of a current BLS for Healthcare Providers certificate or its equivalent. In addition, Minimal Sedation Permit holders must also complete four (4) hours of continuing education in one or more of the following areas every two years: sedation, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current BLS for Healthcare Providers certificate, or its equivalent, may not be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060.

STATUTORY/OTHER AUTHORITY: ORS 679

STATUTES/OTHER IMPLEMENTED: ORS 679.250(7), 679.250(10)

AMEND: 818-035-0030

RULE TITLE: Additional Functions of Dental Hygienists

NOTICE FILED DATE: 11/09/2023

RULE SUMMARY: The rule is being amended to expand and clarify dental hygienists' scope of practice regarding intravenous access and phlebotomy blood draw provided successful completion of a board approved course on related topics.

RULE TEXT:

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

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

(b) Place periodontal dressings;

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

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

(e) Administer and dispense antimicrobial solutions or other antimicrobial agents in the performance of dental hygiene functions.

(f) Prescribe, administer and dispense fluoride, fluoride varnish, antimicrobial solutions for mouth rinsing or other non-systemic antimicrobial agents.

(g) Use high-speed handpieces to polish restorations and to remove cement and adhesive material.

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

(i) Perform all aspects of teeth whitening procedures.

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

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

(b) Apply sealants or fluoride.

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

(a) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a dental hygienist may initiate an intravenous (IV) infusion line for a patient being prepared for IV medications, sedation, or general anesthesia under the indirect supervision of a dentist holding the appropriate anesthesia permit.

(b) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a dental hygienist may perform a phlebotomy blood draw under the indirect supervision of a dentist. Products obtained through a phlebotomy blood draw may only be used by the dentist, to treat a condition that is within the scope of the practice of dentistry.

STATUTORY/OTHER AUTHORITY: ORS 679, 680

STATUTES/OTHER IMPLEMENTED: ORS 679.025(2)(j)

ADOPT: 818-038-0022

RULE TITLE: Additional Functions of Dental Therapists

NOTICE FILED DATE: 11/09/2023

RULE SUMMARY: The rule is being adopted to clarify dental therapists' scope of practice regarding intravenous access and phlebotomy blood draw provided successful completion of a board approved course on related topics.

RULE TEXT:

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

(a) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a dental therapist may initiate an intravenous (IV) infusion line for a patient being prepared for IV medications, sedation, or general anesthesia under the indirect supervision of a dentist holding the appropriate anesthesia permit.

(b) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a dental therapist may perform a phlebotomy blood draw under the indirect supervision of a dentist. Products obtained through a phlebotomy blood draw may only be used by the dentist, to treat a condition that is within the scope of the practice of dentistry.

STATUTORY/OTHER AUTHORITY: ORS 679

STATUTES/OTHER IMPLEMENTED: ORS 679.600

AMEND: 818-042-0020

RULE TITLE: Dentist, Dental Therapist and Dental Hygienist Responsibility

NOTICE FILED DATE: 11/09/2023

RULE SUMMARY: The rule is being amended to clarify that dental assistants may take physical impressions and digital scans.

RULE TEXT:

(1) A dentist is responsible for assuring that a dental assistant has been properly trained, has demonstrated proficiency, and is supervised in all the duties the assistant performs in the dental office. Unless otherwise specified, dental assistants shall work under indirect supervision in the dental office.

(2) A dental hygienist who works under general supervision may supervise dental assistants in the dental office if the dental assistants are rendering assistance to the dental hygienist in providing dental hygiene services and the dentist is not in the office to provide indirect supervision. A dental hygienist with an Expanded Practice Permit may hire and supervise dental assistants who will render assistance to the dental hygienist in providing dental hygiene services.

(3) A dental therapist who works under general supervision may supervise dental assistants in the dental office if the dental assistants are rendering assistance to the dental therapist in providing dental therapy services.

(4) The supervising licensee is responsible for assuring that all required licenses, permits or certificates are current and posted in a conspicuous place.

(5) Dental assistants who are in compliance with written training and screening protocols adopted by the Board may perform oral health screenings under general supervision.

(6) Dental assistants may take physical impressions and digital scans.

STATUTORY/OTHER AUTHORITY: ORS 679, 680

STATUTES/OTHER IMPLEMENTED: ORS 679.025(2)(j), 679.250(7), ORS 679.600

AMEND: 818-042-0100

RULE TITLE: Expanded Functions — Orthodontic Assistant (EFODA)

NOTICE FILED DATE: 11/09/2023

RULE SUMMARY: The rule is being amended to delete reference to out dated procedures related to taking impressions, space maintainers and other items.

RULE TEXT:

(1) An EFODA may perform the following duties while under the indirect supervision of a licensed dentist:

(a) Remove orthodontic bands and brackets and attachments with removal of the bonding material and cement. An ultrasonic scaler, hand scaler or slow speed handpiece may be used. Use of a high speed handpiece is prohibited;

(b) Select or try for the fit of orthodontic bands;

(c) Recement loose orthodontic bands;

(d) Place and remove orthodontic separators;

(e) Prepare teeth for bonding or placement of orthodontic appliances and select, pre-position and cure orthodontic brackets, attachments and/or retainers after their position has been approved by the supervising licensed dentist;

(f) Fit and adjust headgear;

(g) Remove fixed orthodontic appliances;

(h) Remove and replace orthodontic wires. Place and ligate archwires. Place elastic ligatures or chains as directed; and

(i) Cut arch wires.

(2) An EFODA may perform the following duties while under the general supervision of a licensed dentist:

(a) An expanded function orthodontic assistant may remove any portion of an orthodontic appliance causing a patient discomfort and in the process may replace ligatures and/or separators if the dentist is not available, providing that the patient is rescheduled for follow-up care by a licensed dentist as soon as is reasonably appropriate.

(b) An EFODA may recement orthodontic bands if the dentist is not available and the patient is in discomfort, providing that the patient is rescheduled for follow-up care by a licensed dentist as soon as is reasonably appropriate.

STATUTORY/OTHER AUTHORITY: ORS 679

STATUTES/OTHER IMPLEMENTED: ORS 679.025(2)(j), 679.250(7)

AMEND: 818-042-0114

RULE TITLE: Additional Functions of Expanded Function Preventive Dental Assistants (EFPDA)

NOTICE FILED DATE: 11/09/2023

RULE SUMMARY: The rule is being amended to fix a numbering issue, no change to any words or intent of rule.

RULE TEXT:

Upon successful completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association, or other course of instruction approved by the Board, a certified Expanded Function Preventive Dental Assistant may perform the following functions under the indirect supervision of a licensee providing that the procedure is checked by the licensee prior to the patient being dismissed:

(1) Apply pit and fissure sealants provided the patient is examined before the sealants are placed. The sealants must be placed within 45 days of the procedure being authorized by a licensee.

STATUTORY/OTHER AUTHORITY: ORS 676

STATUTES/OTHER IMPLEMENTED: ORS 676, ORS 679.600

AMEND: 818-042-0115

RULE TITLE: Expanded Functions — Certified Anesthesia Dental Assistant

NOTICE FILED DATE: 11/09/2023

RULE SUMMARY: The rule is being amended to include phlebotomy as one of the procedures allowed for this type of certified dental assistant.

RULE TEXT:

(1) A dentist holding the appropriate anesthesia permit may verbally authorize a Certified Anesthesia Dental Assistant, who possesses a Certified Anesthesia Dental Assistant certificate from the Oregon Board of Dentistry to:

(a) Administer medications into an existing intravenous (IV) line of a patient under sedation or anesthesia under direct visual supervision.

(b) Administer emergency medications to a patient in order to assist the licensee in an emergent situation under direct visual supervision.

(c) Perform phlebotomy for dental prrocedures.

(2) A dentist holding the appropriate anesthesia permit may verbally authorize a Certified Anesthesia Dental Assistant to dispense to a patient, oral medications that have been prepared by the dentist and given to the anesthesia dental assistant by the supervising dentist for oral administration to a patient under Indirect Supervision.

STATUTORY/OTHER AUTHORITY: ORS 679

STATUTES/OTHER IMPLEMENTED: ORS 679.020(1), 679.025(1), 679.250(7)

AMEND: 818-042-0117

RULE TITLE: Initiation of IV Line and Phlebotomy Blood Draw

NOTICE FILED DATE: 11/09/2023

RULE SUMMARY: The rule is being amended to add phlebotomy blood draw to rule title and criteria for the procedure.

RULE TEXT:

(1) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a Certified Anesthesia Dental Assistant may initiate an intravenous (IV) infusion line for a patient being prepared for IV medications, sedation, or general anesthesia under the Indirect Supervision of a dentist holding the appropriate anesthesia permit.

(2) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a Certified Anesthesia Dental Assistant may perform a phlebotomy blood draw under the Indirect Supervision of a dentist. Products obtained through a phlebotomy blood draw may only be used by the dentist, to treat a condition that is within the scope of the practice of dentistry.

STATUTORY/OTHER AUTHORITY: ORS 679

STATUTES/OTHER IMPLEMENTED: ORS 679.020(1), 679.025(1), 679.250(7)

OFFICE OF THE SECRETARY OF STATE
LAVONNE GRIFFIN-VALADE
SECRETARY OF STATE

CHERYL MYERS
DEPUTY SECRETARY OF STATE
AND TRIBAL LIAISON

ARCHIVES DIVISION
STEPHANIE CLARK
DIRECTOR

800 SUMMER STREET NE
SALEM, OR 97310
503-373-0701

PERMANENT ADMINISTRATIVE ORDER

FILED
03/08/2024 12:57 PM
ARCHIVES DIVISION
SECRETARY OF STATE
& LEGISLATIVE COUNSEL

OBD 1-2024
CHAPTER 818
OREGON BOARD OF DENTISTRY

FILING CAPTION: The Board is amending 10 rules and adopting 1 new rule.

EFFECTIVE DATE: 05/01/2024

AGENCY APPROVED DATE: 02/23/2024

CONTACT: Stephen Prisby
971-673-3200
stephen.prisby@state.or.us

1500 SW 1st Ave
Suite #770
Portland,OR 97201

Filed By:
Stephen Prisby
Rules Coordinator

RULES:
818-012-0005, 818-021-0060, 818-026-0010, 818-026-0050, 818-035-0030, 818-038-0022, 818-042-0020, 818-042-0100, 818-042-0114, 818-042-0115, 818-042-0117

AMEND: 818-012-0005

NOTICE FILED DATE: 11/09/2023

RULE SUMMARY: The rule is being amended to clarify that any type of dental implant is subject to the rule and the CE requirement as well.

CHANGES TO RULE:

818-012-0005
Scope of Practice ¶

(1) No dentist may perform any of the procedures listed below:¶
(a) Rhinoplasty;¶
(b) Blepharoplasty;¶
(c) Rhytidectomy;¶
(d) Submental liposuction;¶
(e) Laser resurfacing;¶
(f) Browlift, either open or endoscopic technique;¶
(g) Platysmal muscle plication;¶
(h) Otoplasty;¶
(i) Dermabrasion;¶
(j) Hair transplantation, not as an isolated procedure for male pattern baldness; and¶
(k) Harvesting bone extra orally for dental procedures, including oral and maxillofacial procedures.¶
(2) Unless the dentist:¶
(a) Has successfully completed a residency in Oral and Maxillofacial Surgery accredited by the American Dental Association, Commission on Dental Accreditation (CODA), or¶
(b) Holds privileges either:¶
(A) Issued by a credentialing committee of a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to perform these procedures in a hospital setting; or¶

(B) Issued by a credentialing committee for an ambulatory surgical center licensed by the State of Oregon and accredited by either the JCAHO or the Accreditation Association for Ambulatory Health Care (AAAHC).¶
(3) A dentist may utilize Botulinum Toxin Type A to treat conditions that are within the oral and maxillofacial region after completing a minimum of 10 hours in a hands on clinical course(s), in Botulinum Toxin Type A, and the provider is approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) or by the American Dental Association Continuing Education Recognition Program (ADA CERP). Alternatively, a dentist may meet the requirements of subsection (3) by successfully completing training in Botulinum Toxin Type A as part of a CODA accredited program. ¶
(4) A dentist may utilize dermal fillers to treat conditions that are within the oral and maxillofacial region after completing a minimum of 10 hours in a hands on clinical course(s), in dermal fillers, and the provider is approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) or by the American Dental Association Continuing Education Recognition Program (ADA CERP). Alternatively, a dentist may meet the requirements of subsection (4) by successfully completing training in dermal fillers as part of a CODA accredited program. ¶
(5) A dentist may place ~~endosseous~~dental implants to replace natural teeth after completing a minimum of 56 hours of hands on clinical dental implant course(s), which includes treatment planning, appropriate case selection, potential complications and the surgical placement of the implants under direct supervision, and the provider is a Commission on Dental Accreditation (CODA) accredited ~~graduate~~postdoctoral dental education program, or a provider that has been approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) or by the American Dental Association Continuing Education Recognition Program (ADA CERP).¶
(6) A dentist placing ~~endosseous~~dental implants must complete at least seven (7) hours of continuing education related to the placement and or restoration of dental implants every licensure renewal period. (Effective January 1, 2024).
Statutory/Other Authority: ORS 679, 680
Statutes/Other Implemented: ORS 679.010(2), 679.140(1)(c), 679.140(2), 679.170(6), 680.100

AMEND: 818-021-0060

NOTICE FILED DATE: 11/09/2023

RULE SUMMARY: The rule is being amended to clarify that any type of dental implant and restoration is added to the continuing education rule reference , regarding dental implants.

CHANGES TO RULE:

818-021-0060
Continuing Education - Dentists ¶

(1) Each dentist must complete 40 hours of continuing education every two years. Continuing education (C.E.) must be directly related to clinical patient care or the practice of dental public health.¶
(2) Dentists must maintain records of successful completion of continuing education for at least four licensure years consistent with the licensee's licensure cycle. (A licensure year for dentists is April 1 through March 31.) The licensee, upon request by the Board, shall provide proof of successful completion of continuing education courses.¶
(3) Continuing education includes:¶
(a) Attendance at lectures, dental study groups, college post-graduate courses, or scientific sessions at conventions.¶
(b) Research, graduate study, teaching or preparation and presentation of scientific sessions. No more than 12 hours may be in teaching or scientific sessions. (Scientific sessions are defined as scientific presentations, table clinics, poster sessions and lectures.)¶
(c) Correspondence courses, videotapes, distance learning courses or similar self-study course, provided that the course provides a certificate of completion to the dentist. The certificate of completion should list the dentist's name, course title, course completion date, course provider name, and continuing education hours completed.¶
(d) Continuing education credit can be given for volunteer pro bono dental services provided in the state of Oregon; community oral health instruction at a public health facility located in the state of Oregon; authorship of a publication, book, chapter of a book, article or paper published in a professional journal; participation on a state dental board, peer review, or quality of care review procedures; successful completion of the National Board Dental Examinations taken after initial licensure; a recognized specialty examination taken after initial licensure; or test development for clinical dental, dental hygiene or specialty examinations. No more than 6 hours of credit may be in these areas.¶
(4) At least three hours of continuing education must be related to medical emergencies in a dental office. No more than four hours of Practice Management and Patient Relations may be counted toward the C.E. requirement in any renewal period.¶
(5) At each renewal, all dentists licensed by the Oregon Board of Dentistry will complete a one-hour pain management course specific to Oregon provided by the Pain Management Commission of the Oregon Health Authority (Effective July 1, 2022).¶
(6) At least two (2) hours of continuing education must be related to infection control.¶
(7) At least two (2) hours of continuing education must be related to cultural competency (Effective January 1, 2021).¶
(8) A dentist placing ~~endosseous~~dental implants must complete at least seven (7) hours of continuing education related to the placement and/or restoration of dental implants every licensure renewal period (Effective January 1, 2024).
Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679.250(9)

AMEND: 818-026-0010

NOTICE FILED DATE: 11/09/2023

RULE SUMMARY: The rule is being amended to include reference to non-intramuscular under minimal sedation and also define "recovery" in the rule.

CHANGES TO RULE:

818-026-0010
Definitions ¶

As used in these rules: ¶
(1) "Anesthesia Monitor" means a person trained in monitoring patients under sedation and capable of assisting with procedures, problems and emergency incidents that may occur as a result of the sedation or secondary to an unexpected medical complication. ¶
(2) "Anxiolysis" means the diminution or elimination of anxiety. ¶
(3) "General Anesthesia" means a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.¶
(4) "Deep Sedation" means a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. ¶
(5) "Moderate Sedation" means a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. ¶
(6) "Minimal Sedation" means minimally depressed level of consciousness, produced by non-intravenous and/or non-intramuscular pharmacological methods, that retains the patient's ability to independently and continuously maintain an airway and respond normally to tactile stimulation and verbal command. When the intent is minimal sedation for adults, the appropriate initial dosing of a single non-intravenous and/or non-intramuscular pharmacological method is no more than the maximum recommended dose (MRD) of a drug that can be prescribed for unmonitored home use. Nitrous oxide/oxygen may be used in combination with a single non-intravenous and/or non-intramuscular pharmacological method in minimal sedation. ¶
(7) "Nitrous Oxide Sedation" means an induced, controlled state of minimal sedation, produced solely by the inhalation of a combination of nitrous oxide and oxygen in which the patient retains the ability to independently and continuously maintain an airway and to respond purposefully to physical stimulation and to verbal command. ¶
(8) "Maximum recommended dose" (MRD) means maximum Food and Drug Administration (FDA) recommended dose of a drug, as printed in FDA approved labeling for unmonitored use. ¶
(9) "Incremental Dosing" means during minimal sedation, administration of multiple doses of a drug until a desired effect is reached, but not to exceed the maximum recommended dose (MRD).¶
(10) "Supplemental Dosing" means during minimal sedation, supplemental dosing is a single additional dose of the initial drug that is necessary for prolonged procedures. The supplemental dose should not exceed one-half of the initial dose and should not be administered until the dentist has determined the clinical half-life of the initial dosing has passed. The total aggregate dose must not exceed 1.5x the MRD on the day of treatment.¶
(11) "Enteral Route" means administration of medication via the gastrointestinal tract. Administration by mouth, sublingual (dissolving under the tongue), intranasal and rectal administration are included.¶
(12) "Parenteral Route" means administration of medication via a route other than enteral. Administration by intravenous, intramuscular, and subcutaneous routes are included.¶
(13) American Society of Anesthesiologists (ASA) Patient Physical Status Classification System.¶
(a) ASA I "A normal healthy patient".¶
(b) ASA II "A patient with mild systemic disease".¶
(c) ASA III "A patient with severe systemic disease".¶
(d) ASA IV "A patient with severe systemic disease that is a constant threat to life".¶
(e) ASA V "A moribund patient who is not expected to survive without the operation".¶
(f) ASA VI "A declared brain-dead patient whose organs are being removed for donor purposes".¶

(14) "Recovery" means the patient is easily arousable and can independently and continuously maintain their airway with stable vital signs. Once this has occurred, the patient can be monitored by a qualified anesthesia monitor until discharge criteria is met.
Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679.250(7), 679.250(10)

AMEND: 818-026-0050

NOTICE FILED DATE: 11/09/2023

RULE SUMMARY: The rule is being amended to add that no permit holder shall have more than one person under nitrous oxide sedation at the same time as well. This is consistent with all other levels of sedation and permit types.

CHANGES TO RULE:

818-026-0050
Minimal Sedation Permit ¶

Minimal sedation and nitrous oxide sedation.¶
(1) The Board shall issue a Minimal Sedation Permit to an applicant who:¶
(a) Is a licensed dentist in Oregon;¶
(b) Maintains a current BLS for Healthcare Providers certificate or its equivalent; and¶
(c) Completion of a comprehensive training program consisting of at least 16 hours of training and satisfies the requirements of the current ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students at the time training was commenced or postgraduate instruction was completed, or the equivalent of that required in graduate training programs, in sedation, recognition and management of complications and emergency care; or¶
(d) In lieu of these requirements, the Board may accept equivalent training or experience in minimal sedation anesthesia.¶
(2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedures and during recovery:¶
(a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two individuals to freely move about the patient;¶
(b) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;¶
(c) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;¶
(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;¶
(e) An oxygen delivery system with adequate full facemask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;¶
(f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system;¶
(g) Sphygmomanometer, stethoscope, pulse oximeter, and/or automatic blood pressure cuff; and¶
(h) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the drugs used, vasopressors, corticosteroids, bronchodilators, antihistamines, antihypertensives and anticonvulsants.¶
(3) Before inducing minimal sedation, a dentist permit holder who induces minimal sedation shall:¶
(a) Evaluate the patient and document, using the American Society of Anesthesiologists (ASA) Patient Physical Status Classifications, that the patient is an appropriate candidate for minimal sedation;¶
(b) Give written preoperative and postoperative instructions to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian;¶
(c) Certify that the patient is an appropriate candidate for minimal sedation; and¶
(d) Obtain written informed consent from the patient or patient's guardian for the anesthesia. The obtaining of the informed consent shall be documented in the patient's record.¶
(4) No permit holder shall have more than one person under minimal sedation or nitrous oxide sedation at the same time.¶
(5) While the patient is being treated under minimal sedation, an anesthesia monitor shall be present in the room in addition to the treatment provider. The anesthesia monitor may be the dental assistant. After training, a dental assistant, when directed by a dentist permit holder, may administer oral sedative agents or anxiolysis agents calculated and dispensed by a dentist permit holder under the direct supervision of a dentist permit holder.¶
(6) A patient under minimal sedation shall be visually monitored at all times, including recovery phase. The record must include documentation of all medications administered with dosages, time intervals and route of administration. The dentist permit holder or anesthesia monitor shall monitor and record the patient's condition.¶
(7) Persons serving as anesthesia monitors for minimal sedation in a dental office shall maintain current certification in BLS for Healthcare Providers Basic Life Support (BLS)/Cardio Pulmonary Resuscitation (CPR)

training, or its equivalent, shall be trained and competent in monitoring patient vital signs, in the use of monitoring and emergency equipment appropriate for the level of sedation utilized. ("competent" means displaying special skill or knowledge derived from training and experience.)¶
(8) The patient shall be monitored as follows:¶
(a) Color of mucosa, skin or blood must be evaluated continually. Patients must have continuous monitoring using pulse oximetry. The patient's response to verbal stimuli, blood pressure, heart rate, pulse oximetry and respiration shall be monitored and documented every fifteen minutes, if they can reasonably be obtained.¶
(b) A discharge entry shall be made by the dentist permit holder in the patient's record indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.¶
(9) The dentist permit holder shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:¶
(a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;¶
(b) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;¶
(c) The patient can talk and respond coherently to verbal questioning;¶
(d) The patient can sit up unaided;¶
(e) The patient can ambulate with minimal assistance; and¶
(f) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.¶
(g) A dentist permit holder shall not release a patient who has undergone minimal sedation except to the care of a responsible third party.¶
(10) The permit holder shall make a discharge entry in the patient's record indicating the patient's condition upon discharge.¶
(11) Permit renewal. In order to renew a Minimal Sedation Permit, the permit holder must provide documentation of a current BLS for Healthcare Providers certificate or its equivalent. In addition, Minimal Sedation Permit holders must also complete four (4) hours of continuing education in one or more of the following areas every two years: sedation, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current BLS for Healthcare Providers certificate, or its equivalent, may not be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060.
Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679.250(7), 679.250(10)

AMEND: 818-035-0030

NOTICE FILED DATE: 11/09/2023

RULE SUMMARY: The rule is being amended to expand and clarify dental hygienists' scope of practice regarding intravenous access and phlebotomy blood draw provided successful completion of a board approved course on related topics.

CHANGES TO RULE:

818-035-0030
Additional Functions of Dental Hygienists ¶

(1) In addition to functions set forth in ORS 679.010, a dental hygienist may perform the following functions under the general supervision of a licensed dentist:¶
(a) Make preliminary intra-oral and extra-oral examinations and record findings;¶
(b) Place periodontal dressings;¶
(c) Remove periodontal dressings or direct a dental assistant to remove periodontal dressings;¶
(d) Perform all functions delegable to dental assistants and expanded function dental assistants providing that the dental hygienist is appropriately trained;¶
(e) Administer and dispense antimicrobial solutions or other antimicrobial agents in the performance of dental hygiene functions.¶
(f) Prescribe, administer and dispense fluoride, fluoride varnish, antimicrobial solutions for mouth rinsing or other non-systemic antimicrobial agents.¶
(g) Use high-speed handpieces to polish restorations and to remove cement and adhesive material.¶
(h) Apply temporary soft relines to complete dentures for the purpose of tissue conditioning.¶
(i) Perform all aspects of teeth whitening procedures.¶
(2) A dental hygienist may perform the following functions at the locations and for the persons described in ORS 680.205(1) and (2) without the supervision of a dentist:¶
(a) Determine the need for and appropriateness of sealants or fluoride; and¶
(b) Apply sealants or fluoride.¶
(3) In addition to functions set forth in ORS 679.010, a dental hygienist may perform the following functions under the indirect supervision of a licensed dentist: ¶
(a) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a dental hygienist may initiate an intravenous (IV) infusion line for a patient being prepared for IV medications, sedation, or general anesthesia under the indirect supervision of a dentist holding the appropriate anesthesia permit. ¶
(b) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a dental hygienist may perform a phlebotomy blood draw under the indirect supervision of a dentist. Products obtained through a phlebotomy blood draw may only be used by the dentist, to treat a condition that is within the scope of the practice of dentistry.
Statutory/Other Authority: ORS 679, 680
Statutes/Other Implemented: ORS 679.025(2)(j)

ADOPT: 818-038-0022

NOTICE FILED DATE: 11/09/2023

RULE SUMMARY: The rule is being adopted to clarify dental therapists' scope of practice regarding intravenous access and phlebotomy blood draw provided successful completion of a board approved course on related topics.

CHANGES TO RULE:

818-038-0022
Additional Functions of Dental Therapists
In addition to functions set forth in ORS 679.010, a dental therapist may perform the following functions under the indirect supervision of a licensed dentist:¶
(1) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a dental therapist may initiate an intravenous (IV) infusion line for a patient being prepared for IV medications, sedation, or general anesthesia under the indirect supervision of a dentist holding the appropriate anesthesia permit.¶
(2) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a dental therapist may perform a phlebotomy blood draw under the indirect supervision of a dentist. Products obtained through a phlebotomy blood draw may only be used by the dentist, to treat a condition that is within the scope of the practice of dentistry.
Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679.600

AMEND: 818-042-0020

NOTICE FILED DATE: 11/09/2023

RULE SUMMARY: The rule is being amended to clarify that dental assistants may take physical impressions and digital scans.

CHANGES TO RULE:

818-042-0020
Dentist, Dental Therapist and Dental Hygienist Responsibility ¶

(1) A dentist is responsible for assuring that a dental assistant has been properly trained, has demonstrated proficiency, and is supervised in all the duties the assistant performs in the dental office. Unless otherwise specified, dental assistants shall work under indirect supervision in the dental office.¶
(2) A dental hygienist who works under general supervision may supervise dental assistants in the dental office if the dental assistants are rendering assistance to the dental hygienist in providing dental hygiene services and the dentist is not in the office to provide indirect supervision. A dental hygienist with an Expanded Practice Permit may hire and supervise dental assistants who will render assistance to the dental hygienist in providing dental hygiene services.¶
(3) A dental therapist who works under general supervision may supervise dental assistants in the dental office if the dental assistants are rendering assistance to the dental therapist in providing dental therapy services. ¶
(4) The supervising licensee is responsible for assuring that all required licenses, permits or certificates are current and posted in a conspicuous place.¶
(5) Dental assistants who are in compliance with written training and screening protocols adopted by the Board may perform oral health screenings under general supervision.¶
(6) Dental assistants may take physical impressions and digital scans.
Statutory/Other Authority: ORS 679, 680
Statutes/Other Implemented: ORS 679.025(2)(j), 679.250(7), ORS 679.600

AMEND: 818-042-0100

NOTICE FILED DATE: 11/09/2023

RULE SUMMARY: The rule is being amended to delete reference to out dated procedures related to taking impressions, space maintainers and other items.

CHANGES TO RULE:

818-042-0100
Expanded Functions - Orthodontic Assistant (EFODA) ¶

(1) An EFODA may perform the following duties while under the indirect supervision of a licensed dentist:¶
(a) Remove orthodontic bands and brackets and attachments with removal of the bonding material and cement. An ultrasonic scaler, hand scaler or slow speed handpiece may be used. Use of a high speed handpiece is prohibited;¶
(b) Select or try for the fit of orthodontic bands;¶
(c) Recement loose orthodontic bands;¶
(d) Place and remove orthodontic separators;¶
(e) Prepare teeth for bonding or placement of orthodontic appliances and select, pre-position and cure orthodontic brackets, attachments and/or retainers after their position has been approved by the supervising licensed dentist;¶
(f) Fit and adjust headgear;¶
(g) Remove fixed orthodontic appliances;¶
(h) Remove and replace orthodontic wires. Place and ligate archwires. Place elastic ligatures or chains as directed; and¶
(i) Cut arch wires~~; and~~¶
~~(j) Take impressions for study models or temporary oral devices such as, but not limited to, space maintainers, orthodontic retainers and occlusal guards.~~¶
(2) An EFODA may perform the following duties while under the general supervision of a licensed dentist:¶
(a) An expanded function orthodontic assistant may remove any portion of an orthodontic appliance causing a patient discomfort and in the process may replace ligatures and/or separators if the dentist is not available, providing that the patient is rescheduled for follow-up care by a licensed dentist as soon as is reasonably appropriate.¶
(b) An EFODA may recement orthodontic bands if the dentist is not available and the patient is in discomfort, providing that the patient is rescheduled for follow-up care by a licensed dentist as soon as is reasonably appropriate.
Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679.025(2)(j), 679.250(7)

AMEND: 818-042-0114

NOTICE FILED DATE: 11/09/2023

RULE SUMMARY: The rule is being amended to fix a numbering issue, no change to any words or intent of rule.

CHANGES TO RULE:

818-042-0114
Additional Functions of Expanded Function Preventive Dental Assistants (EFPDA)
(1) Upon successful completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association, or other course of instruction approved by the Board, a certified Expanded Function Preventive Dental Assistant may perform the following functions under the indirect supervision of a licensee providing that the procedure is checked by the licensee prior to the patient being dismissed:¶
(2) Apply pit and fissure sealants provided the patient is examined before the sealants are placed. The sealants must be placed within 45 days of the procedure being authorized by a licensee.
Statutory/Other Authority: ORS 676
Statutes/Other Implemented: ORS 676, ORS 679.600

AMEND: 818-042-0115

NOTICE FILED DATE: 11/09/2023

RULE SUMMARY: The rule is being amended to include phlebotomy as one of the procedures allowed for this type of certified dental assistant.

CHANGES TO RULE:

818-042-0115
Expanded Functions - Certified Anesthesia Dental Assistant ¶

(1) A dentist holding the appropriate anesthesia permit may verbally authorize a Certified Anesthesia Dental Assistant, who possesses a Certified Anesthesia Dental Assistant certificate from the Oregon Board of Dentistry to:¶
(a) Administer medications into an existing intravenous (IV) line of a patient under sedation or anesthesia under direct visual supervision.¶
(b) Administer emergency medications to a patient in order to assist the licensee in an emergent situation under direct visual supervision.¶
(c) Perform phlebotomy for dental prrocedures. ¶
(2) A dentist holding the appropriate anesthesia permit may verbally authorize a Certified Anesthesia Dental Assistant to dispense to a patient, oral medications that have been prepared by the dentist and given to the anesthesia dental assistant by the supervising dentist for oral administration to a patient under Indirect Supervision.
Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679.020(1), 679.025(1), 679.250(7)

AMEND: 818-042-0117

NOTICE FILED DATE: 11/09/2023

RULE SUMMARY: The rule is being amended to add phlebotomy blood draw to rule title and criteria for the procedure.

CHANGES TO RULE:

818-042-0117
Initiation of IV Line-and Phlebotomy Blood Draw ¶

(1) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a Certified Anesthesia Dental Assistant may initiate an intravenous (IV) infusion line for a patient being prepared for IV medications, sedation, or general anesthesia under the Indirect Supervision of a dentist holding the appropriate anesthesia permit.¶
(2) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a Certified Anesthesia Dental Assistant may perform a phlebotomy blood draw under the Indirect Supervision of a dentist. Products obtained through a phlebotomy blood draw may only be used by the dentist, to treat a condition that is within the scope of the practice of dentistry.
Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679.020(1), 679.025(1), 679.250(7)

CORRESPONDENCE

Good Morning Haley,

Thank you so much for taking the time to chat last week about the OBD Diversion program and possible alternatives to care for dentists.

I appreciate you sharing resources from the OBD to better frame a request for a rule change.

I have talked to Uprise Health about the differences between the Oregon Medical Board allowances and the Oregon Dental Board. I have attached their website's "Potential Participants" section to demonstrate the differences.

I want to make a formal request to allow Dentists the option for "Self-Referral." Under the section for the OMB, Potential Participants, it reads, " Self-Referral - If not currently under investigation by the Board, licensees may choose to self-refer to HPSP for monitoring if they have a substance use disorder and/or mental health disorder. Licensees who self-refer to HPSP and successfully complete five years of monitoring, without having any non-compliance events, will graduate the program without Board involvement."

I understand there will be a meeting to review requests in the near future. If you could let me know when the meeting is scheduled, I would like the opportunity to attend.

Thanks again and let me know if you need anything else from me.

Julie

Julie Spaniel DDS (she/her/hers)
President Washington County Dental Society
ADA Wellness Ambassadors
ADA Dental Wellness Advisory Council
President-elect Academy for Private Dental Practice
ODA Chair Wellness Ambassadors

Dr Julie Spaniel
Founder/President One World Brigades 501(c)3
Summerwood Dental Associates
Office: 503-906-8600 Cell: 802-598-1112
10835 SW Lower Boones Ferry Road
Tigard, Oregon 97224

uprisehealth

Potential Participants

Each participating Oregon licensing board has different HPSP eligibility requirements. Currently the Oregon Medical Board, Board of Nursing, Board of Dentistry, and Board of Pharmacy participate in HPSP. Click on the tab for the appropriate board to learn more.

OSBN | OBD | OMB | OBP

Monitoring for the Oregon Board of Dentistry

HPSP is an alternative to disciplinary action or may be part of a disciplinary action by the Oregon Board of Dentistry for any licensee who has come to the attention of the board and has a substance use disorder and/or mental health disorder. Participation in HPSP is confidential for all licensees enrolled in the program and information is released only with signed consent from the licensee or in accordance with state or federal law.

Licensees may enter HPSP under one of the following categories:

Board Referral – Licensees may be referred to HPSP by the Oregon Board of Dentistry as a result of impaired professional practice or behavior and must have a substance use disorder and/or mental health disorder.

Monitoring Services Include:

- Random Toxicology Testing
- Worksite Monitoring (If not self-employed)
- Agreement Monitors
- Weekly reporting by licensees
- Independent Third Party Evaluations
- Medical Review Officer oversight
- Interactive Voice Response (IVR) system for daily testing requirements
- Care Coordination
- Safe practice evaluations

Still have questions? Please feel free to call us at (888)802-2843 or email at hpsp@uprisehealth.com

uprisehealth

Potential Participants

Each participating Oregon licensing board has different HPSP eligibility requirements. Currently the Oregon Medical Board, Board of Nursing, Board of Dentistry, and Board of Pharmacy participate in HPSP. Click on the tab for the appropriate board to learn more.

OSBN | OBD | OMB | OBP

Monitoring for the Oregon Medical Board

HPSP is an alternative to disciplinary action or may be part of a disciplinary action by the Oregon Medical Board for any licensee who has come to the attention of the board and has a substance use disorder and/or mental health disorder. Participation in HPSP is confidential for all licensees enrolled in the program and information is released only with signed consent from the licensee or in accordance with state or federal law.

Licensees may enter HPSP under one of the following categories:

Board Referral – Licensees may be referred to HPSP by the Oregon Medical Board as a result of impaired professional practice or behavior and must have a substance use disorder and/or mental health disorder.

Self-Referral – If not currently under investigation by the Board, licensees may choose to self-refer to HPSP for monitoring if they have a substance use disorder and/or mental health disorder. Licensees who self-refer to HPSP and successfully complete five years of monitoring, without having any non-compliance events, will graduate the program without Board involvement.

Monitoring Services Include:

- Random Toxicology Testing
- Worksite Monitoring
- Agreement Monitors
- Weekly reporting by licensees
- Periodic Monitoring Consultants-monthly/quarterly
- Group Monitoring Consultants-weekly group for two years
- Independent Third Party Evaluations
- Medical Review Officer oversight
- Interactive Voice Response (IVR) system for random toxicology testing check-in
- Care Coordination
- Safe practice evaluations (self-referrals only)

Still have questions? Please feel free to call us at (888)802-2843 or email at hpsp@uprisehealth.com

Uprise Health Monitoring
Health Professionals' Services Program (HPSP)
Satisfaction Report

Year 13 Annual Report: January and July 2023 Surveys

Health Professionals' Services Program
PO Box 8668
Portland, Oregon 97207
Phone: 888.802.2843
Fax: 503.961.7142
Hpspmonitoring.com

Attachment #7

Executive Summary

Health Professionals' Services Program Satisfaction Survey: Year 13 Annual Report

Overview: This Health Professionals' Services Program report reviews the satisfaction survey results for the thirteenth year of the program. Surveys were sent at the beginning of both January and July 2023 to the following groups of stakeholders: Licensees, Workplace Monitors, Providers (GMC/PMCs and third-party evaluators), and Professional Health Associations.

An overview of the number of surveys sent, number of responses received, and the response rate by stakeholder group is displayed below:

Table 1: Response Rate – Year 13	Licensees	Workplace Monitors	Providers (GMC/PMC/3rd Party Evaluators)	Health Associations
# Sent	239	173	37	36
# Of Responses	29	10	7	0
Response Rate	12.1%	5.8%	18.9%	0.0%

Highlights

1. Licensee responses were received from three of four boards. No responses from any Board of Pharmacy licensees were received this year:
    a. Over 95% of respondents "agree" or "strongly agree" that they understand the program's statutory monitoring requirements
    b. A majority feel that they are treated with dignity (58.6%) and respect (68.9%).
    c. 82.1% feel that the program requirements are clearly explained.
    d. 96.5% feel that HPSP provides a "significant amount" or between a "significant amount" and "some" structure. 100% of respondents feel this way about the program's accountability.
    e. A minimum of 83% of respondents "agree" or "strongly agree" that:
        i. questions/concerns are addressed fully;
        ii. information is communicated clearly and professionally; and
        iii. the Agreement Monitor is knowledgeable about his/her case.
    f. The HPSP website was used by 69% of respondents and, of those, 65% find it "useful" or "extremely useful."
    g. RecoveryTrek's tools (portal and app) were included in this period's survey for the first time. 77% of respondents used the portal, of which 60% were "very satisfied" or "satisfied." 100% of respondents used the app, and 53.9% were "very satisfied" or "satisfied."
    h. 82.2% rated HPSP as "excellent," "above average," or "average."
2. Responses were received from Workplace Monitors for licensees from all boards except the Board of Dentistry:
    a. 100% of workplace monitor respondents indicated that they are satisfied or very satisfied with Uprise Health's support in their role as a workplace monitor.
    b. Uprise Health's ability to monitor licensees to ensure safety in the workplace is also endorsed by 100% of monitors.
    c. "Excellent" was the most frequent response to four out of five of the items rating Uprise Health's services, including response timeframe; ability to respond to questions regarding program administration; frequency of feedback; and overall services.
    d. 100% rated their overall experience working with Uprise Health as "excellent," "above average," or "average."
3. All GMC/PMC providers and evaluator respondents rated the program positively.
    a. 100% of respondents felt that questions and concerns were responded to promptly and that information was communicated clearly and professionally.
    b. 71.5% indicated that they had all necessary information was on hand when they met with the licensee.

    c. All but one respondent provided an “excellent” or “above average” rating of their overall experience working with HPSP staff. The other respondent provided an “average” rating. Notably, 71.4% provided an excellent rating.
4. While 18 members of professional healthcare associations were surveyed twice this year, no responses were received. Uprise Health will continue to foster relationships with these important stakeholders in the coming year.

All responses will be reviewed by the PAC and an action plan will be put into place to provide for continued improvement.

Uprise Health Monitoring
Health Professionals' Services Program (HPSP)
Satisfaction of LICENSEES

Purpose

The purpose of assessing participants (licensees) in the Health Professionals' Services Program (HPSP) is to obtain constructive feedback that can be used to improve and maintain the quality, effectiveness, and efficiency of HPSP. In order to provide continuous quality services, Uprise Health evaluates licensees' satisfaction with HPSP twice yearly.

Feedback is obtained from licensees via a satisfaction survey that is mailed or emailed to each licensee. When mailed, licensees are given the option of completing the enclosed survey and mailing it back to Uprise Health in the postage-paid envelope or completing the survey online through the included link. The survey is short and can be completed in 2-3 minutes. Feedback includes information about program administration, Uprise Health customer service, communication, Agreement Monitors, the portal, and overall services.

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

Data Results

Response Rate

Table 1: Response Rate	This Period	Year 13	Year 12	Year 11	Year 10	Year 9
# Sent	108	239	296	354	387	383
# Of Responses	13	29	44	55	65	80
Response Rate	12.0%	12.1%	14.9%	15.5%	16.8%	20.1%

The HPSP Licensee Satisfaction Survey was issued to all the licensees who had been enrolled for more than four months. This delay allows licensees to become established in the program before providing program feedback.

The survey was emailed to 103 licensees and mailed to five this period, for a total of 108 surveys distributed. A total of 13 responses were received, representing a response rate of 12.0%. This continues the years-long trend of decreasing responses.

For the year, a total of 239 surveys were distributed with 29 responses received, nearly exactly the same response rate (12.1%) for period one. There was a decrease in response rate of nearly three percent from year 12. Results should be continue to be considered with caution as it cannot be assumed that the results represent all participants.

Respondents

Question 1: Respondents are first asked the board by which they are licensed. Data is displayed in Table 2. The Medical Board was overrepresented for both the period and the year (much more so for the period). The Board of Nursing had the next highest response rate for both the period and the year and was accurately represented among all boards for the year. The Board of Dentistry had the third lowest response rate for the year and had no responses for the period. The Board of Pharmacy was not represented in either the period or the year as a whole.

Data Table 2:

Table 2: Respondents by Board	This Period (n=13)		Year 13 (n=29)		Year 12 (n=44)	
	#	%	#	%	#	%
Medical Board	11	84.6%	20	69.0%	24	54.5%
Board of Nursing	2	15.4%	7	24.1%	12	27.3%
Board of Dentistry			2	6.9%	7	15.9%
Board of Pharmacy					1	2.3%
No Response						

Question 2: Continuing to learn about the response pool, the survey then asks if the respondent is currently participating in the toxicology program. Results for the period and the year show that nearly 100% of respondents were testing. Licensees with mental health only diagnoses with no indication of a substance use disorder are not required to test unless required by their board or recommended by their independent third-party evaluator (after six tests in the first six months).

Data Table 3:

Table 3: Participating in Toxicology Program?	This Period (n=13)		Year 13 (n=29)		Year 12 (n=44)	
	#	%	#	%	#	%
Yes	13	100%	28	95.6%	42	95.5%
No			1	3.4%	2	4.6%
No Response						

Overall Program

Question #3: This question asks licensees to respond to four statements regarding the overall program. These statements include understanding the program's statutory requirements, the ability of the program to treat the licensee with dignity and with respect, and the program requirements being clearly explained. Although original response data is displayed in Tables 4a-c, the chart below combines the data for the year to provide additional insight into the response patterns:

	Strongly Agree or Agree	Disagree or Strongly Disagree
I understand the program's statutory monitoring requirements (regardless if I agree with it or not).	96.5%	3.5%
The program treats me with dignity.	58.6%	41.4%
The program treats me with respect.	68.9%	31.1%
The program requirements are clearly explained.	82.1%	17.9%

It is affirming to note that the overwhelming majority of respondents endorsed understanding the program's statutory requirements, with only one respondent disagreeing. (It should be noted that the same respondent answered all survey questions negatively, which should be considered when reviewing the overall results.) Additionally, greater than 80% of respondents felt that program requirements are clearly explained. As in period one of year 13, respondents expressed a decrease in ratings concerning the program treating them with dignity and respect over year 12. Specific comments (included at the end of this report) indicate that dissatisfied respondents largely point to statutory and/or contractual limitations and restrictions rather than actual customer service and agreement monitor satisfaction.

Data Table 4a, b and c: The mode (most frequent) response is highlighted in red.

Table 4a: This Period (n=13)	Strongly Agree		Agree		Disagree		Strongly Disagree		No Response	
	#	%	#	%	#	%	#	%	#	%
I understand the program's statutory monitoring requirements (regardless if I agree with it or not).	4	30.8%	**8**	**61.5%**			1	7.7%		
The program treats me with dignity.	1	7.7%	**7**	**53.9%**	4	30.8%	1	7.7%		
The program treats me with respect.	3	23.1%	**6**	**46.2%**	3	23.1%	1	7.7%		
The program requirements are clearly explained.	2	15.4%	**9**	**69.2%**	2	15.4%				

Table 4b: Year 13 (n=29)	Strongly Agree		Agree		Disagree		Strongly Disagree		No Response	
	#	%	#	%	#	%	#	%	#	%
I understand the program's statutory monitoring requirements (regardless if I agree with it or not).	**15**	**53.6%**	12	42.9%			1	3.6%	1	3.4%
The program treats me with dignity.	7	24.1%	10	34.5%	10	34.5%	2	6.9%		
The program treats me with respect.	9	31.0%	**11**	**37.9%**	8	27.6%	1	3.5%		
The program requirements are clearly explained.	9	32.1%	**14**	**50.0%**	5	17.9%			1	3.4%

Table 4c: Year 12 (n=44)	Strongly Agree		Agree		Disagree		Strongly Disagree		No Response	
	#	%	#	%	#	%	#	%	#	%
I understand the program's statutory monitoring requirements (regardless if I agree with it or not).	**23**	**52.3%**	19	43.2%	2	4.5%				
The program treats me with dignity.	14	31.8%	**20**	**45.5%**	10	22.7%				
The program treats me with respect.	**17**	**38.6%**	15	34.1%	12	27.2%				
The program requirements are clearly explained.	15	34.1%	**21**	**47.7%**	5	11.7%	3	6.8%		

Question #4: Continuing to evaluate the overall program, the next question asks respondents to rate the amount of structure and the amount of accountability the program provides. The scale is "0" (none) to "4" (a significant amount) with "2" representing "some." The mode response was a "significant amount" (4) for both items for the period and the year, with weighted averages of 3.38 for structure and 3.77 for accountability. These responses are consistent with previous years.

Data Table 5a, b and c: The mode (most frequent) response is highlighted in red.

Table 5a: This Period (n=13)	4 (significant amount)		3		2 (some)		1		0 (none)		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
The amount of structure the program provides	**9**	**69.2%**	1	7.7%	2	15.4%	1	7.7%				
The amount of accountability the program provides	**11**	**84.6%**	1	7.7%	1	7.7%						

Table 5b: Year 13 (n=29)	4 (significant amount)		3		2 (some)		1		0 (none)		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
The amount of structure the program provides	**18**	**62.1%**	7	24.1%	3	10.3%	1	3.5%				
The amount of accountability the program provides	**24**	**82.8%**	2	6.9%	3	10.3%						

Table 5c: Year 12 (n=44)	4 (significant amount)		3		2 (some)		1		0 (none)		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
The amount of structure the program provides	**25**	**56.8%**	12	27.3%	5	11.4%	2	4.5%				
The amount of accountability the program provides	**32**	**72.7%**	8	18.2%	4	9.1%	0	0.0%				

Customer Service

Question #5: This question queries response time frame, quality of response, communication style, and Agreement Monitor knowledge. Data tables 6a-c show the specific responses to each item and the mode responses. The chart below combines the "strongly agree" and "agree" responses as well as the "strongly disagree" or "disagree" responses for the year:

	Strongly Agree or Agree	Strongly Disagree or Disagree
My questions and/or concerns are responded to within one business day	86.2%	10.4%
My questions and/or concerns are addressed fully within the structure of the program	79.3%	17.3%
Information is communicated clearly and professionally	82.8%	10.3%
My Agreement Monitor is knowledgeable about my case.	86.2%	10.3%

The clear majority of respondents continue to positively endorse each item, indicating overall satisfaction with all areas of communication. Compared to last year, we note a strong increase in resondents who "strongly agree" or "agree" that their questions and/or concerns are responded to within one business day (86.2% this year versus 72.7% last year). However, we also note a small decrease in satisfaction with the other three questions. Although responses are well within acceptable ranges, the HPSP team is committed to increasing "strongly agree" or "agree" responses in year 14.

Data Table 6a, b and c: The mode (most frequent) response is highlighted in red.

Table 6a: This Period (n=13)	Strongly Agree		Agree		Disagree		Strongly Disagree		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%
My questions and/or concerns are responded to within one business day	4	30.8%	**6**	**46.2%**	1	7.7%	1	7.7%		
My questions and/or concerns are addressed fully within the structure of the program	3	23.1%	**5**	**38.5%**	3	23.1%	1	7.7%	1	7.7%
Information is communicated clearly and professionally	5	38.5%	5	38.5%	2	15.4%	1	7.7%		
My Agreement Monitor is knowledgeable about my case	**6**	**46.2%**	4	30.8%	3	23.1%				

Table 6b: Year 13 (n=29)	Strongly Agree		Agree		Disagree		Strongly Disagree		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%
My questions and/or concerns are responded to within one business day	10	34.5%	**15**	**51.7%**	2	6.9%	1	3.5%	1	3.5%
My questions and/or concerns are addressed fully within the structure of the program	9	31.0%	**14**	**48.3%**	4	13.8%	1	3.5%	1	3.5%

Information is communicated clearly and professionally	12	41.4%	12	41.4%	3	10.3%			1	3.5%
My Agreement Monitor is knowledgeable about my case	**16**	**55.2%**	9	31.0%	3	10.3%			1	3.5%

Table 6c: Year 12 (n=44)	**Strongly Agree**		**Agree**		**Disagree**		**Strongly Disagree**		**N/A or No Response**	
	#	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
My questions and/or concerns are responded to within one business day	13	29.5%	**19**	**43.2%**	11	25.0%	1	2.3%		
My questions and/or concerns are addressed fully within the structure of the program	17	38.6%	**19**	**43.2%**	8	18.2%				
Information is communicated clearly and professionally	19	43.2%	**20**	**45.4%**	4	9.1%	1	2.3%		
My Agreement Monitor is knowledgeable about my case	**27**	**61.4%**	14	31.8%	2	4.5%	1	2.3%		

HPSP Website

Question #6: This question asks respondents to rate the usefulness of the HPSP website ***if*** they have used it. This year, 69% of respondents (20) indicated that they had used the website, which is nearly the same as those who used the website last year (68.2%). Of those who used the website, 65% find it "useful" or "extremely useful."

It is relevant to note a change in this question. Previously, the survey asked participants to rate the "HPSP portal," which is where participants could log in to see specific and personalized information such as: whether a test was scheduled that day, account balance, test sites, and check in history. As of July 5, 2022, the HPSP ***portal*** no longer exists, as that information is now available on the RecoveryTrek participant portal. Question 7 below will address the RecoveryTrek portal. However, the HPSP ***website*** is still active, where anyone can see general program information such as guidelines, forms, resources, and evaluator lists. There may be confusion among respondents between the HPSP website and the RecoveryTrek portal, as is evident in the comments below.

A revision of the content of the HPSP website (hpspmonitoring.com) took place on 7/9/2023, where information, forms, and resources were updated and consolidated.

Data Table 7: The mode (most frequent) response is highlighted in red.

Table 7: If you used the HPSP website (hpspmonitoring.com) in the last six months, please rate its usefulness.	**This Period (n=8)**		**Year 13 (n=20)**		**Year 12 (n=30)**	
	#	**%**	**#**	**%**	**#**	**%**
Extremely Useful	0	0.0%	4	20.0%	7	23.3%
Useful	**4**	**50.0%**	**9**	**45.0%**	**11**	**36.7%**
Somewhat Useful	2	25.0%	3	15.0%	10	33.3%
Not Useful	2	25.0%	4	20.0%	2	6.7%

Respondents are asked to provide comments specific to the website and told that they will have room for general comments at the end of the survey.

Actual Comments – This Period:

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

1. It is okay.
2. I spend up to 2 hours approximately for ech drug screen at [test site] in [city]. I have filed complaints with [test site] with no improvement. They have limited hours and days they are available to do the drug screening. The other huge problem is that without an email from the drug testing group they will not allow me to test. Fortunately [agreement monitor] answers [their] phone but this is contributing to the overall dissatisfaction I am enduring and no other place to go as [former test site] closed. [Former test site] usually had main and out in 10 minutes.
3. Information is out of date and many questions are not answered on the website
4. The App is not user friendly and is subject to going down. When the app is not working there is little warning. If any. The alternatives when the app is down are sometimes also down as well. The app location function for tests sites when out of town does not work.

RecoveryTrek

Question #7: This is a new question for this period (July, 2023 survey). As such, there is no data with which to compare at this time. This question asks respondents to rate their satisfaction with the RecoveryTrek website/portal and app if they have used them in the past six months. This period, 10 respondents (77%) used the website/portal, and 100% of respondents used the app. Preliminary results indicate that a majority of respondents who used the website/portal were satisfied or very satisfied with the platform (60%), and over half of respondents were satisfied or very satisfied with the app (53.9%). Uprise Health will carefully review this data and work with RecoveryTrek to determine if there are any changes that can be made to these platforms to enhance the user experience.

Data Table 8: The mode (most frequent) response is highlighted in red.

Table 8: (n=13) If you used the RecoveryTrek website/participant portal (recoverytrek.com) or app in the last six months, please rate your level of satisfaction.	Very Satisfied		Satisfied		Dissatisfied		Very Dissatisfied		N/A – I Did not Use in the Past 6 Months	
	#	%	#	%	#	%	#	%	#	%
RecoveryTrek website/portal	2	20.0%	**4**	**40.0%**	2	20.0%	2	20.0%	3	23.1%
RecoveryTrek app	4	30.8%	3	23.1%	4	30.8%	2	15.4%		

Respondents are asked to provide comments specific to the RecoveryTrek platforms and told that they will have room for general comments at the end of the survey.

Actual Comments – This Period:

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

1. Website is awkward and time consuming to use. App is okay, as long as it is working. It is better than the old app.
2. Poor response when site goes down.
3. Malfunctions often. Information on testing sites is incorrect at times
4. See comments above
5. occasionally doesn't work

Overall Rating of Services

Question #8: Respondents are asked to rate the overall services. For the period, 75% of respondents rated the program overall as average or better, which increases to 82.2% looking at all of year 13. This represents a minor decrease in overall satisfaction from year 12's average or better rating of 86.3%. One rating of "poor" was received this period (this respondent was highly critical of all aspects of the program and Uprise Health).

Data Table 9: The mode (most frequent) response is highlighted in red.

Table 9: Overall Rating	This Period (n=13)		Year 13 (n=29)		Year 12 (n=44)		Year 11 (n=55)		Year 10 (n=65)		Year 9 (n=80)		Year 8 (n=99)	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Excellent	2	16.7%	8	28.6%	13	29.5%	**19**	**34.5%**	18	27.7%	**27**	**33.8%**	34	34.3%
Above Average	**4**	**33.3%**	8	28.6%	11	25.0%	10	18.2%	**19**	**29.2%**	24	30.0%	**37**	**37.4%**
Average	3	25.0%	7	25.0%	**14**	**31.8%**	17	30.9%	14	21.5%	21	26.3%	18	18.2%
Below Average	2	16.7%	4	14.3%	6	13.6%	5	9.1%	7	10.8%	5	6.3%	6	6.1%
Poor	1	8.3%	1	3.6%			3	5.5%	7	10.8%	3	3.8%	4	4.0%
No Response	1	7.7%	1	3.4%			1	1.8%						

Additional Comments

At the conclusion of the survey, respondents are asked for any additional comments. In addition to the nine comments received earlier in the survey, eight concluding comments were received this period. All seventeen of these substantive comments will be reviewed and addressed individually by the PAC over the next month.

Actual Comments Received – This Period

***Note that comments are shown as the respondent typed or wrote them. Spelling, punctuation, and grammar have not been corrected. Names and locations have been removed for confidentiality purposes.*

1. It would be great if we could check in starting at midnight rather than three AM. Midnight would make it MUCH easier for me to plan my day at work if I know I have to test. (As it is now, I wake up routinely at 3 to 5 AM to check in and see if I have to test. Not the best use of my sleep time...) My agreement monitor is an asset.
2. I realize your group is a tool for the Medical Board but this treatment of me is concerning.
3. This program treats addiction as a crime rather than a disease. Steps to "keep the public safe" do not consider downstream effects that actually make health care in Oregon less safe. The program needs recovered health care addicts as advocates with a genuine say in the program. If needed, take it back to the state legislature to modify the program rather than say "our hands are tied by the laws". If Uprise and the state medical boards care about the citizens of Oregon, make this program better. Don't abandon our dedicated health care providers. Help them to achieve recovery. They will be some of your best, most caring, dedicated providers in the state if you show them compassion in their recovery. Monitoring is necessary. A policing, fear based program is not.
4. Rating would be below average if not for my agreement monitor who I rate as excellent
5. My only comment is since Covid, hours of testing sites have become very limited, which makes it challenging to work and get tested in the allotted hours.
6. I fired [name]. [They are] terrible

7. The HPSP program is degrading. I have experienced work place discrimination and demoralization. You need to give participants more autonomy and freedom to go about their lives. My monitoring liason [agreement monitor name] is very understanding and works with me.
8. [Agreement monitor name] is the most professional, kind, and personable monitor I've had the pleasure of working with over my time in HPSP. I hope [they] find ongoing fulfillment in this job, as [they are] a major asset to this program.

Summary Analysis

The response rate for year 13 was 12.1%, down from a 14.9% response rate last year. Response rates have steadily decreased since year 6 of the program. Results should continue to be interpreted with the caution that they may not be representative of program participants as a whole. Most respondents (69%) were licensed by the Oregon Medical Board, with just under a quarter licensed by the Oregon State Board of Nursing. The remaining seven percent of respondents were from the Board of Dentistry. The Board of Pharmacy was not represented in this year's satisfaction survey.

Respondents continue to report overall satisfaction with HPSP. The majority of respondents understand the program's statutory requirements, believe that the program treats them with dignity and respect, and find that the program requirements are clearly explained. Additionally, approximately 80% or greater of respondents agree that their questions and concerns are addressed within one business day, that their questions and concerns are addressed within the scope of the program, that information is communicated clearly and professionally, and that their agreement monitor is knowledgeable about their case. Satisfaction with the HPSP program website decreased overall this year, and we are now inquiring about the RecoveryTrek programs and applications to track satisfaction and usefulness thereof. Overall, 82.2% of respondents rate HPSP as "average" or above.

All responses, including comments, will be reviewed closely by the PAC and addressed accordingly.

Uprise Health Monitoring
Health Professionals' Services Program (HPSP)
Satisfaction of WORKPLACE MONITORS

Purpose

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

Feedback is obtained from Workplace Monitor via a satisfaction survey that is emailed to Workplace Monitors who are asked to complete the survey online. The survey is short and can be completed in 2-3 minutes. Feedback includes information about timeliness of response, knowledge level of staff, the monthly safe practice form and an overall rating of Uprise Health's support of the supervision of licensees. The survey also asks for any additional comments.

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

Data Results

Response Rate

Table 1: Response Rate	This Period	Year 13	Year 12	Year 11	Year 10	Year 9
# Sent	74	173	264	327	331	340
# Responses	4	10	8	20	60	42
Response Rate	5.4%	5.8%	3.0%	6.1%	18.1%	12.4%

This period the Workplace Monitors' satisfaction survey had a response rate of 5.4%, with four responses out of 74 surveys sent. The response rate for the year was virtually identical, with 10 surveys received out of 173 sent out (5.8%). This represents a slight increase from last year's historically low response rate of 3%, but is still far below what can be considered an ideal response rate. Given the low response rate, results should not be considered representative of the population of workplace monitors.

Report continues next page

Professional Licensing Board

Question 1: Respondents are first asked which professional board licenses the employee they monitor. This period, two were licensed by the Medical Board, one by the Board of Nursing, and one by the Board of Pharmacy. For the year, there were again responses from Workplace Monitors of Medical Board (five, or 50%), Nursing Board (four, or 40%), and Pharmacy Board (one, or 10%) licensees. Workplace Monitors of Board of Dentistry licensees are not represented in this year's responses.

Data Table 2: The mode (most frequent) response is highlighted in red.

Table 2: Type of Services Provided	This Period (n=4)		Year 13 (n=10)		Year 12 (n=8)	
	#	%	#	%	#	%
Medical Board	**2**	**50.0%**	**5**	**50.0%**	4	50.0%
Board of Nursing	1	25.0%	4	40.0%	4	50.0%
Board of Pharmacy	1	25.0%	1	10.0%		
Board of Dentistry						
Other / Not Identified						
No Response						

Supervision Support

Question 2: The next item reads: "Uprise Health supports you in your role as workplace monitor. How satisfied are you with our support?" This year, as was the case last year, all respondents were either "very satisfied" (60%) or "satisfied" (40%) with Uprise Health's support. The same is true for the period, although the mode response was "very satisfied" with 75% of responses. Overall, this represents a slight increase in satisfaction as compared to last year, as indicated by the increase in "very satisfied" responses.

Data Table 3: The mode (most frequent) response is in red:

Table 3: Supervision Support	This Period (n=4)		Year 13 (n=10)		Year 12 (n=8)	
	#	%	#	%	#	%
Very Satisfied	**3**	**75.0%**	**6**	**60.0%**	4	50.0%
Satisfied	1	25.0%	4	40.0%	4	50.0%
Unsatisfied						
Very Unsatisfied						
No Response						

Workplace Safety

Question 3: Uprise Health's ability to monitor the licensee to ensure safety in the workplace is queried in the next item. This is one of HPSP's most vital functions, so it is important to note that responses continue to be positive. This period, 100% of respondents indicated that Uprise Health does an "excellent" or "above average" job at monitoring licensees to ensure public safety. "Excellent" and "above average" ratings are also strong when looking at the year, at 80%. These responses demonstrate an increase from last year's 62.5% "excellent" and "above average" ratings.

Data Table 4: The mode (most frequent) response is highlighted in red:

Table 4: Workplace Safety	This Period (n=4)		Year 13 (n=10)		Year 12 (n=8)	
	#	%	#	%	#	%
Excellent	**3**	**75.0%**	**5**	**50.0%**	**4**	**50.0%**
Above Average	1	25.0%	3	30.0%	1	12.5%
Average			2	20.0%	3	37.5%
Below Average						
Poor						
No Response						

A follow-up question requests any suggested changes or recommendations. The following comment was received this period. All comments will be addressed by the PAC.

Actual Comments – This Period:

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

1. Online forms for monthly reports!

Services

Question 4: Respondents are asked to think about their recent contacts with Uprise Health and rate the following: response timeframe, knowledge of licensee when there is a concern in the workplace; ability to respond to questions regarding program administration; and frequency of feedback from Uprise Health. Finally, an overall rating is requested.

For the period, 100% of respondents who answered the questions gave a rating of "excellent." For the year, mode responses for items one, three, four, and five were "excellent," with the mode response for item two being split between "excellent" and "above average." These results are identical to last year's results.

Data for this period, this year and the prior year follows on the next page.

Data Tables 5a and b: The mode (most frequent) response is highlighted in red.

Table 5a This Period (n=4)	Excellent		Above Average		Average		Below Average		Poor		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
Response timeframe when I request information	**3**	**75.0%**									1	25.0%
Staff knowledge of a licensee when there is concern in the workplace	**2**	**50.0%**									2	50.0%
Our ability to respond to questions regarding program administration	**2**	**50.0%**									2	50.0%
Frequency of feedback from Uprise Health regarding licensee's compliance	**4**	**100.0%**										
Overall rating of our services	**4**	**100.0%**										

Table 5b Year 13 (n=10)	Excellent		Above Average		Average		Below Average		Poor		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
Response timeframe when I request information	**5**	**50.0%**	1	10.0%	2	20.0%					2	20.0%
Staff knowledge of a licensee when there is concern in the workplace	3	30.0%	3	30.0%	1	10.0%					3	30.0%
Our ability to respond to questions regarding program administration	**4**	**40.0%**			3	30.0%					3	30.0%
Frequency of feedback from Uprise Health regarding licensee's compliance	**7**	**70.0%**	1	10.0%	1	10.0%						
Overall rating of our services	**7**	**70.0%**	1	10.0%	2	20.0%						

Table 5c Year 12 (n=8)	Excellent		Above Average		Average		Below Average		Poor		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
Response timeframe when I request information	**4**	**50.0%**	2	25.0%	2	25.0%						
Staff knowledge of a licensee when there is concern in the workplace	2	25.0%	2	25.0%	1	12.5%					**3**	**37.5%**
Our ability to respond to questions regarding program administration	**4**	**50.0%**	2	25.0%	1	12.5%					1	12.5%
Frequency of feedback from Uprise Health regarding licensee's compliance	**3**	**37.5%**	2	25.0%	2	25.0%					1	12.5%
Overall rating of our services	**4**	**50.0%**	2	25.0%	2	25.0%						

Overall Experience

Question 5: Respondents are asked to rate their overall experience working with Uprise Health. The mode response was "excellent" for both the period (100%) and year (60%). We are pleased to again report receiving no "below average" or "poor" ratings this year.

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

Table 6: Overall Experience	This Period (n=4)		Year 13 (n=10)		Year 12 (n=8)	
	#	%	#	%	#	%
Excellent	4	100.0%	6	60.0%	4	50.0%
Above Average			2	20.0%	3	37.5%
Average			2	20.0%	1	12.5%
Below Average						
Poor						
N/A or No Response						

Additional Comments

No additional comments were received this period.

Summary Analysis

The response rate for this survey was again low, both for the period (5.4%) and the year (5.8%). However, this does represent a slight increase over responses from last year. As such, results should be interpreted carefully as they may not be representative of the entire population. That said, results are not dissimilar from what has been reported in past years.

We are pleased to report that once again, there were no responses indicating dissatisfaction with Uprise Health's services, communication, or ability to ensure public safety. All responses were either "very satisfied," "satisfied," "excellent," "above average," or "average."

The PAC committee will review the survey data and the comment carefully.

Uprise Health Monitoring
Health Professionals' Services Program (HPSP)
Satisfaction of PROFESSIONAL ASSOCIATIONS

Purpose

The purpose of assessing representatives from the related professional associations is to obtain constructive feedback that can be used to improve and maintain the quality, effectiveness, and efficiency of HPSP. In order to provide continuous quality services, Uprise Health evaluates this stakeholder group's satisfaction with HPSP twice yearly.

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

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

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

Data Results

Response Rate

Table 1: Response Rate	This Period	Year 13	Year 12	Year 11	Year 10	Year 9
# Sent	15	33	36	16	10	10
# Responses	0	0	0	3	2	2
Response Rate	0.0%	0.0%	0.0%	18.8%	20.0%	20.0%

Fifteen surveys were sent out this period to various contacts at related professional associations, however, no responses were received in year thirteen. Uprise Health staff has continued to foster relationships with representatives from these associations by holding quarterly or semi-annual conversations, and this will continue.

Report continues next page

Uprise Health Monitoring
Health Professionals' Services Program (HPSP)
Satisfaction of PROVIDERS

Purpose

The purpose of assessing GMC/PMC providers and third-party evaluators is to solicit feedback that can be used to improve the services provided through HPSP. Uprise Health strives to maintain the quality, effectiveness, and efficiency of the program, and evaluates these providers' satisfaction with HPSP twice yearly.

Feedback is obtained from these providers via a satisfaction survey that is emailed. The survey is short and can be completed in 2-3 minutes. Feedback includes information about Uprise Health's communication, responsiveness of staff, overall rating of experience, and any additional comments.

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

Data Results

Response Rate

Table 1: Response Rate	This Period	Year 13	Year 12	Year 11	Year 10
# Sent	18	37	48	48	51
# Responses	3	7	9	12	10
Response Rate	16.7%	18.9%	18.8%	25.0%	19.6%

Surveys were sent to six GMC/PMC providers and 12 third-party evaluators this period (one PMC retired between the first and second periods of this year), and received responses from three providers this period (16.7%) and seven providers for the year (18.9%). Response rates for the year are virtually identical to response rates last year.

Role of Respondent

The first question asks the respondents the capacity in which they provide services to HPSP licensees (evaluator or monitor). This period, two respondents indicated they are "Monitors – GMC, PMC, or Quarterly," and one respondent did not answer. For the year, two respondents indicated they were "evaluators" with the four as "monitors" (GMC/PMC), and the seventh respondent who did not answer.

There is also room for a write-in response as "Other." Two comments were provided in the "other" category: "therapist" and "treator [sic]."

Customer Service and Communication

Question 2: Survey respondents are asked to rate three different statements relating to communication between HPSP and the provider. Specifically, they were asked if questions and concerns were responded to promptly, information was communicated clearly and professionally, and if they had all the necessary information when they met with the licensee. For the period, the mode was "strongly agree" for the first two statements and split evenly with one response each of "strongly agree," "agree," and "disagree" for the third. For the year as a whole, responses were more positive, with the mode response for all three questions being "strongly agree."

Data Tables 2a and b: The mode (most frequent) response is highlighted in red.

Table 2a: This Period (n=3)	Strongly Agree		Agree		Disagree		Strongly Disagree		N/A		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
My questions and/or concerns were responded to promptly	**2**	**66.7%**	**1**	**33.3%**								
Information was communicated clearly and professionally	**2**	**66.7%**	**1**	**33.3%**								
I had all the information I needed when I saw the licensee	1	33.3%	1	33.3%	1	33.3%						

Table 2b: This Year (n=7)	Strongly Agree		Agree		Disagree		Strongly Disagree		N/A		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
My questions and/or concerns were responded to promptly	**4**	**57.1%**	3	42.9%								
Information was communicated clearly and professionally	**4**	**57.1%**	3	42.9%								
I had all the information I needed when I saw the licensee	**3**	**42.9%**	2	28.6%	2	28.6%						

Table 2c: Year 12 (n=9)	Strongly Agree		Agree		Disagree		Strongly Disagree		N/A		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
My questions and/or concerns were responded to promptly	**7**	**77.8%**	2	22.2%								
Information was communicated clearly and professionally	**6**	**66.7%**	3	33.3%								
I had all the information I needed when I saw the licensee	**5**	**55.6%**	3	33.3%	1	11.1%						

Overall Experience

Question 3: Respondents are next asked "Overall, how would you rate your experience working with Uprise Health staff of HPSP?" For the period, the mode response was "excellent," with the remaining response as "above average." For the year, the mode response was "excellent" with over 70% of the responses. There was one "above average" response for the year as well as one "average." Ratings of "excellent" represented a higher percentage of responses in year 13 versus year 12.

Data Table 3: The mode (most frequent) response is highlighted in red where applicable.

Table 3: Overall Rating	This Period (n=3)		Year 13 (n=7)		Year 12 (n=9)	
	#	%	#	%	#	%
Excellent	**2**	**66.7%**	**5**	**71.4%**	**5**	**55.6%**
Above Average	1	33.3%	1	14.3%	2	22.2%
Average			1	14.3%	1	11.1%
Below Average						
Poor						
N/A or No Response					1	11.1%

Additional Comments

Actual Comments – This Period:

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

1. Bit of billing confusion but we were able to clear it up. Perhaps a problem between how things go to who writes the checks?
2. Professional, courteous, easy to work with.
3. Interacting with Uprise staff is always a pleasure.

Summary Analysis

The response rate was 16.7% for the period and 18.9% for the year. These rates are similar to responses in previous years.

Overall, responses for the year were positive. Nearly all respondents "strongly agreed" or "agreed" that all aspects of Uprise Health's communication with providers was clear, complete, and timely. Further, most respondents this year rated overall services as "excellent" or "above average," and none rated overall services as "below average" or "poor."

Three comments were received for this period. The PAC will review all survey data and comments.

Health Professionals' Services Program Summary Annual Report
Highlights of Year Thirteen 7/1/2022-6/30/2023

The purpose of this report is to provide a summary of the highlights of the thirteenth year of the Health Professionals' Services Program (HPSP) to the representatives of the participating health licensing boards. HPSP began provision of monitoring services to the Oregon Board of Dentistry, Oregon Board of Nursing, Oregon Medical Board, and the Oregon Board of Pharmacy on July 1, 2010. The Oregon Health Authority previously oversaw HPSP's provision of services to the boards.

The following data tables were developed to give an overview of the HPSP program during the period from July 1, 2022, through June 30, 2023.

Table 1: Enrollment Overview: Year 13

Enrollment Overview: Year 13 (7/1/22 - 6/30/23)	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Total Enrolled End of Year 12 (6/30/22)	13	50	13	72	**148**
Enrolled: Board Referral*	0	1	1	13	**15**
Enrolled: Self-Referral*	0	0	0	3	**3**
Successfully Completed	4	19	4	17	**44**
Terminations	1	3	0	6	**10**
Total Enrolled End of Year 13 (6/30/23)	**8**	**29**	**9**	**65**	**111**
Referred but Not Enrolled/Inquiry Only	*1*	*8*	*1*	*7*	*17*

**Referral Type at the time of enrollment*

Table 1 provides a summary of year 13 enrollment, beginning with the number of licensees enrolled at the end of year eleven and reviewing the changes in enrollment during the year. In particular it displays: the number of licensees referred by the licensing board to the program, the number of self-referrals to the program, the number of licensees who successfully completed the program, and the number of licensees who were terminated from the program by the licensing boards. The total enrollees at the end of year 13 follows from this data. Table 1 also displays the number of licensees who did not yet enroll but were referred or self-initiated contact with the program prior to the end of the year. Table 2 provides the same information but for year 12 enrollment (see next page).

At the end of year 13, the program had 111 participants, a 25% decrease from the 148 participants at the beginning of the year. This sharp decrease is due to a decision made by the Oregon State Board of Nursing this year to stop referring licensees to the alternative-to-discipline program. Had the OSBN maintained their referral numbers from year 12, there would have been an estimated 7% decrease in enrollment this year. The Board of Dentistry did not refer any new participants to HPSP this year (compared to three referrals in year 12), and the Board of Pharmacy referred one licensee (compared to two in year 12). The Oregon Medical Board's enrollment increased from a total of 11 in year 12 to 16 in year 13.

Completions and terminations were similar this year (44 completions; 10 terminations) to last year (48 completions; 13 terminations). This continues our trend of successful completions far outweighing terminations. Participants were 3.5 times more likely to successfully complete the program versus being dismissed (termed) or closed without successful

Health Professionals' Services Program
PO Box 8668
Portland, Oregon 97207
Phone: 888.802.2843
Fax: 503.961.7142

completion. This continues to underline the overall success of the program in demonstrating that the majority of participants will complete successfully.

The number of people who inquired about HPSP as self-referrals, but did not enroll, continued to increase this year (17) over last year (11). One unique change this year, as opposed to prior years, is that more than half of inquiry calls were from licensees of the OSBN. In most cases, they were ineligible for self-referral into HPSP due to license status and/or current investigation. Potential participants who call for information and are not eligible for self-referral are given information about Uprise Health's Extended Monitoring Program as well as connected with community resources when indicated.

Table 2: Enrollment Overview: Year 12

Enrollment Overview: Year 12 (7/1/21 - 6/30/22)	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Total Enrolled End of Year 11 (6/30/21)	12	62	19	87	**180**
Enrolled: Board Referral*	3	13	2	9	**27**
Enrolled: Self-Referral*	0	0	0	2	**2**
Successfully Completed	2	16	8	22	**48**
Terminations	0	9	0	4	**13**
Total Enrolled End of Year 12 (6/30/22)	**13**	**50**	**13**	**72**	**148**
Referred but Not Enrolled/Inquiry Only	*0*	*3*	*0*	*8*	*11*

**Referral Type at the time of enrollment*

Report continued next page

Health Professionals' Services Program
PO Box 8668
Portland, Oregon 97207
Phone: 888.802.2843
Fax: 503.961.7142

Table 3: Case Disposition (7/1/10 – 6/30/23)

Case Disposition as of 6/30/23	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Total Enrolled	**52**	**612**	**68**	**359**	**1091**
Number Successfully Completed	31	328	42	222	623
Number Active	8	29	9	65	111
Total Successful (Active + Completions)	39	359	51	287	734
Percentage Successful	**75.0%**	**58.7%**	**75.0%**	**80.0%**	**67.3%**
Number Termed	13	255	16	72	356
Percentage Unsuccessful	**25.0%**	**41.3%**	**25.0%**	**20.0%**	**32.6%**

Table 3 displays the cumulative data on the disposition of cases since the program's inception. To date, 1,091 licensees have enrolled, and 623 of these have completed; an additional 111 are on track to complete for a total of 67.3% (similar to year 12's 67.8%). The percentage of successful completion ranges across the Boards from 58.7% (Board of Nursing), to 75% (Board of Pharmacy and Board of Dentistry) and 80% (Medical Board).

Unfortunately, 356 licensees have been terminated from the program. These cases include situations where HPSP and the Boards acted to protect public safety. The Board of Nursing has consistently had the highest number of program terminations, which is likely because they are the only board running their own, separate, probation program. Two of the three Board of Nursing licensees whose participation was terminated were moved instead to public discipline (probation). We are glad to see a decrease in terminations this year.

Table 4: Video/In-Person Contacts

Video/In-Person Contacts: Year 13	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Number of Video/In-Person Contacts (including Intakes)					**0**
Number of Video/In-Person Intakes					**0**
Total Enrolled During Year 13	0	1	1	16	**18**
Percent with Video/In-Person Intakes	N/A	0	0	0	**0**

During year 13, no licensees completed in-person or video contacts. Intake appointments are offered to participants as phone or videoconference meetings, and this year, all licensees who were offered a videoconference declined this option.

Table 5: Program Termination Reasons

Health Professionals' Services Program
PO Box 8668
Portland, Oregon 97207
Phone: 888.802.2843
Fax: 503.961.7142

Termination Reasons: Year 13	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Deceased	1	0	0	2	**3**
Inappropriate Referral (Determined after Enrollment)	0	0	0	0	**0**
License Inactivated	0	0	0	0	**0**
License Retired	0	0	0	0	**0**
License Revoked	0	0	0	0	**0**
License Surrendered	0	1	0	4	**5**
License Suspended	0	0	0	0	**0**
Probation	0	2	0	0	**2**
TOTAL	**1**	**3**	**0**	**6**	**10**

Table 5 reviews the reasons for terminations from HPSP this year. A total of 10 licensees were terminated from the program in year 13, which is a decrease from year twelve's 13 terminations. Sadly, three (30%) of those 10 terminations were due to the licensees' deaths. Two of the remaining terminations were moved to probation (OSBN), and five were due to surrendered licenses.

Table 6: Licensees Formally Not Participating During the Program Year

Licensees Formally Not Participating (At Any Time During Year 13)	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Formally Not Participating (But Not Suspended)					**0**
Suspended: Board Request					**0**
Suspended: Expired License					**0**
Suspended: Health - Severe Issues					**0**
Suspended: Incarcerated					
Suspended: Non-Compliance - Financial					**0**
Suspended: Per Board, Open HPSP But Not Participating					**0**
TOTAL	**0**	**0**	**0**	**0**	**0**

Table 7: Licensees Formally Not Participating at the End of the Year

Health Professionals' Services Program
PO Box 8668
Portland, Oregon 97207
Phone: 888.802.2843
Fax: 503.961.7142

Licensees Formally Not Participating (At End of Year 13)	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Formally Not Participating (But Not Suspended)					0
Suspended: Board Request					0
Suspended: Expired License					0
Suspended: Health - Severe Issues					0
Suspended: Incarcerated					
Suspended: Non-Compliance - Financial					0
Suspended: Per Board, Open HPSP But Not Participating					0
TOTAL	0	0	0	0	0

Tables 6 & 7 show licensees who have been “formally not participating” in HPSP during the course of the year, and as of the end of the year. In year 13, there were no licensees who were suspended or otherwise considered to be “formally not participating” in HPSP.

Table 8: Non-Compliance Reports by Licensee

Non-Compliance Reports by Licensee: Year 13	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Total Non-Compliance Reports	2	4	1	18	**25**
Total Non-Compliance Reports as a Percentage of Average # of Licensees Enrolled in Year 12	18.0%	10.0%	9.1%	26.1%	**19.1%**
# of Licensees with NC Reports	2	3	1	13	**19**
# of Licensees with NC Reports as a Percentage of Average # of Licensees Enrolled in Year 12	18.0%	7.5%	9.1%	18.9%	**14.5%**
# of Licensees with >1 NC report	0	1	0	4	**5**
# of Licensees with >3 NC report	0	0	0	0	**0**

Table 8 gives the total number of non-compliance reports by board and then reports this number as a percentage of the average number of licensees enrolled during the year. A breakdown of these reports is then listed, showing the number of licensees who received reports, the number with more than one report throughout the year, and the number with more than three reports throughout the year. Further, the number of licensees with a non-compliance report is reflected as a percentage of the average number of licensees enrolled in the program. This figure was 14.5% for year 13, which is down significantly from 22.2% the prior year. This figure ranged from 18.9% (Medical Board) to 7.5% (OSBN).

A total of 19 licensees had one or more non-compliance reports this year, a decrease of nearly 50% from last year’s 37 licensees. A total of 25 non-compliance reports were submitted this year, also a substantial decrease from the 139 last year. It is relevant to note that in the prior year, there were many non-compliance reports due to non-participation and positive toxicology for marijuana, both of which result in a large number of actual reports. The Board of Nursing licensees had four reports this year, the Medical Board had 18, the Board of Dentistry had two, and the Board of Pharmacy had one.

Health Professionals’ Services Program
PO Box 8668
Portland, Oregon 97207
Phone: 888.802.2843
Fax: 503.961.7142

Five licensees had more than one non-compliance report (compared to eight last year), and there were no licensees with more than three non-compliance reports this year (compared to 10 last year).

The total number of non-compliance reports submitted as a percentage of the average number of enrolled licensees was 19.1%, a substantial decrease from last year's 83.2%.

Table 9: Self-Referrals Known to Board After Report of Non-Compliance

Self-Referrals Known to Board After Report of Non-Compliance	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Year 1 (7/1/10 - 6/30/11)	0	0	0	11	**11**
Year 2 (7/1/11 - 6/30/12)	0	1	0	8	**9**
Year 3 (7/1/12 - 6/30/13)	1	0	0	5	**6**
Year 4 (7/1/13 - 6/30/14)	0	0	0	4	**4**
Year 5 (7/1/14 - 6/30/15)	0	4	0	7	**11**
Year 6 (7/1/15 - 6/30/16)	0	0	0	3	**3**
Year 7 (7/1/16 - 6/30/17)	0	0	0	4	**4**
Year 8 (7/1/17 - 6/30/18)	0	0	0	3	**3**
Year 9 (7/1/18 - 6/30/19)	0	2	0	4	**6**
Year 10 (7/1/19 - 6/30/20)	0	2	0	4	**6**
Year 11 (7/1/20 - 6/30/21)	0	2	0	2	**4**
Year 12 (7/1/21 – 6/30/22)	0	0	0	3	**3**
Year 13 (7/1/22 – 6/30/23)	0	0	0	1	**1**
TOTAL	**1**	**11**	**0**	**59**	**71**

The self-referral option remains an effective way to encourage early intervention. Table 9 shows the cumulative number of self-referred licensees who were reported non-compliant and are thus now known to the board. This year, there was only one self-referral, licensed by the Oregon Medical Board, who became known to the board as a result of a non-compliance report.

Report continued next page

Health Professionals' Services Program
PO Box 8668
Portland, Oregon 97207
Phone: 888.802.2843
Fax: 503.961.7142

Table 10: Non-Compliance Reasons

Non-Compliance Reasons*: Year 13	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Failure to Enroll	0	0	0	0	**0**
Failure to Participate: Missed AM Check-in	0	0	0	0	**0**
Failure to Participate: Missed IVR Call**	2	1	0	4	**7**
Failure to Participate: Missed Test (includes failure to provide specimen)	2	1	1	8	**12**
Failure to Participate: Non-Payment	0	0	0	0	**0**
Failure to Participate: Other	0	0	0	0	**0**
Hospitalization	0	0	0	0	**0**
Violated Restriction on Practice	0	0	0	0	**0**
Positive Non-Uprise Health Test	0	0	0	1	**1**
Positive Toxicology Test	0	1	0	7	**8**
Impaired in a Health Care Setting in the Course of Employment (including admitted substance use & diversion of medications)	0	0	0	0	**0**
Impaired Outside of Employment (including admitted substance use & diversion of medications)	0	1	0	1	**2**
Public Endangerment	0	1	0	0	**1**
Criminal Behavior (including DUI)	0	0	0	0	**0**
Unapproved Use of Prescription Medication	0	0	0	1	**1**
TOTAL	**4**	**5**	**1**	**22**	**32**
Unique Licensees with 1 or More Non-Compliance Reports	***2***	***3***	***1***	***13***	

** There may be more than 1 reason per report*

*** "IVR Call" refers to all forms of daily testing check-in, including the IVR, mobile app, and web portal*

Table 10 shows the reasons why a non-compliance report was submitted to the appropriate board. It is not uncommon for a single non-compliance report to have multiple reasons for the non-compliance; all of these reasons are captured in the table. The most common reason for non-compliance was again the licensee failing to test as scheduled. This was the case on 12 reports, down from 64 last year. Failure to test has been the most frequent reason for a non-compliance report for the past ten years. Positive toxicology tests and missed IVR calls (resulting in missed tests) were the next most common reasons. Note that "missed IVR calls" (or any missed check-in to the testing notification system) is only reported in conjunction with another non-compliance instance, most commonly a missed test.

Health Professionals' Services Program
PO Box 8668
Portland, Oregon 97207
Phone: 888.802.2843
Fax: 503.961.7142

Table 11: Non-Negative Toxicology Tests

Non-Negative Toxicology Tests: Year 13	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Invalid Tests	0	0	1	0	**1**
Positive Tests (non-negative results)	0	1	0	7	**8**
Total Non-Negative Tests (Positive + Invalid)	**0**	**1**	**1**	**7**	**9**
Number of Licensees with a Positive Test	0	1	0	5	**6**
Number of Licensees with a Positive Test as a Percentage of Average # of Licensees Enrolled in Year 12	0.0%	2.5%	0.0%	7.2%	**4.6%**

Table 11 shows the number of invalid and positive toxicology tests per board. These include urinalysis (UA), hair, and blood tests. There were a total of eight positive toxicology tests during year thirteen, down significantly from 61 last year. Seven of the positive tests were from Medical Board licensees and one was from a Board of Nursing licensee. The Pharmacy and Dental Boards did not have any licensees with positive toxicology this year. Table 11 also includes the number of licensees with a positive test, which is then reflected as a percentage of the average number of licensees enrolled in the program. Across the program, the percentage of licensees with a positive test is 4.6%, a decrease from last year's 10.8%. The Medical Board's percentage is 7.2%, based on five licensees with positive tests. This is followed by the Board of Nursing with 2.5% (one licensee). There was one invalid test this year, down from three last year.

Report continued next page

Health Professionals' Services Program
PO Box 8668
Portland, Oregon 97207
Phone: 888.802.2843
Fax: 503.961.7142

Table 12: Drugs Resulting in Positive Tests

Drugs Resulting in Positive Tests: Year 13	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
amphetamines / methamphetamines	0	0	0	0	**0**
cocaine metabolite	0	0	0	0	**0**
ethyl glucuronide (ETG)	0	0	0	3	**3**
ethyl glucuronide (ETG) – PETH	0	1	0	4	**5**
marijuana metabolite (THC)	0	0	0	0	**0**
opioids (narcotics/opiates)	0	0	0	0	**0**
TOTAL	0	**1**	0	**7**	**8**
Number of Licensees with a Positive Test	***0***	***1***	***0***	***5***	***6***

Table 12 shows the various drugs that resulted in a positive test result. This table ***only*** includes the drugs resulting in the positive test, excluding any substances excused by the Medical Review Officer (MRO) due to a valid prescription. This year, alcohol was the only substance resulting in a positive test. Five of the eight positives were PEth (blood) tests, and the remaining three were urine tests. Last year, nearly two-thirds of positive tests were due to alcohol, with the other one-third caused by marijuana and stimulants.

Table 13: Missed Test Details – Breakdown by Reason

Missed Test Breakdown by Reason: Year 13	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
No Call	2	1	0	4	**7**
No Show	0	0	1	4	**5**
Refused	0	0	0	0	**0**
TOTAL	**2**	**1**	**1**	**8**	**12**

Table 13 gives details on licensees who failed to take a scheduled toxicology test. “No Call” refers to licensees who failed to check in to the daily testing notification system (IVR/portal/app) and did not test as scheduled. “No Show” refers to situations when the licensee did not go to the collection site to give a specimen but did check to see if a test was required through the daily testing notification system (IVR/portal/app). “Refused” refers to licensees who went to the collection site but did not provide an adequate specimen. This is considered a refusal to test which is treated like a positive test unless the licensee can provide a medical explanation from a physician, verifying that the licensee has a medical condition which prevents the licensee from providing an adequate sample. There were no refusals this year.

There were a total of 12 missed tests this year compared to 94 last year. The majority (seven) of misses were due to No Call while the remaining five were due to No Show. This means that many more licensees missed a test after failing to check-in than did not test despite apparent knowledge of the requirement to do so. This has been the case for the past several years.

Table 14: Missed Test Details – By Licensees

Missed Test Details: Year 13	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Total Number of Missed Tests	2	1	1	8	**12**
Number of Licensees with a Missed Test	2	1	1	7	**11**
Licensees with a Missed Test as a Percentage of Average # of Licensees Enrolled in Year 12	19.0%	5.1%	9.1%	10.2%	**8.5%**

Table 14 shows the total number of missed tests (also reported in Table 13) as compared to the number of unique licensees who missed a scheduled toxicology test. If these numbers were identical, it would mean that each licensee was only responsible for one missed test. The larger the difference in these numbers, the more times a single licensee is responsible for multiple missed tests. This year, only one licensee missed more than one test, making the numbers nearly 1:1.

Table 14 also shows the number of missed tests as a percentage of the average number of licensees enrolled in year eleven. Across the boards, this percentage was 8.5%. The Board of Dentistry was highest with 19%, meaning that about a fifth of licensees missed at least one test. The Medical Board had 10.2% of licensees miss a test, the Board of Pharmacy had 9.1%, and the Board of Nursing had 5.1% of licensees miss a test.

Report continued next page

Health Professionals' Services Program
PO Box 8668
Portland, Oregon 97207
Phone: 888.802.2843
Fax: 503.961.7142

Table 15: Workplace Safe Practice Reports

Workplace Safe Practice Reports: Year 13	Board of Dentistry	Board of Nursing	Board of Pharmacy	Medical Board	TOTAL
Number of Licensees who had Reports Submitted	13	45	10	64	**132**
Number of Reports Received / Reviewed	120	473	83	663	**1,339**
Percentage of Required Reports Received	95.2%	96.3%	87.3%	96.2 %	**95.6%**
Number of Reports Received with Concerns Noted	0	0	0	0	**0**
Percentage of Reports with Concerns Noted	0	0	0	0	**0**
Percentage of Reports in which Noted Concerns were Addressed	N/A	N/A	N/A	N/A	**N/A**
Number of Licensees with a Report with Concerns Noted	0	0	0	0	**0**
Number of Licensees with Concerns Reported who also had a NC report	0	0	0	0	**0**

Table 15 displays details on the workplace safe practice reports received from workplace monitors during the year, including the number of licensees who had reports submitted, the total number of reports received and reviewed and the percentage of the required reports that were actually received. This year, 95.6% of the required reports were received with a total of 1,339 reports received and carefully reviewed for 132 licensees. This represents an increase from last year's 92% received rate and is in fact the highest received rate to date. HPSP will continue to employ the tools that are in place to carefully track and follow-up on these reports each month.

Table 15 additionally displays information about workplace reports with noted concerns, the frequency of which reports with concerns were addressed, and the number of licensees who received workplace reports noting concerns. There were no concerns noted on any workplace reports this year, which is not surprising considering the low levels of non-compliance with the program.

Report continued next page

Health Professionals' Services Program
PO Box 8668
Portland, Oregon 97207
Phone: 888.802.2843
Fax: 503.961.7142

What's Next? Year Fourteen

We are pleased to demonstrate that HPSP remains a strong alternative to discipline option for Oregon health professionals. We again saw decreases in positive toxicology, non-compliance reports, missed tests, and invalid tests. We continue to experience an ongoing decrease in enrollment, due in large part this year to the Oregon State Board of Nursing's decision to cease referring licensees to the alternative to discipline option. Due to the existing funding model in which boards pay for HPSP services based on median number of actual licensees enrolled (50%) and total number of potentially eligible licensees (50%) every six months, the three remaining boards are now anticipating increases in their monthly costs. Uprise Health will be glad to partner with licensing boards to explore any possible alternatives to the funding model and/or statutory regulations. Uprise Health will also conduct targeted outreach to non-participating boards with the goal of increasing participation in HPSP.

Last year, we were hopeful that we could begin to introduce at home, DNA-verified urine testing (PROOF) as an alternative to traditional site-based testing. However, the lab that is used for testing these samples remains without one of the required lab certifications (CAP or SAMHSA), which prohibits us from pursuing PROOF urine testing at this time. We were recently made aware of the option to provide blood spot PEth testing and nail testing in the home environment, with the collection process monitored via videorecording. These samples are testing in a CAP-certified lab. Uprise Health will present this information more formally to the Advisory Committee, with the goal of implementing these testing modalities when appropriate.

Kate Manelis, LMSW, HPSP Program Manager
July 24, 2023

Health Professionals' Services Program
PO Box 8668
Portland, Oregon 97207
Phone: 888.802.2843
Fax: 503.961.7142

Uprise Health Monitoring
Health Professionals' Services Program (HPSP)
Exit Interview Report

Year 13: July 1, 2022 – June 30, 2023

Purpose

Exit Interviews are conducted when a licensee successfully completes the Health Professionals' Services Program (HPSP). The purpose of the Exit Interview is to gather information about the licensee's experience as a participant and to help Uprise Health Monitoring evaluate the importance and effectiveness of each aspect of the monitoring program.

Exit Interviews are emailed to licensees within one week of their date of completion from the program.

Requested feedback includes length of time in the program, their rating of the support systems that aided them in successful completion, their rating of their Agreement Monitor, Customer Service, and the Toxicology Program, and the value of the newsletter and website. The Exit Interview also includes a series of outcome related items focusing on the workplace, personal life, and interpersonal relationships. An overall evaluation of the impact of participation in the program is requested at the conclusion of the survey along with any comments.

Response Rate

The Exit Interview was distributed to all 44 licensees who successfully completed the program between July 1, 2022, and June 30, 2023. Note that responses are recorded based on when they are received rather than when the licensee completed.

Nineteen responses were received during the year, resulting in a 43.2% response rate. This is a significant increase from the last several years.

Table 1: Response Rate	**Year 13**	**Year 12**	**Year 11**	**Year 10**
# Sent	44	48	41	35
# Returned	19	14	13	11
Response Rate	43.2%	29.2%	31.7%	31.4%

Data Results

*Mode responses (the most frequent response in each dataset) are in **red**, excluding N/A responses. Not all items have a mode response. Note that comments are shown as the respondent typed or wrote them: Spelling, punctuation, and grammar have not been corrected.*

Characteristics of Responder Pool

The first two questions give us a picture of the characteristics of the licensees who responded to the exit interview.

Question 1 - Length of Time in Program

Licensees are first asked to indicate how long they were enrolled in the program. We continue to see variability in length of program represented in the responses. The mode for this year was approximately four years, with over 40% of responses.

Table 2: Length of Time in Program	Year 13 (n=19)		Year 12 (n=14)	
	#	%	#	%
Approximately 2 years	4	21.1%	2	14.3%
Approximately 3 years				
Approximately 4 years	**8**	**42.1%**	4	28.6%
Approximately 5 years	3	15.8%	**5**	**35.7%**
More than 5 years (but not career length)	2	10.5%	3	21.4%
Career Length	1	5.3%		

Report continues on the next page

Question 2: Board Licensing Respondent

Of the 44 successful completers this year who received surveys: 17 (38.6%) were licensed by the Board of Nursing, 19 (43.2%) by the Oregon Medical Board, and four each (4.2%) by the Boards of Dentistry and Pharmacy.

Of the 19 submitted survey responses: six of the respondents were licensed by the Board of Nursing (31.6%), 9 by the Oregon Medical Board (47.4%), and two each (10.5%) by the Boards of Pharmacy and Dentistry. This data is reflected in Table 3.

Table 3: Board Licensing Respondent	**Year 13 (n=19)**		**Year 12 (n=14)**	
	#	**%**	**#**	**%**
Oregon Medical Board	**9**	**47.4%**	**10**	**71.4%**
Board of Nursing	6	31.6%	3	21.4%
Board of Dentistry	2	10.5%		
Board of Pharmacy	2	10.5%	1	7.1%

From this, we can calculate a response rate for each board and compare it to the 43.2% overall response rate. Response rates for Medical Board licensees were very close to the overall response rate, with the other three boards being slightly over-represented (Dentistry and Pharmacy) or slightly under-represented (Nursing).

- Medical Board - 47.4% (9 responders out of 19 completers)
- Board of Nursing - 35.3% (6 responders out of 17 completers)
- Board of Dentistry - 50.0% (2 responders out of 4 completers)
- Board of Pharmacy - 50.0% (2 responders out of 4 completers)

Program Ratings

The remainder of the survey questions ask responders to rate various aspects of the program and their impact on their personal and work life.

Report continues on the next page

Question 3 - Support Systems

Question three asks respondents to rate the support systems that aided in their successful completion of the program. Percentages are calculated against responses that answered the questions (did not select N/A – No Response).

Table 4a: Support Systems - Year 13 (n=19); OMB only questions (n=9)	**Extremely Useful**		**Useful**		**Neutral** (Neither Useful Nor Unuseful)		**Unuseful**		**Extremely Unuseful**		**N/A or No Response**	
	#	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
Individual Meeting with Monitoring Consultant (PMC) ***(OMB licensee only)***	3	37.5%	**4**	**50.0%**	1	12.5%					11	57.9%
Group Monitoring Meeting (GMC) ***(OMB licensee only)***	2	33.3%	1	16.7%	**3**	**50.0%**					13	68.4%
Regular contacts with Agreement Monitor	3	15.8%	**8**	**42.1%**	3	15.8%	5	26.3%				
Participating in random toxicology testing	4	22.2%	**10**	**55.6%**	3	16.7%	1	5.6%			1	5.3%
Having a monitoring agreement and addendums	1	5.3%	**10**	**52.6%**	7	36.8%	1	5.3%				
Submitting documentation for requirements	1	5.6%	6	33.3%	**8**	**44.4%**	1	5.6%	2	11.1%	1	5.3%
Attending evaluations by third party assessors			3	37.5%	3	37.5%	2	25.0%			11	57.9%

We are very pleased to report that ratings in nearly all areas improved compared to last year's results (on next page). The most notable improvements were in usefulness of PMC (87.5% compared to 55.5%) and GMC (50% compared to 16.7%) meetings and random toxicology testing (77.8% compared to 61.6%). It is also significant that ratings of "unuseful" and "extremely unuseful" declined in all areas, some quite dramatically. Whereas last year, one-third of responses were dissatisfied with PMC meetings, zero responses this year indicated dissatisfaction with the same. Additionally, random toxicology testing had a 30.8% dissatisfaction rating last year, which decreased sharply to 5.6% for this year.

	Useful/Extremely Useful	**Unuseful/Extremely Unuseful**
PMC	87.5%	0%
GMC	50.0%	50.0%
Agreement Monitor Contact	57.9%	26.3%
Random Testing	77.8%	5.6%
Monitoring Agreement	57.9%	5.3%
Submitting Documentation	38.9%	16.7%
3rd Party Evaluations	37.5%	25.0%

Additional comments about the support systems that aided in your successful completion:

1. *Meetings with psychologist brought the most value. Group meetings were fine, but became a bit redundant.*
2. *The 6 month requirement to go to the doctor to fill out my prescriptions was really stressful and didn't add to my particular recovery program. I think it would be useful to only get a new medication management form if there are changes in medications. Going to the doctor every six months and trying to get them to get the paperwork done didn't help me feel like it was useful in my recovery. Felt like unnecessary work when people already are struggling to get the other program requirements done.*
3. *reaching a monitor or someone to help was always extremely easy - very reassuring*
4. *AA*

Last year's data is shown below for comparison.

Table 4b: Support Systems - Year 12 (n=14); OMB only questions (n=10)	**Extremely Useful**		**Useful**		**Neutral** (Neither Useful Nor Unuseful)		**Unuseful**		**Extremely Unuseful**		**N/A or No Response**	
	#	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
Individual Meeting with Monitoring Consultant (PMC) ***(OMB licensee only)***	2	22.2%	**3**	**33.3%**	1	11.1%	2	22.2%	1	11.1%	5	35.7%
Group Monitoring Meeting (GMC) ***(OMB licensee only)***			1	16.7%	1	16.7%	**3**	**50.0%**	1	16.7%	8	57.1%
Regular contacts with Agreement Monitor	3	23.1%	3	23.1%	2	15.4%	2	15.4%	3	23.1%	1	7.1%
Participating in random toxicology testing	3	23.1%	**5**	**38.5%**	1	7.7%			4	30.8%	1	7.1%
Having a monitoring agreement and addendums	1	7.1%	**5**	**38.5%**	4	28.6%	2	14.3%	2	14.3%		
Submitting documentation for requirements	1	7.7%	3	23.1%	4	30.8%	1	7.7%	4	30.8%	1	7.1%
Attending evaluations by third party assessors	1	14.3%	2	28.6%	2	28.6%	1	14.3%	1	14.3%	7	50.0%

Question 4: Agreement Monitors, Customer Service, Toxicology Program

The next question asks for a rating of agreement monitors, customer service and the toxicology program using a scale of "below average" to "excellent."

Licensee experience with agreement monitors, Uprise Health Monitoring customer service, and the toxicology program continues to be positive. 89.5% of respondents rated their agreement monitor as "excellent" or above average, with no responses of "below average." Uprise Health Monitoring customer service was rated as "excellent" or "above average" by 73.7% of respondents, also with no responses of "below average." The HPSP toxicology program was endorsed as "excellent" or "above average" by 66.6% of respondents, a sharp increase from last year's combined rating of 45.5%.

The survey instrument has been updated for year 14 to include an item in this question regarding RecoveryTrek customer service. Additionally, the item regarding the toxicology program has been removed from this question, as usefulness of the toxicology program is already queried above in question three, and

respondents are given ample opportunity to provide additional feedback about any program component, including the toxicology program, in an open-ended comment section at the end of the survey.

Table 5a: Program Components - Year 13 (n=19)	Excellent		Above Average		Average		Below Average		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%
Your Agreement Monitor	12	63.2%	5	26.3%	2	10.5%				
Uprise Health MONITORING Customer Service	8	42.1%	6	31.6%	5	26.3%				
HPSP Toxicology Program	6	33.3%	6	33.3%	3	16.7%	3	16.7%	1	5.3%

Table 5b: Program Components - Year 12 (n=13)	Excellent		Above Average		Average		Below Average		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%
Your Agreement Monitor	8	66.7%	4	33.3%					1	7.7%
IBH MONITORING Customer Service	5	50.0%	3	30.0%	1	10.0%	1	10.0%	3	23.1%
HPSP Toxicology Program	3	27.3%	2	18.2%	3	27.3%	3	27.3%	2	15.4%

Question 5: Value of the Newsletter and the Website

Licensees are next asked to rate the value of the newsletter and the HPSP website ("portal").

Satisfaction with both tools increased significantly this year. The newsletter, which was modified this year to be shorter, more concise, and easier to access, was deemed "extremely valuable" or "valuable" by 61.2% of respondents, compared to 35.7% last year. The percentage of respondents who found "no value" in the newsletters decreased by nearly half, at 22.2% down from 42.9%. The HPSP website was also found to be much more valuable this year, with 75.1% finding it "valuable" or "extremely valuable" – more than twice as many who found it valuable last year (37.5%).

The survey instrument has been updated for year 14 to include items in this question that ask for perceived value in RecoveryTrek's website and app.

Table 6a: Communication Tools - Year 13 (n=19)	Extremely Valuable		Valuable		Little Value		No Value		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%
HPSP Newsletter	1	5.6%	**10**	**55.6%**	3	16.67%	4	22.2%	1	5.3%
HPSP Website (hpspmonitoring.com)	3	18.8%	**9**	**56.3%**	3	18.8%	1	6.3%	3	15.8%

Table 6b: Communication Tools - Year 12 (n=14)	Extremely Valuable		Valuable		Little Value		No Value		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%
HPSP Newsletter			5	35.7%	3	21.4%	**6**	**42.9%**		
HPSP Website (hpspmonitoring.com)	2	14.3%	3	21.4%	4	28.6%	**5**	**35.7%**		

Question 6: Program's Impact on Professional Life

This question asks licensees to reflect on the impact of the program on their professional life. Specifically, the question states: "Now that you have completed monitoring, please indicate the extent to which you agree or disagree with the following statements about your professional life." Agreement with the first two items in this question increased significantly, with 73.7% of respondents indicating agreement or strong agreement that they are more satisfied with work (compared to 58.4% last year), and 73.6% of respondents indicating agreement or strong agreement that they feel less stressed or burned out at work (compared to 50% last year). The remaining four items in the question were rated very similarly with last year. It is encouraging to note that there were no responses of "strongly disagree" to any items in this question this year.

Table 7a: Professional Life Year 13 (n=19)	Strongly Agree		Agree		Neither Agree Nor Disagree		Disagree		Strongly Disagree		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
I am more satisfied with work.	5	26.3%	**9**	**47.4%**	5	26.3%						
I feel less stressed or burned out at work.	7	36.8%	7	36.8%	5	26.3%						
I am better able to understand or empathize with my patients.	6	31.6%	6	31.6%	6	31.6%	1	5.3%				
The medical care I provide to my patients has improved.	6	31.6%	**7**	**36.8%**	5	26.3%	1	5.3%				
My professional relationships have improved.	6	31.6%	**7**	**36.8%**	5	26.3%	1	5.3%				
My work feels more meaningful.	4	21.1%	**8**	**42.1%**	6	31.6%	1	5.3%				

Table 7b: Professional Life Year 12 (n=14)	Strongly Agree		Agree		Neither Agree Nor Disagree		Disagree		Strongly Disagree		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
I am more satisfied with work.	**5**	**41.7%**	2	16.7%	4	33.3%			1	8.3%	2	14.3%
I feel less stressed or burned out at work.	3	25.0%	3	25.0%	**4**	**33.3%**	1	8.3%	1	8.3%	2	14.3%
I am better able to understand or empathize with my patients.	**6**	**46.2%**	3	23.1%	3	23.1%			1	7.7%	1	7.1%
The medical care I provide to my patients has improved.	**5**	**38.5%**	4	30.8%	2	15.4%			2	15.4%	1	7.1%
My professional relationships have improved.	**5**	**38.5%**	4	30.8%	2	15.4%			2	15.4%	1	7.1%
My work feels more meaningful.	4	30.8%	4	30.8%	3	23.1%			2	15.4%	1	7.1%

Question 7: Program's Impact on Personal and Interpersonal Life

This question asks licensees to reflect on the impact of the program on their personal and interpersonal life. Specifically, the item states: "Now that you have completed monitoring, please indicate the extent to which you agree or disagree with the following statements about your personal and interpersonal life." Continuing the overall trend of this year's survey responses, results were generally more favorable than last year. The mode response for eight out of the 11 items was "strongly agree," an improvement over last year's typical mode response of "agree." There were no responses of "strongly disagree" on any items in this question this year.

Table 8a: Personal and Interpersonal Life - Year 13 (n=19)	Strongly Agree		Agree		Neither Agree Nor Disagree		Disagree		Strongly Disagree		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
I feel better able to cope with life changes.	**10**	**52.6%**	6	31.6%	3	15.8%						
I feel better equipped to manage my own health.	**10**	**52.6%**	6	31.6%	3	15.8%						
My self-esteem improved.	**9**	**47.4%**	6	31.6%	3	15.8%	1	5.3%				
My mood improved.	7	36.8%	**9**	**47.4%**	3	15.8%						
I have a better work-life balance.	8	42.1%	8	42.1%	3	15.8%						
I am more engaged in my community.	**7**	**36.8%**	5	26.3%	4	21.1%	3	15.8%				
My personal life is less stressful.	**10**	**52.6%**	6	31.6%	3	15.8%						
My spouse/partner and I communicate better.	5	31.3%	**6**	**37.5%**	4	25.0%	1	6.3%			3	15.8%
I am more satisfied with my personal relationships.	**8**	**42.1%**	6	31.6%	5	26.3%						

I am better equipped to manage problems at home.	9	47.4%	6	31.6%	4	21.1%						
I spend more meaningful time with family or friends.	9	47.4%	5	26.3%	5	26.3%						

Table 8b: Personal and Interpersonal Life - Year 12 (n=14)	Strongly Agree		Agree		Neither Agree Nor Disagree		Disagree		Strongly Disagree		N/A or No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
I feel better able to cope with life changes.	7	50.0%	4	28.6%					1	7.1%	2	14.3%
I feel better equipped to manage my own health.	5	35.7%	6	42.9%					1	7.1%	2	14.3%
My self-esteem improved.	4	28.6%	5	35.7%	2	14.3%			1	7.1%	2	14.3%
My mood improved.	4	28.6%	5	35.7%	2	14.3%			1	7.1%	2	14.3%
I have a better work-life balance.	4	28.6%	5	35.7%	2	14.3%			1	7.1%	2	14.3%
I am more engaged in my community.	3	21.4%	1	7.1%	6	42.9%	2	14.3%	1	7.1%	1	7.1%
My personal life is less stressful.	2	14.3%	6	42.9%	2	14.3%	2	14.3%	1	7.1%	1	7.1%
My spouse/partner and I communicate better.	3	21.4%	5	35.7%	2	14.3%			1	7.1%	3	21.4%
I am more satisfied with my personal relationships.	3	21.4%	6	42.9%	2	14.3%			1	7.1%	2	14.3%
I am better equipped to manage problems at home.	5	35.7%	5	35.7%	2	14.3%			1	7.1%	1	7.1%
I spend more meaningful time with family or friends.	4	28.6%	5	35.7%	3	21.4%			1	7.1%	1	7.1%

Question 8: Overall Impact of HPSP

The final question asks, “All things considered, how would you describe the impact of your participation in HPSP?” Respondents are given space to expand on their response. Continuing a years’ long trend, the mode response was “I feel I am much better off than prior to my participation in HPSP,” which was an increase of 10 percentage points from last year. One participant this year did indicate that they are “slightly worse” than prior to participating in HPSP.

Table 9: Overall Impact of HPSP	Year 13 (n=19)		Year 12 (n=14)		Year 11 (n=13)	
	#	%	#	%	#	%
I feel I am much better off than prior to my participation in HPSP.	13	68.4%	8	57.1%	7	53.9%
I feel I am slightly better off than prior to my participation in HPSP.	2	10.5%	2	14.3%	4	30.8%
I feel I am neither better nor worse off after participating in HPSP.	3	15.8%	4	28.6%	1	7.7%
I feel I am slightly worse than prior to my participation in HPSP.	1	5.3%				
I feel I am much worse than prior to my participation in HPSP.					1	7.7%

Please expand on your response:

1. *The added stress of having to be in town or close to some approved collection center was very challenging and negatively impacted my quality of life. The financial burden was not insignificant either.*

2. *I think this response is more due to my sobriety than HPSP - although HPSP was part of my sobriety journey, therefore I am grateful :)*

3. *HPSP is not the only component of my continued sobriety and positive movement in my recovery. My continued work in AA and having a sponsor and home group has made a huge impact, Also going through outpatient therapy at the beginning.*

4. *My situation is unique. As I noted from the outset, I am not an addict. My time in the program was required due to very old behaviors, and police encounters, that are no longer a part of my life. That said, I can definitely see how this would be a useful program for someone who is actively suffering through an addictive process, and I did find some parts of the program helpful.*

5. *The last four years have changed my life. HPSP and my sobriety has been the biggest blessing to me. I'm so grateful to keep my nursing license and though HPSP is "over," my monitoring is never done. My daughter is always watching me and that is the most important person that I won't let down. I feel like generally it was on me to do with this program what I wanted, but it gave me some structure and daily reminders of where I was at in my recovery. Also, at times the program length seemed daunting and overwhelming, but I faced so many different life circumstances during that four years and I did it all sober and now I have those experiences to reflect on and they give me so much motivation and pride that I did it all sober. Seriously, thank you for giving me this option to do the four year program, I think the full four years was so necessary. I'm a better nurse and a better person for it.*

6. *HPSP coupled with individual counseling and participation in recovery community have greatly improved my life*

Additional Comments

At the conclusion of the survey, respondents are asked to share any additional comments. The following were shared this year:

1. *So very glad to be done. It felt like 4 years of one size fits all legalized extortion. The most stressful thing in my life for the last 4 years was this program.*

2. *Agreement monitors were super easy to work with, appreciate their kindness and lack of judgement. I wish there was more flexibility with testing - for example a 48 hr window rather than 24 hrs. I am on call for 24 hours (OBGYN) and getting to a testing site while on call was very stress inducing. But clearly I made it work :)*
3. *NA*
4. *[Agreement monitor name] was a great agreement monitor. I felt like [they] knew where I was at in my recovery and matched my energy and let me do my thing while still being very supportive. THANK YOU [name].*

Summary

The response rate for this year was 43.2%, representing 19 respondents out of 44 licensees who completed the program this year. Licensees were enrolled for anywhere from two to more than five years, although most common response was approximately four years. Licensees of all four boards were represented in survey responses this year.

Licensees are asked to rate the usefulness of a variety of support systems that they experienced while participating in HPSP. Program components were rated positively or neutrally this year. There was an overall increase in perceived usefulness of these components, as well as a sharp decrease in “unuseful” ratings.

Agreement Monitors continue to receive overwhelmingly positive ratings, with 89.5% of respondents indicating that their agreement monitor was “excellent” or “above average.” Additionally, 73.7% of respondents rated Uprise Health customer service as “excellent” or “above average.” No respondents rated those services as “below average.” The toxicology program was also rated positively, with 66.6% of respondents rating this as “excellent” or “above average.” This was a significant increase over last year’s results, where only 45.5% of respondents rated toxicology the same.

Both the newsletter and the website experienced a sharp increase in satisfaction this year. The newsletter was re-designed this past year to be shorter, more concise, and easier to access, and we are pleased to see that those changes have led to an increase in value for participants.

Respondents overall felt that the program had a positive impact on their professional, personal and interpersonal lives. Across all 17 specific items queried across two questions, the majority of respondents indicated agreement that their satisfaction in their work and personal lives had improved since participating in HPSP.

The final question asks, “All things considered, how would you describe the impact of your participation in HPSP?” Continuing the trend from the last several years, the mode response was “I feel I am **much** better off than prior to my participation in HPSP.” In total, 78.9% of licensees thought they were better off after participating in HPSP, an increase from last year’s rating of 71.4% endorsing the same.

Fourteen substantive written responses were received throughout the survey. The Uprise Health Monitoring PAC will review the survey data along with each of the comments carefully. The Uprise Health Monitoring PAC will then identify opportunities for improvement and develop interventions if necessary.

From: garydmarks
To: SMORRA Angela * OBD
Cc: PRISBY Stephen * OBD; OBD Info * OBD; Gary Marks
Subject: Re: Questions for the Oregon Board of Dentistry || From Dr. Gary Marks || Screening Dental X-rays
Date: Wednesday, March 6, 2024 9:50:16 AM

Dear Dr. Angela Smorra,

Thank you for your prompt response. I have reviewed the document you provided (and information from the ADA), but unfortunately, it doesn't address the specific inquiries I have for the Board. It's essential to note that the regulation of medical practices and the establishment of practice requirements fall within the jurisdiction of individual states. Furthermore, based on discussions with my Dentist, it's evident that the opinion of the Oregon Board of Dentistry holds paramount importance to him, and likely to other dental professionals as well. He emphasized that national guidelines carry less weight compared to the regulations set forth by the licensing and certification board of Oregon.

Given the specificity of these questions concerning dentistry practices in Oregon, I respectfully request that the Board thoroughly review and respond to the inquiries outlined below.

I'm grateful for the information regarding the timing of the next Board meeting. I understand if these questions cannot be addressed until that meeting takes place.

Thank you for your attention to this matter.

Sincerely,

Gary Marks, DO

On Mar 6, 2024, at 8:59 AM, SMORRA Angela * OBD <Angela.Smorra@obd.oregon.gov> wrote:

Dear Dr. Marks,

Thank you for your inquiry. The Board meets 6 times per year, and the next meeting is on Friday, April 26, 2024.

I have attached the currently posted FDA guidelines titled “ADA / FDA Guide to Patient Selection for Dental Radiographs” for your review and interpretation. As these guidelines are published at the national level by the U.S. Department of Health and Human Services- Public Health Service & Food and Drug Administration, with input by the ADA, you can pose questions related to dental radiographs to those agencies.

I look forward to hearing from you when you receive a response.

Sincerely,
Angela M. Smorra D.M.D.
Dental Director/Chief Investigator
Oregon Board of Dentistry
1500 SW 1st Avenue, Suite #770
Portland, OR 97201
Phone: 971-673-3200
angela.smorra@obd.oregon.gov
https://www.oregon.gov/DENTISTRY/Pages/index.aspx

<image001.png>

From: garydmarks <garydmarks@charter.net>
Sent: Tuesday, March 5, 2024 4:43 PM
To: OBD Info * OBD <Information@obd.oregon.gov>; PRISBY Stephen * OBD <Stephen.Prisby@obd.oregon.gov>; SMORRA Angela * OBD <Angela.Smorra@obd.oregon.gov>
Subject: Questions for the Oregon Board of Dentistry || From Dr. Gary Marks || Screening Dental X-rays

Dear Members of the Oregon Board of Dentistry,

I hope this message finds you well.

My name is Gary D. Marks, and I am a physician based in Southern Oregon. I hold board certifications in Emergency Medicine and Clinical Informatics. I am reaching out to inquire about routine screening dental X-rays and seek clarification from the Board on related matters. I apologize for the length of this email, but I believe this is a crucial issue that warrants thorough discussion.

Background:

I am aware that screening dental X-rays are a standard practice in dentistry and are often conducted during annual exams. Currently, I am in good health with no symptoms or signs of dental disease. During discussions with my dentist, I expressed my preference to avoid X-rays (ionizing radiation) whenever possible. My dentist indicated that Oregon Board of Dentistry regulations necessitate dental X-rays. In response, I shared a link from the Board's website, which states:

> "The Oregon Board of Dentistry (Board) regularly receives questions about the requirement for radiographs/X-rays and how often they are required. The decision to take or not to take radiographs is the responsibility of an Oregon licensed Dentist or an Expanded Practice Permit Dental Hygienist and is based on factors including the patient’s oral health, patient’s age, the risk for disease, and any signs or symptoms of oral disease that a patient may be experiencing. The Board does not have a time requirement for how often radiographs or X-rays are to be taken."

In response, my dentist pointed out that in this document it also states that:

> "To put this in perspective, in order to diagnose dental pathology and do an adequate examination on a new or existing patient, the Dentist must have adequate dental radiographs, periodontal probings if appropriate and a current medical history."

My dentist informed me that he could not continue to provide routine dental cleanings without screening X-rays, citing it as the standard of care.

Efficacy of Screening Dental X-rays:

Dental X-rays serve as diagnostic tools for symptomatic individuals and as screening tools for those without apparent signs or symptoms of disease. Similar to other screening tests in medicine (e.g., colonoscopy, mammography, PSA test, and PAP test), dental X-rays have a Number Needed to Screen (NNS) established in medical literature. The NNS is the number of people requiring screening to prevent one negative outcome. This NNS should be weighed against the Number Needed to Harm (NNH), which includes complications from the screening procedure, false positives, costs, and over-diagnosis. The best trials on screening tests randomize people to screening or no screening and then look at the outcomes over time. I tried to find similar information for screening dental X-rays to better understand the NNS and NNH for screening dental X-rays. In my research, I came across a randomized clinical trial published in BMC Oral Health titled:

> "Negligible therapeutic impact, false positives, overdiagnosis and lead-time are the reasons why radiographs bring more harm than benefits in the caries diagnosis of preschool children."

The conclusion of this trial was that simultaneous visual inspection and radiographic assessment for caries detection in preschool children causes more harm than benefits, advocating for visual inspection alone in regular clinical practice.

Additionally, a paper from the FDA states:

> "A study of 490 patients found that basing selection criteria on clinical evaluations for asymptomatic patients, combined with selected periapical radiographs for symptomatic patients, can result in a 43 percent reduction in the number of radiographs taken without a clinically consequential increase in the rate of undiagnosed disease."

Patient Centered Care:

Irrespective of the efficacy of screening dental X-rays, patient-centered care remains a cornerstone of healthcare quality. Patient-centered care emphasizes respect for patients' preferences, needs, and values, guiding clinical decisions accordingly. The Agency for Healthcare Research and Quality (AHRQ) names Patient-Centered Care as one of the 6 Domains of HealthCare Quality (reference Here). Informed refusal (reference Here), a fundamental ethical principle in medicine, underscores and is based on patient autonomy. This principle holds significant importance for both treatment and screening tests.

Informed refusal is common in medical practice. When patients decline screening tests such as colonoscopy, PSA test, or mammography, the standard of care involves discussing potential risks and potential benefits with patients, then allowing them to make informed decisions. Patients who decline screening tests are not typically dismissed from practices; instead, their decisions are documented in their medical records. Such practices align with ethical patient care principles and avoid undue coercion.

It makes perfect sense that a dentist or other physician may decline to perform a procedure that requires some diagnostic test that the patient is refusing (e.g., CT scan to determine best surgical route). But when it comes to screening tests, by definition there is no intervention planned and no symptoms to treat.

For example: It would be contrary to standard medical practice for a gynecologist to refuse to do an annual exam (e.g., clinical breast exam and general physical) for a patient who decided they did not want to get a mammogram.

As another example: Although vaccinations are different than screening tests, they are similar in that they are meant to treat healthy populations to prevent future illness. When parents refuse vaccinations for their children, the recommendation for pediatricians is not to fire patients from their practice, but to provide all the appropriate and needed care that is allowed and to continue to educate patients and families on the benefits of vaccines.

The ADA states: "The ADA encourages dentists and patients to discuss dental treatment recommendations, including the need for X-rays, **to make informed decisions together**"

In Summary

- **Patient Autonomy and Collaborative Decision-Making:** These are the foundational elements of ethical and high-quality healthcare across various medical disciplines.
- **Screening Tests in Healthy Populations:** Screening tests aim to detect early stages of disease in asymptomatic individuals. Patients often exercise their right to informed refusal of such tests. Discontinuing care for a patient due to their informed refusal of a screening test contradicts the principle of patient autonomy (as it precludes true joint decision making and may be interpreted as undue coercion). The recommended approach is to persist in providing all other necessary care while continuing educational and counseling efforts.
- **Value of Routine Examinations and Dental Cleanings:** These procedures are likely beneficial irrespective of whether screening dental X-rays are performed. They provide opportunities for ongoing patient education and enable the detection of clinically evident conditions that might require treatment or further diagnostic evaluation, such as diagnostic X-rays rather than screening ones.
- **Continuation of Dental Care Post-Refusal of X-rays:** Declining screening X-rays should not preclude patients from receiving routine dental cleanings and clinical examinations, as these are important preventive healthcare measures.

My Inquiry to the Board:

I am committed to maintaining routine dental cleanings and oral cavity examinations. I am willing to provide documentation or verbally confirm my understanding of the risks associated with forgoing screening X-rays. I respectfully pose the following questions to the Board in relation to *screening dental X-rays* and *routine dental cleaning/exams in Oregon*:

- Does the Board endorse the principles of joint medical decision-making and patient-centered care regarding screening dental X-rays, as advocated by the ADA?
- Does the Board recognize the independent value of dental cleaning and clinical exams for patients, irrespective of whether screening X-rays are performed?
- Is it considered within the standard of care for a dentist (based on their clinical judgment) to continue providing routine cleaning and clinical evaluation to a patient who declines screening X-rays, following appropriate documentation and informed refusal? Restated, does allowing informed refusal of screening tests, such as dental X-rays, inherently breach the standard of care in dentistry?

Thank you for your attention to this matter. I eagerly await your response.

Sincerely,

Gary Marks, DO

<The Selection of Patients for Dental Radiographic Examinations _ FDA.pdf>

ADA American Dental Association®
America's leading advocate for oral health

FDA

DENTAL RADIOGRAPHIC EXAMINATIONS: RECOMMENDATIONS FOR PATIENT SELECTION AND LIMITING RADIATION EXPOSURE

REVISED: 2012

AMERICAN DENTAL ASSOCIATION
Council on Scientific Affairs

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Food and Drug Administration

TABLE OF CONTENTS

DENTAL RADIOGRAPHIC EXAMINATIONS: RECOMMENDATIONS FOR PATIENT SELECTION AND LIMITING RADIATION EXPOSURE

BACKGROUND

The dental profession is committed to delivering the highest quality of care to each of its individual patients and applying advancements in technology and science to continually improve the oral health status of the U.S. population. These guidelines were developed to serve as an adjunct to the dentist's professional judgment of how to best use diagnostic imaging for each patient. Radiographs can help the dental practitioner evaluate and definitively diagnose many oral diseases and conditions. However, the dentist must weigh the benefits of taking dental radiographs against the risk of exposing a patient to x-rays, the effects of which accumulate from multiple sources over time. The dentist, knowing the patient's health history and vulnerability to oral disease, is in the best position to make this judgment in the interest of each patient. For this reason, the guidelines are intended to serve as a resource for the practitioner and are not intended as standards of care, requirements or regulations.

The guidelines are not substitutes for clinical examinations and health histories. The dentist is advised to conduct a clinical examination, consider the patient's signs, symptoms and oral and medical histories, as well as consider the patient's vulnerability to environmental factors that may affect oral health. This diagnostic and evaluative information may determine the type of imaging to be used or the frequency of its use. Dentists should only order radiographs when they expect that the additional diagnostic information will affect patient care.

Based on this premise, the guidelines can be used by the dentist to optimize patient care, minimize radiation exposure and responsibly allocate health care resources.

This document deals only with standard dental imaging techniques of intraoral and common extraoral examinations, excluding cone-beam computed tomography (CBCT). At this time the indications for CBCT examinations are not well developed. The ADA Council on Scientific Affairs has developed a statement on use of CBCT.[1]

INTRODUCTION

The guidelines titled, "The Selection of Patients for X-Ray Examination" were first developed in 1987 by a panel of dental experts convened by the Center for Devices and Radiological Health of the U.S. Food and Drug Administration (FDA). The development of the guidelines at that time was spurred by concern about the U.S. population's total exposure to radiation from all sources. Thus, the guidelines were developed to promote the appropriate use of x-rays. In 2002, the American Dental Association, recognizing that dental technology and science continually advance, recommended to the FDA that

the guidelines be reviewed for possible updating. The FDA welcomed organized dentistry's interest in maintaining the guidelines, and so the American Dental Association, in collaboration with a number of dental specialty organizations and the FDA, published updated guidelines in 2004. This report updates the 2004 guidelines and includes recommendations for limiting exposure to radiation.

PATIENT SELECTION CRITERIA

Radiographs and other imaging modalities are used to diagnose and monitor oral diseases, as well as to monitor dentofacial development and the progress or prognosis of therapy. Radiographic examinations can be performed using digital imaging or conventional film. The available evidence suggests that either is a suitable diagnostic method.[2-4] Digital imaging may offer reduced radiation exposure and the advantage of image analysis that may enhance sensitivity and reduce error introduced by subjective analysis.[5]

A study of 490 patients found that basing selection criteria on clinical evaluations for asymptomatic patients, combined with selected periapical radiographs for symptomatic patients, can result in a 43 percent reduction in the number of radiographs taken without a clinically consequential increase in the rate of undiagnosed disease.[6,7] The development and progress of many oral conditions are associated with a patient's age, stage of dental development, and vulnerability to known risk factors. Therefore, the guidelines in Table 1 are presented within a matrix of common clinical and patient factors, which may determine the type(s) of radiographs that is commonly needed. The guidelines assume that diagnostically adequate radiographs can be obtained. If not, appropriate management techniques should be used after consideration of the relative risks and benefits for the patient.

Along the horizontal axis of the matrix, patient age categories are described, each with its usual dental developmental stage: child with primary dentition (prior to eruption of the first permanent tooth); child with transitional dentition (after eruption of the first permanent tooth); adolescent with permanent dentition (prior to eruption of third molars); adult who is dentate or partially edentulous; and adult who is edentulous.

Along the vertical axis, the type of encounter with the dental system is categorized (as "New Patient" or "Recall Patient") along with the clinical circumstances and oral diseases that may be present during such an encounter. The "New Patient" category refers to patients who are new to the dentist, and thus are being evaluated by the dentist for oral disease and for the status of dental development. Typically, such a patient receives a comprehensive evaluation or, in some cases, a limited evaluation for a specific problem. The "Recall Patient" categories describe patients who have had a recent comprehensive evaluation by the dentist and, typically, have returned as a patient of record for a periodic evaluation or for treatment. However, a "Recall Patient" may also return for a limited evaluation of a specific problem, a detailed and extensive evaluation for a specific problem(s), or a comprehensive evaluation.

Both categories are marked with a single asterisk that corresponds to a footnote that appears below the matrix; the footnote lists “Positive Historical Findings” and “Positive Clinical Signs/Symptoms” for which radiographs may be indicated. The lists are not intended to be all-inclusive, rather they offer the clinician further guidance on clarifying his or her specific judgment on a case.

The clinical circumstances and oral diseases that are presented with the types of encounters include: clinical caries or increased risk for caries; no clinical caries or no increased risk for caries; periodontal disease or a history of periodontal treatment; growth and development assessment; and other circumstances. A few examples of “Other Circumstances” proposed are: existing implants, other dental and craniofacial pathoses, endodontic/restorative needs and remineralization of dental caries. These examples are not intended to be an exhaustive list of circumstances for which radiographs or other imaging may be appropriate.

The categories, “Clinical Caries or Increased Risk for Caries” and “No Clinical Caries and No Increased Risk for Caries” are marked with a double asterisk that corresponds to a footnote that appears below the matrix; the footnote contains links to the ADA Caries Risk Assessment Forms (0 – 6 years of age and over 6 years of age). It should be noted that a patient’s risk status can change over time and should be periodically reassessed.[8]

The panel also has made the following recommendations that are applicable to all categories:

1. Intraoral radiography is useful for the evaluation of dentoalveolar trauma. If the area of interest extends beyond the dentoalveolar complex, extraoral imaging may be indicated.
2. Care should be taken to examine all radiographs for any evidence of caries, bone loss from periodontal disease, developmental anomalies and occult disease.
3. Radiographic screening for the purpose of detecting disease before clinical examination should not be performed. A thorough clinical examination, consideration of the patient history, review of any prior radiographs, caries risk assessment and consideration of both the dental and the general health needs of the patient should precede radiographic examination.[9-15]

In the practice of dentistry, patients often seek care on a routine basis in part because oral disease may develop in the absence of clinical symptoms. Since attempts to identify specific criteria that will accurately predict a high probability of finding interproximal carious lesions have not been successful for individuals, it was necessary to recommend time-based schedules for making radiographs intended primarily for the detection of dental caries. Each schedule provides a range of recommended intervals that are derived from the results of research into the rates at which interproximal caries progresses through tooth enamel. The recommendations also are modified by criteria that place an individual at an increased risk for dental caries. Professional judgment

should be used to determine the optimum time for radiographic examination within the suggested interval.

RECOMMENDATIONS FOR PRESCRIBING DENTAL RADIOGRAPHS

These recommendations are subject to clinical judgment and may not apply to every patient. They are to be used by dentists only after reviewing the patient's health history and completing a clinical examination. Even though radiation exposure from dental radiographs is low, once a decision to obtain radiographs is made it is the dentist's responsibility to follow the ALARA Principle (As Low as Reasonably Achievable) to minimize the patient's exposure.

Table 1.

<table>
<tr><th rowspan="2">TYPE OF ENCOUNTER</th><th colspan="5">PATIENT AGE AND DENTAL DEVELOPMENTAL STAGE</th></tr>
<tr><th>Child with Primary Dentition (prior to eruption of first permanent tooth)</th><th>Child with Transitional Dentition (after eruption of first permanent tooth)</th><th>Adolescent with Permanent Dentition (prior to eruption of third molars)</th><th>Adult, Dentate or Partially Edentulous</th><th>Adult, Edentulous</th></tr>
<tr><td>New Patient*
being evaluated for oral diseases</td><td>Individualized radiographic exam consisting of selected periapical/occlusal views and/or posterior bitewings if proximal surfaces cannot be visualized or probed. Patients without evidence of disease and with open proximal contacts may not require a radiographic exam at this time.</td><td>Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images.</td><td colspan="2">Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images. A full mouth intraoral radiographic exam is preferred when the patient has clinical evidence of generalized oral disease or a history of extensive dental treatment.</td><td>Individualized radiographic exam, based on clinical signs and symptoms.</td></tr>
<tr><td>Recall Patient* with clinical caries or at increased risk for caries**</td><td colspan="3">Posterior bitewing exam at 6-12 month intervals if proximal surfaces cannot be examined visually or with a probe</td><td>Posterior bitewing exam at 6-18 month intervals</td><td>Not applicable</td></tr>
<tr><td>Recall Patient* with no clinical caries and not at increased risk for caries**</td><td colspan="2">Posterior bitewing exam at 12-24 month intervals if proximal surfaces cannot be examined visually or with a probe</td><td>Posterior bitewing exam at 18-36 month intervals</td><td>Posterior bitewing exam at 24-36 month intervals</td><td>Not applicable</td></tr>
</table>

TYPE OF ENCOUNTER (continued)	**Child with Primary Dentition** (prior to eruption of first permanent tooth)	**Child with Transitional Dentition** (after eruption of first permanent tooth)	**Adolescent with Permanent Dentition** (prior to eruption of third molars)	**Adult, Dentate and Partially Edentulous**	**Adult, Edentulous**
Recall Patient* with periodontal disease	Clinical judgment as to the need for and type of radiographic images for the evaluation of periodontal disease. Imaging may consist of, but is not limited to, selected bitewing and/or periapical images of areas where periodontal disease (other than nonspecific gingivitis) can be demonstrated clinically.				Not applicable
Patient (New and Recall) for monitoring of dentofacial growth and development, and/or assessment of dental/skeletal relationships	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development or assessment of dental and skeletal relationships		Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development, or assessment of dental and skeletal relationships. Panoramic or periapical exam to assess developing third molars	Usually not indicated for monitoring of growth and development. Clinical judgment as to the need for and type of radiographic image for evaluation of dental and skeletal relationships.	
Patient with other circumstances including, but not limited to, proposed or existing implants, other dental and craniofacial pathoses, restorative/endodontic needs, treated periodontal disease and caries remineralization	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of these conditions				

***Clinical situations for which radiographs may be indicated include, but are not limited to:**

A. Positive Historical Findings

1. Previous periodontal or endodontic treatment
2. History of pain or trauma
3. Familial history of dental anomalies

4. Postoperative evaluation of healing
5. Remineralization monitoring
6. Presence of implants, previous implant-related pathosis or evaluation for implant placement

B. Positive Clinical Signs/Symptoms

1. Clinical evidence of periodontal disease
2. Large or deep restorations
3. Deep carious lesions
4. Malposed or clinically impacted teeth
5. Swelling
6. Evidence of dental/facial trauma
7. Mobility of teeth
8. Sinus tract ("fistula")
9. Clinically suspected sinus pathosis
10. Growth abnormalities
11. Oral involvement in known or suspected systemic disease
12. Positive neurologic findings in the head and neck
13. Evidence of foreign objects
14. Pain and/or dysfunction of the temporomandibular joint
15. Facial asymmetry
16. Abutment teeth for fixed or removable partial prosthesis
17. Unexplained bleeding
18. Unexplained sensitivity of teeth
19. Unusual eruption, spacing or migration of teeth
20. Unusual tooth morphology, calcification or color
21. Unexplained absence of teeth
22. Clinical tooth erosion
23. Peri-implantitis

****Factors increasing risk for caries may be assessed using the ADA Caries Risk Assessment forms (0 – 6 years of age and over 6 years of age).**

EXPLANATION OF RECOMMENDATIONS FOR PRESCRIBING DENTAL RADIOGRAPHS

The explanation below presents the rationale for each recommendation by type of encounter and patient age and dental developmental stages.

New Patient Being Evaluated for Oral Diseases

Child (Primary Dentition)

Proximal carious lesions may develop after the interproximal spaces between posterior primary teeth close. Open contacts in the primary dentition will allow a dentist to visually inspect the proximal posterior surfaces. Closure of proximal contacts requires radiographic assessment.[16-18] However, evidence suggests that many of these lesions will remain in the enamel for at least 12 months or longer depending on fluoride exposure, allowing sufficient time for implementation and evaluation of preventive interventions.[19-21] A periapical/anterior occlusal examination may be indicated because of the need to evaluate dental development, dentoalveolar trauma, or suspected pathoses. Periapical and bitewing radiographs may be required to evaluate pulp pathosis in primary molars.

Therefore, an individualized radiographic examination consisting of selected periapical/occlusal views and/or posterior bitewings if proximal surfaces cannot be examined visually or with a probe is recommended. Patients without evidence of disease and with open proximal contacts may not require radiographic examination at this time.

Child (Transitional Dentition)

Overall dental caries in the primary teeth of children from 2-11 years of age declined from the early 1970s until the mid 1990s.[22-24] From the mid 1990s until the 1999-2004 National Health and Nutrition Examination Survey, there was a small but significant increase in primary decay. This trend reversal was larger for younger children. Tooth decay affects more than one-fourth of U.S. children aged 2–5 years and half of those aged 12-15 years; however, its prevalence is not uniformly distributed. About half of all children and two-thirds of adolescents aged 12–19 years from lower-income families have had decay.[25]

Children and adolescents of some racial and ethnic groups and those from lower-income families have more untreated tooth decay. For example, 40 percent of Mexican American children aged 6–8 years have untreated decay, compared with 25 percent of non-Hispanic whites.[25] It is, therefore, important to consider a child's risk factors for caries before taking radiographs.

Although periodontal disease is uncommon in this age group,[26] when clinical evidence exists (except for nonspecific gingivitis), selected periapical and bitewing radiographs are indicated to determine the extent of aggressive periodontitis, other forms of uncontrolled periodontal disease and the extent of osseous destruction related to metabolic diseases.[27,28]

A periapical or panoramic examination is useful for evaluating dental development. A panoramic radiograph also is useful for the evaluation of craniofacial trauma.[15,29,30] Intraoral radiographs are more accurate than panoramic radiographs for the evaluation of dentoalveolar

trauma, root shape, root resorption[31,32] and pulp pathosis. However, panoramic examinations may have the advantage of reduced radiation dose, cost and imaging of a larger area.

Occlusal radiographs may be used separately or in combination with panoramic radiographs in the following situations: 1. unsatisfactory image in panoramic radiographs due to abnormal incisor relationship, 2. localizations of tooth position, and 3. when clinical grounds provide a reasonable expectation that pathosis exists.[32-34]

Therefore, an individualized radiographic examination consisting of posterior bitewings with panoramic examination or posterior bitewings and selected periapical images is recommended.

Adolescent (Permanent Dentition)

Caries in permanent teeth declined among adolescents, while the prevalence of dental sealants increased significantly.[35] However, increasing independence and socialization, changing dietary patterns, and decreasing attention to daily oral hygiene can characterize this age group. Each of these factors may result in an increased risk of dental caries. Another consideration, although uncommon, is the increased incidence of periodontal disease found in this age group compared to children.[36]

Panoramic radiography is effective in dental diagnosis and treatment planning.[30,37,38] Specifically, the status of dental development can be assessed using panoramic radiography.[39] Occlusal and/or periapical radiographs can be used to detect the position of an unerupted or supernumerary tooth.[40-42] Third molars also should be evaluated in this age group for their presence, position, and stage of development.

Therefore, an individualized radiographic examination consisting of posterior bitewings with panoramic examination or posterior bitewings and selected periapical images is recommended. A full mouth intraoral radiographic examination is preferred when the patient has clinical evidence of generalized oral disease or a history of extensive dental treatment.

Adult (Dentate or Partially Edentulous)

The overall dental caries experience of the adult population has declined from the early 1970s until the most recent (1999-2004) National Health and Nutrition Examination Survey.[43] However, risk for dental caries exists on a continuum and changes over time as risk factors change.[44] Therefore, it is important to evaluate proximal surfaces in the new adult patient for carious lesions. In addition, it is important to examine patients for recurrent dental caries.

The incidence of root surface caries increases with age.[45] Although bitewing radiographs can assist in detecting root surface caries in proximal areas, the usual method of detecting root surface caries is by clinical examination.[46]

The incidence of periodontal disease increases with age.[47] Although new adult patients may not have symptoms of active periodontal disease, it is important to evaluate previous experience with periodontal disease and/or treatment. Therefore, a high percentage of adults may require selected intraoral radiographs to determine the current status of the disease.

Taking posterior bitewing radiographs of new adult patients was found to reduce the number of radiological findings and the diagnostic yield of panoramic radiography.[48,49] In addition, the following clinical indicators for panoramic radiography were identified as the best predictors for useful diagnostic yield: suspicion of teeth with periapical pathologic conditions, presence of partially erupted teeth, caries lesions, swelling, and suspected unerupted teeth.[50]

Therefore, an individualized radiographic examination, consisting of posterior bitewings with selected periapical images or panoramic examination when indicated is recommended. A full mouth intraoral radiographic examination is preferred when the patient has clinical evidence of generalized oral disease or a history of extensive dental treatment.

Adult (Edentulous)

The clinical and radiographic examinations of edentulous patients generally occur during an assessment of the need for prostheses. The most common pathological conditions detected are impacted teeth and retained roots with and without associated disease.[51] Other less common conditions also may be detected: bony spicules along the alveolar ridge, residual cysts or infections, developmental abnormalities of the jaws, intraosseous tumors, and systemic conditions affecting bone metabolism.

The original recommendations for this group called for a full-mouth intraoral radiographic examination or a panoramic examination for the new, edentulous adult patient. Firstly, this recommendation was made because examinations of edentulous patients generally occur during an assessment of the need for prostheses. Secondly, the original recommendation considered edentulous patients to be at increased risk for oral disease.

Studies have found that from 30 to 50 percent of edentulous patients exhibited abnormalities in panoramic radiographs.[51-55] In addition, the radiographic examination revealed anatomic considerations that could influence prosthetic treatment, such as the location of the mandibular canal, the position of the mental foramen and maxillary sinus, and relative thickness of the soft tissue covering the edentulous ridge.[51,53,55] However, in studies that considered treatment outcomes, there was little evidence to support screening radiography for new edentulous patients. For example, one study reported that less than 4 percent of such findings resulted in treatment modification before denture fabrication, and another showed no difference in post-denture delivery complaints in patients who did not receive screening pretreatment radiographs.[54,56]

This panel concluded that prescription of radiographs is appropriate as part of the initial assessment of edentulous areas for possible prosthetic treatment. A full mouth series of periapical radiographs or a combination of panoramic, occlusal or other extraoral radiographs may be used to achieve diagnostic and therapeutic goals. Particularly with the option of dental implant therapy for edentulous patients,[57] radiographs can be an important aid in diagnosis, prognosis, and the determination of treatment complexity.

Therefore, an individualized radiographic examination, based on clinical signs, symptoms, and treatment plan is recommended.

Recall Patient with Clinical Caries or Increased Risk for Caries

Child (Primary and Transitional Dentition) and Adolescent (Permanent Dentition)
Clinically detectable dental caries may suggest the presence of proximal carious lesions that can only be detected with a radiographic examination. In addition, patients who are at increased risk for developing dental caries because of such factors as poor oral hygiene, high frequency of exposure to sucrose-containing foods, and deficient fluoride intake (see caries risk assessment forms, 0 – 6 years of age and over 6 years of age) are more likely to have proximal carious lesions.

The bitewing examination is the most efficient method for detecting proximal lesions.[16,18,58] The frequency of radiographic recall should be determined on the basis of caries risk assessment.[15,59,60] It should be noted that a patient's caries risk status may change over time and that an individual's radiographic recall interval may need to be changed accordingly.[61]

Therefore, a posterior bitewing examination is recommended at 6 to 12 month intervals if proximal surfaces cannot be examined visually or with a probe.

Adult (Dentate and Partially Edentulous)
Adults who exhibit clinical dental caries or who have other increased risk factors should be monitored carefully for any new or recurrent lesions that are detectable only by radiographic examination. The frequency of radiographic recall should be determined on the basis of caries risk assessment.[15,59,60] It should be noted that a patient's risk status can change over time and that an individual's radiographic recall interval may need to be changed accordingly.[61]

Therefore, a posterior bitewing examination is recommended at 6 to 18 month intervals.

Recall Patient (Edentulous Adult)

A study that assessed radiographs of edentulous recall patients showed that previously detected incidental findings did not progress and that no intervention was indicated.[62] The data suggest that patients who receive continuous dental care do not exhibit new findings that require treatment.

An examination for occult disease in this group cannot be justified on the basis of prevalence, morbidity, mortality, radiation dose, and cost.[53-55]

Therefore, no radiographic examination is recommended without evidence of disease.

Recall Patient with No Clinical Caries and No Increased Risk for Caries

Child (Primary and Transitional Dentition)
Despite the general decline in dental caries activity, recent data show that subgroups of children have a higher caries experience than the overall population.[63,64] The identification of

patients in these subgroups may be difficult on an individual basis. For children who present for recall examination without evidence of clinical caries and who are not considered at increased risk for the development of caries, it remains important to evaluate proximal surfaces by radiographic examination. In primary teeth the caries process can take approximately one year to progress through the outer half of the enamel and about another year through the inner half.[20,65-68] Considering this rate of progression of carious lesions through primary teeth, a time-based interval of radiographic examinations from one to two years for this group appears appropriate. The prevalence of carious lesions has been shown to increase during the stage of transitional dentition.[25,69] Children under routine professional care would be expected to be at a lower risk for caries. Nevertheless, newly erupted teeth are at risk for the development of dental caries.

Therefore, a radiographic examination consisting of posterior bitewings is recommended at intervals of 12 to 24 months if proximal surfaces cannot be examined visually or with a probe.

Adolescent (Permanent Dentition)
Adolescents with permanent dentition, who are free of clinical dental caries and factors that would place them at increased risk for developing dental caries, should be monitored carefully for development of proximal carious lesions, which may only be detected by radiographic examination. The caries process, on average, takes more than three years to progress through the enamel.[20,65-68] However, evidence suggests that the enamel of permanent teeth undergoes posteruptive maturation and that young permanent teeth are susceptible to faster progression of carious lesions.[70-73]

Therefore, a radiographic examination consisting of posterior bitewings is recommended at intervals of 18 to 36 months.

Adult (Dentate and Partially Edentulous)
Adult dentate patients, who receive regularly scheduled professional care and are free of signs and symptoms of oral disease, are at a low risk for dental caries. Nevertheless, consideration should be given to the fact that caries risk can vary over time as risk factors change. Advancing age and changes in diet, medical history and periodontal status may increase the risk for dental caries.

Therefore, a radiographic examination consisting of posterior bitewings is recommended at intervals of 24 to 36 months.

<u>Recall Patient with Periodontal Disease</u>

Child (Primary and Transitional Dentition), Adolescent (Permanent Dentition), and Adult (Dentate and Partially Edentulous)
The decision to obtain radiographs for patients who have clinical evidence or a history of periodontal disease/treatment should be determined on the basis of the anticipation that important diagnostic and prognostic information will result. Structures or conditions to be assessed should include the level of supporting alveolar bone, condition of the interproximal bony crest, length and shape of roots, bone loss in furcations, and calculus deposits. The

frequency and type of radiographic examinations for these patients should be determined on the basis of a clinical examination of the periodontium and documented signs and symptoms of periodontal disease. The procedure for prescribing radiographs for the follow-up/recall periodontal patient would be to use selected intraoral radiographs to verify clinical findings on a patient-by-patient basis.[28,74]

Therefore, it is recommended that clinical judgment be used in determining the need for, and type of radiographic images necessary for, evaluation of periodontal disease. Imaging may consist of, but is not limited to, selected bitewing and/or periapical images of areas where periodontal disease (other than nonspecific gingivitis) can be identified clinically.

Patient (New and Recall) for Monitoring of Dentofacial Growth and Development, and/or Assessment of Dental/Skeletal Relationships

Child (Primary and Transitional Dentition)
For children with primary dentition, before the eruption of the first permanent tooth, radiographic examination to assess growth and development in the absence of clinical signs or symptoms is unlikely to yield productive information. Any abnormality of growth and development suggested by clinical findings should be evaluated radiographically on an individual basis. After eruption of the first permanent tooth, the child may have a radiographic examination to assess growth and development. This examination need not be repeated unless dictated by clinical signs or symptoms. Cephalometric radiographs may be useful for assessing growth, and/or dental and skeletal relationships.

Therefore, it is recommended that clinical judgment be used in determining the need for, and type of radiographic images necessary for, evaluation and/or monitoring of dentofacial growth and development, or assessment of dental and skeletal relationships.

Adolescent (Permanent Dentition)
During adolescence there is often a need to assess the growth status and/or the dental and skeletal relationships of patients in order to diagnose and treat their malocclusion. Appropriate radiographic assessment of the malocclusion should be determined on an individual basis.

An additional concern relating to growth and development for patients in this age group is to determine the presence, position and development of third molars. This determination can best be made by the use of selected periapical images or a panoramic examination, once the patient is in late adolescence (16 to 19 years of age).

Therefore, it is recommended that clinical judgment be used in determining the need for, and type of radiographic images necessary for, evaluation and/or monitoring of dentofacial growth and development, or assessment of dental and skeletal relationships. Panoramic or periapical examination may be used to assess developing third molars.

Adult (Dentate, Partially Edentulous and Edentulous)
In the absence of any clinical signs or symptoms suggesting abnormalities of growth and development in adults, no radiographic examinations are indicated for this purpose.

Therefore, in the absence of clinical signs and symptoms, no radiographic examination is recommended.

Patients with Other Circumstances
(including, but not limited to, proposed or existing implants, other dental and craniofacial pathoses, restorative/endodontic needs, treated periodontal disease and caries remineralization)

All Patient Categories
The use of imaging, as a diagnostic and evaluative tool, has progressed beyond the longstanding need to diagnose caries and evaluate the status of periodontal disease. The expanded technology in imaging is now used to diagnose other orofacial clinical conditions and evaluate treatment options. A few examples of other clinical circumstances are the use of imaging for dental implant treatment planning, placement, or evaluation; the monitoring of dental caries and remineralization; the assessment of restorative and endodontic needs; and the diagnosis of soft and hard tissue pathoses.

Therefore it is recommended that clinical judgment be used in determining the need for, and type of radiographic images necessary for, evaluation and/or monitoring in these circumstances.

LIMITING RADIATION EXPOSURE

Dental radiographs account for approximately 2.5 percent of the effective dose received from medical radiographs and fluoroscopies.[75] Even though radiation exposure from dental radiographs is low, once a decision to obtain radiographs is made it is the dentist's responsibility to follow the ALARA Principle (As Low as Reasonably Achievable) to minimize the patient's exposure. Examples of good radiologic practice include

- use of the fastest image receptor compatible with the diagnostic task (F-speed film or digital);
- collimation of the beam to the size of the receptor whenever feasible;
- proper film exposure and processing techniques;
- use of protective aprons and thyroid collars, when appropriate; and
- limiting the number of images obtained to the minimum necessary to obtain essential diagnostic information.

RECEPTOR SELECTION

The American National Standards Institute and the International Organization for Standardization have established standards for film speed.[76,77] Film speeds available for dental radiography are D-speed, E-speed and F-speed, with D-speed being the slowest and F-speed the fastest. According to the U.S. Food and Drug Administration, switching from D to E speed can produce a 30 to 40 percent reduction in radiation exposure.[78] The use of F-speed film can reduce exposure 20 to 50 percent compared to use of E-speed film, without compromising diagnostic quality.[79-85]

Exposure of extraoral films such as panoramic radiographs requires intensifying screens to minimize radiation exposure to patients. The intensifying screen consists of layers of phosphor crystals that fluoresce when exposed to radiation. In addition to the radiation incident on the film, the film is exposed primarily to the light emitted from the intensifying screen. Previous generations of intensifying screens were composed of phosphors such as calcium tungstate. However, rare-earth intensifying screens are recommended because they reduce a patient's radiation exposure by 50 percent compared with calcium tungstate-intensifying screens.[86-89] Rare-earth film systems, combined with a high-speed film of 400 or greater, can be used for panoramic radiographs.[86] Older panoramic equipment can be retrofitted to reduce the radiation exposure to accommodate the use of rare-earth, high-speed systems.

Digital imaging provides an opportunity to further reduce the radiation dose by 40 to 60 percent.[90-93] In digital radiography, there are three types of receptors that take the place of conventional film: charge-coupled device (CCD), complementary-metal-oxide-semiconductor (CMOS), and photo-stimulable phosphor (PSP) plates. Systems that use CCD and CMOS-based, solid-state detectors are called "direct." When these sensors receive energy from the x-ray beam, the CCD or CMOS chip sends a signal to the computer and an image appears on the monitor within seconds. Systems that use PSP plates are called "indirect." When these plates are irradiated, a latent image is stored on them. The plate is then scanned and the scanner transmits the image to the computer.

RECEPTOR HOLDERS

Holders that align the receptor precisely with the collimated beam are recommended for periapical and bitewing radiographs. Heat-sterilizable or disposable intraoral radiograph receptor-holding devices are recommended for optimal infection control.[94] Dental professionals should not hold the receptor holder during exposure.[86] Under extraordinary circumstances in which members of the patient's family (or other caregiver) must provide restraint or hold a receptor holder in place during exposure, such a person should wear appropriate shielding.[86]

COLLIMATION

Collimation limits the amount of radiation, both primary and scattered, to which the patient is exposed. An added benefit of rectangular collimation is an improvement in contrast as a result of a reduction in fogging caused by secondary and scattered radiation.[89] The x-ray beam should not exceed the minimum coverage necessary, and each dimension of the beam should be collimated so that the beam does not exceed the receptor by more than 2 percent of the source-to-image receptor distance.[86] Since a rectangular collimator decreases the radiation dose by up to fivefold as compared with a circular one, [86,95,96] radiographic equipment should provide rectangular collimation for exposure of periapical and bitewing radiographs.[86] Use of a receptor-holding device minimizes the risk of cone-cutting (non-exposure of part of the image receptor due to malalignment of the x-ray beam). The position-indicating device should be open ended and have a metallic lining to restrict the primary beam and reduce the tissue volume exposed to radiation.[86] Use of long source-to-skin distances of 40 cm, rather than short distances of 20 cm, decreases exposure by 10 to 25 percent.[86,97] Distances between 20 cm and 40 cm are appropriate, but the longer distances are optimal.[86]

OPERATING POTENTIAL AND EXPOSURE TIME

The operating potential of dental x-ray units affects the radiation dose and backscatter radiation. Lower voltages produce higher-contrast images and higher entrance skin doses, and lower deep-tissue doses and levels of backscatter radiation. However, higher voltages produce lower contrast images that enable better separation of objects with differing densities. Thus, the diagnostic purposes of the radiograph should be used to determine the selection of kilovolt setting. A setting above 90 kV(p) will increase the patient dose and should not be used.[89] The optimal operating potential of dental x-ray units is between 60 and 70 kVp.[86,89]

Filmless technology is much more forgiving to overexposure often resulting in unnecessary radiation exposure. Facilities should strive to set the x-ray unit exposure timer to the lowest setting providing an image of diagnostic quality. If available, the operator should always confirm that the dose delivered falls within the manufacturer's exposure index. Imaging plates should be evaluated at least monthly and cleaned as necessary.

PATIENT SHIELDING AND POSITIONING

The amount of scattered radiation striking the patient's abdomen during a properly conducted radiographic examination is negligible.[98] The thyroid gland is more susceptible to radiation exposure during dental radiographic exams given its anatomic position, particularly in children.[93,99,100] Protective thyroid collars and collimation substantially reduce radiation exposure to the thyroid during dental radiographic procedures.[101,102] Because every precaution should be taken to minimize radiation exposure, protective thyroid collars should be used whenever possible. If all the recommendations for limiting radiation exposure are put into practice, the gonadal radiation dose will not be significantly affected by use of abdominal shielding.[86] Therefore, use of abdominal shielding may not be necessary.

Protective aprons and thyroid shields should be hung or laid flat and never folded, and manufacturer's instructions should be followed. All protective shields should be evaluated for damage (e.g. tears, folds, and cracks) monthly using visual and manual inspection.

Proper education and training in patient positioning is necessary to ensure that panoramic radiographs are of diagnostic quality.

OPERATOR PROTECTION

Although dental professionals receive less exposure to ionizing radiation than do other occupationally exposed health care workers,[75,86] operator protection measures are essential to minimize exposure. Operator protection measures include education, the implementation of a radiation protection program, occupational radiation exposure limits, recommendations for personal dosimeters and the use of barrier shielding.[103] The maximum permissible annual dose of ionizing radiation for health care workers is 50 millisieverts (mSv) and the maximum permissible lifetime dose is 10 mSv multiplied by a person's age in years.[86] Personal dosimeters should be used by workers who may receive an annual dose greater than 1 mSv to monitor their exposure levels. Pregnant dental personnel operating x-ray equipment should use personal dosimeters, regardless of anticipated exposure levels.[86]

Operators of radiographic equipment should use barrier protection when possible, and barriers should ideally contain a leaded glass window to enable the operator to view the patient during exposure.[86] When shielding is not possible, the operator should stand at least two meters from the tube head and out of the path of the primary beam.[103] The National Council on Radiation Protection & Measurements report "Radiation Protection in Dentistry" offers detailed information on shielding and office design.[86] State radiation control agencies can help assess whether barriers meet minimum standards.

HAND-HELD X-RAY UNITS

Hand-held, battery-powered x-ray systems are available for intra-oral radiographic imaging. The hand-held exposure device is activated by a trigger on the handle of the device. However, dosimetry studies indicate that these hand-held devices present no greater radiation risk than standard dental radiographic units to the patient or the operator. No additional radiation protection precautions are needed when the device is used according to the manufacturer's instructions. These include: 1. holding the device at mid-torso height, 2. orienting the shielding ring properly with respect to the operator, and 3. keeping the cone as close to the patient's face as practical. If the hand-held device is operated without the ring shield in place, it is recommended that the operator wear a lead apron.

All operators of hand-held units should be instructed on their proper storage. Due to the portable nature of these devices, they should be secured properly when not in use to prevent accidental damage, theft, or operation by an unauthorized user. Hand-held units should be stored in locked cabinets, locked storage rooms, or locked work areas when not under the direct supervision of an individual authorized to use them. Units with user-removable batteries should be stored with the batteries removed. Records listing the names of approved individuals who are granted access and use privileges should be prepared and kept current.

FILM EXPOSURE AND PROCESSING

All film should be processed following the film and processer manufacturer recommendations. Once this is achieved, the x-ray operator can adjust the tube current and time and establish a technique that will provide consistent dental radiographs of diagnostic quality. Poor processing technique, including sight-developing, most often results in underdeveloped films, forcing the x-ray operator to increase the dose to compensate, resulting in patient and personnel being exposed to unnecessary radiation.

A safelight does not provide completely safe exposure for an indefinite period of time. Extraoral film is much more sensitive to fogging. The length of time for which a film can be exposed to the safelight should be determined for the specific safelight/film combination in use.

QUALITY ASSURANCE

Quality assurance protocols for the x-ray unit, imaging receptor, film processing, dark room, and patient shielding should be developed and implemented for each dental health care setting.[86] All quality assurance procedures, including date, procedure, results, and corrective action, should be logged for documentation purposes. A qualified expert should survey all x-ray units on their placement and should resurvey the equipment every four years or after any

changes that may affect the radiation exposure of the operator and others.[86] Surveys typically are performed by state agencies, and individual state regulations should be consulted regarding specific survey intervals. The film processor should be evaluated at its initial installation and on a monthly basis afterward. The processing chemistry should be evaluated daily, and each type of film should be evaluated monthly or when a new box or batch of film is opened.[86] Abdominal shielding and thyroid collars should be inspected visually for creases or clumping that may indicate voids in their integrity on a monthly basis.[86] Damaged abdominal shielding and collars should be replaced. Table 2 lists specific methods of quality assurance procedures, covering not only inspection of the x-ray unit itself but also of the film processor, the image receptor devices, the darkroom and abdominal shielding and collars.[103,104]

It is imperative that the operator's manual for all imaging acquisition hardware is readily available to the user, and that the equipment is operated and maintained following the manufacturer's instructions, including any appropriate adjustments for optimizing dose and image quality.

TECHNIQUE CHARTS/PROTOCOLS

Size-based technique charts/protocols with suggested parameter settings are important for ensuring that radiation exposure is optimized for all patients. Technique charts should be used for all systems with adjustable settings, such as tube potential, tube current, and time or pulses. The purpose of using the charts is to control the amount of radiation to the patient and receptor. Technique charts are tables that indicate appropriate settings on the x-ray unit for a specific anatomical area and will ensure the least amount of radiation exposure to produce a consistently good-quality radiograph.

Technique charts for intraoral and extraoral radiography should list the type of exam, the patient size (small, medium, large) for adults and a pediatric setting. The speed of film used, or use of a digital receptor, should also be listed on the technique chart. The chart should be posted near the control panel where the technique is adjusted for each x-ray unit. A technique chart that is regularly updated should be developed for each x-ray unit. The charts will also need to be updated when a different film or sensor, new unit, or new screens are used.

RADIATION RISK COMMUNICATION

Dentists should be prepared to discuss with their patients the benefits and risks of the x-ray exam.[105] To help answer patient and parent questions about dental radiology radiation safety, the American Academy of Oral and Maxillofacial Radiology and the Alliance for Radiation Safety in Pediatric Imaging partnered to create a brochure targeted at parents and patients.[106]

Table 2.

Quality Assurance Procedures for Assessment of Radiographic Equipment		
The following procedures for periodic assessment of the performance of radiographic equipment, film processing, equipment, image receptor devices, dark room integrity, and abdominal and thyroid shielding are adapted from the National Council for Radiation Protection and Measurements report, "Radiation Protection in Dentistry."[86] Please refer to state guidelines for specific regulations.		
Equipment	**Frequency**	**Method**
X-ray Machine	On installation At regular intervals as recommended by state regulations Whenever there are any changes in installation workload or operating conditions	Inspection by qualified expert (as specified by government regulations and manufacturers recommendations).
Film Processor	On installation Daily	**Method 1: Sensitometry and Densitometry** A sensitometer is used to expose a film, followed by standard processing of the film. The processed film will have a defined pattern of optical densities. The densities are measured with a densitometer. The densitometer measurements are compared to the densities of films exposed and processed under ideal conditions. A change in densitometer values indicates a problem with either the development time, temperature or the developer solutions. *Advantages* Accuracy Speed *Disadvantage* Expense of additional equipment **Method 2: Reference Film** A film exposed and processed under ideal conditions is attached to the corner of a view box as a reference film. Subsequent films are compared with the reference film. *Advantage* Cost effectiveness *Disadvantage* Less sensitive
Image Receptor Devices Intensifying Screen and	Monthly With each new batch of film Every six months	**Method 1: Sensitometry and Densitometry** (as described above) **Method 2: Reference Image** (as described above) Visual inspection of cassette integrity Examination of intensifying screen for

Extraoral Cassettes		scratches Development of an unexposed film that has been in the cassette exposed to normal lighting for one hour or more
Darkroom Integrity	On installation Monthly After a change in the lighting filter or lamp	While in a darkroom with the safelight on, place metal object (such as a coin) on unwrapped film for a period that is equivalent to the time required for a typical darkroom procedure Develop film Detection of the object indicates a problem with the safelight or light leaks in the darkroom
Abdominal and Thyroid Shielding	Monthly (visual and manual inspection)	All protective shields should be evaluated for damage (e.g., tears, folds, and cracks) monthly using visual and manual inspection. If a defect in the attenuating material is suspected, radiographic or fluoroscopic inspection may be performed as an alternative to immediately removing the item from service. Consideration should be given to minimizing the radiation exposure of inspectors by minimizing unnecessary fluoroscopy.

TRAINING AND EDUCATION

Where permitted by law, auxiliary dental personnel can perform intraoral and extraoral imaging.[103] Personnel certified to take dental radiographs should receive appropriate education. Practitioners should remain informed about safety updates and the availability of new equipment, supplies and techniques that could further improve the diagnostic quality of radiographs and decrease radiation exposure. Free training materials are available for limiting radiation exposure in dental imaging through the International Atomic Energy Agency.[107]

CONCLUSION

Dentists should conduct a clinical examination, consider the patient's oral and medical histories, as well as consider the patient's vulnerability to environmental factors that may affect oral health before conducting a radiographic examination. This information should guide the dentist in the determination of the type of imaging to be used, the frequency of its use, and the number of images to obtain. Radiographs should be taken only when there is an expectation that the diagnostic yield will affect patient care.

Dentists should develop and implement a radiation protection program in their offices. In addition, practitioners should remain informed on safety updates and the availability of new equipment, supplies, and techniques that could further improve the diagnostic ability of radiographs and decrease exposure.

REFERENCES

1. The American Dental Association Council on Scientific Affairs. The use of cone-beam computed tomography in dentistry. *J Am Dent Assoc* 2012;143(8):899-202.
2. Anbiaee N, Mohassel AR, Imanimoghaddam M, Moazzami SM. A comparison of the accuracy of digital and conventional radiography in the diagnosis of recurrent caries. *J Contemp Dent Pract* 2010;11(6):E025-032.
3. Senel B, Kamburoglu K, Ucok O, et al. Diagnostic accuracy of different imaging modalities in detection of proximal caries. *Dentomaxillofac Radiol* 2010;39(8):501-11.
4. Ulusu T, Bodur H, Odabas ME. In vitro comparison of digital and conventional bitewing radiographs for the detection of approximal caries in primary teeth exposed and viewed by a new wireless handheld unit. *Dentomaxillofac Radiol* 2010;39(2):91-4.
5. Tracy KD, Dykstra BA, Gakenheimer DC, et al. Utility and effectiveness of computer-aided diagnosis of dental caries. *Gen Dent* 2011;59(2):136-44.
6. Atchison KA, White SC, Flack VF, Hewlett ER. Assessing the FDA guidelines for ordering dental radiographs. *J Am Dent Assoc* 1995;126(10):1372-83.
7. Atchison KA, White SC, Flack VF, Hewlett ER, Kinder SA. Efficacy of the FDA selection criteria for radiographic assessment of the periodontium. *J Dent Res* 1995;74(7):1424-32.
8. Pitts NB, Kidd EA. The prescription and timing of bitewing radiography in the diagnosis and management of dental caries: contemporary recommendations. *Br Dent J* 1992;172(6):225-7.
9. Smith NJ. Selection criteria for dental radiography. *Br Dent J* 1992;173(4):120-1.
10. Hintze H. Screening with conventional and digital bite-wing radiography compared to clinical examination alone for caries detection in low-risk children. *Caries Res* 1993;27(6):499-504.
11. Hintze H, Wenzel A. Clinically undetected dental caries assessed by bitewing screening in children with little caries experience. *Dentomaxillofac Radiol* 1994;23(1):19-23.
12. Ferguson F, Festa SA. Radiography for children and adolescents. *N Y State Dent J* 1993;59(2):25-9.
13. Henderson NJ, Crawford PJ. Guidelines for taking radiographs of children. *Dent Update* 1995;22(4):158-61.
14. Wenzel A. Current trends in radiographic caries imaging. *Oral Surg Oral Med Oral Pathol* 1995;80(5):527-39.
15. White SC, Heslop EW, Hollender LG, et al. Parameters of radiologic care: An official report of the American Academy of Oral and Maxillofacial Radiology. *Oral Surg Oral Med Oral Pathol Oral Radiol Endod* 2001;91(5):498-511.
16. Newman B, Seow WK, Kazoullis S, Ford D, Holcombe T. Clinical detection of caries in the primary dentition with and without bitewing radiography. *Aust Dent J* 2009;54(1):23-30.
17. Clark HC, Curzon ME. A prospective comparison between findings from a clinical examination and results of bitewing and panoramic radiographs for dental caries diagnosis in children. *Eur J Paediatr Dent* 2004;5(4):203-9.
18. Hopcraft MS, Morgan MV. Comparison of radiographic and clinical diagnosis of approximal and occlusal dental caries in a young adult population. *Community Dent Oral Epidemiol* 2005;33(3):212-8.

19. Tinanoff N, Douglass JM. Clinical decision-making for caries management in primary teeth. *J Dent Educ* 2001;65(10):1133-42.
20. Arrow P. Incidence and progression of approximal carious lesions among school children in Western Australia. *Aust Dent J* 2007;52(3):216-26.
21. Lith A. Frequency of radiographic caries examinations and development of dental caries. *Swed Dent J Suppl* 2001(147):1-72.
22. National Institute of Dental Research. The prevalence of dental caries in United States children, 1979-1980. *Department of Health and Human Services - National Institutes of Health.* 1981;NIH publication no. 82-2245.
23. National Institute of Dental Research. The national survey of dental caries in U.S. School Children: 1986-1987. *Department of Health and Human Services - National Institutes of Health.* 1989;NIH publication no. 89-2247.
24. Kaste LM, Selwitz RH, Oldakowski RJ, et al. Coronal caries in the primary and permanent dentition of children and adolescents 1-17 years of age: United States, 1988-1991. *J Dent Res* 1996;75 Spec No:631-41.
25. National Center for Chronic Disease Prevention and Health Promotion. Oral Health: Preventing Cavities, Gum Disease, Tooth Loss, and Oral Cancers at a Glance 2011. www.cdc.gov/chronicdisease/resources/publications/AAG/doh.htm (accessed November 14, 2011).
26. Research Science and Therapy Committee American Academy of Periodontology. Position paper: Periodontal diseases of children and adolescents. *J Periodontol* 2003;74(11):1696-704.
27. Oh TJ, Eber R, Wang HL. Periodontal diseases in the child and adolescent. *J Clin Periodontol* 2002;29(5):400-10.
28. Corbet EF, Ho DK, Lai SM. Radiographs in periodontal disease diagnosis and management. *Aust Dent J* 2009;54 Suppl 1:S27-43.
29. Hollier LH, Jr., Sharabi SE, Koshy JC, Stal S. Facial trauma: general principles of management. *J Craniofac Surg* 2010;21(4):1051-3.
30. Alcala-Galiano A, Arribas-Garcia IJ, Martin-Perez MA, et al. Pediatric facial fractures: children are not just small adults. *Radiographics* 2008;28(2):441-61; quiz 618.
31. Sameshima GT, Asgarifar KO. Assessment of root resorption and root shape: periapical vs panoramic films. *Angle Orthod* 2001;71(3):185-9.
32. Witcher TP, Brand S, Gwilliam JR, McDonald F. Assessment of the anterior maxilla in orthodontic patients using upper anterior occlusal radiographs and dental panoramic tomography: a comparison. *Oral Surg Oral Med Oral Pathol Oral Radiol Endod* 2010;109(5):765-74.
33. Tai CC, Miller PA, Packota GV, Wood RE. The occlusal radiograph revisited. *Oral Health* 1994;84(11):47-50, 53.
34. Taylor NG, Jones AG. Are anterior occlusal radiographs indicated to supplement panoramic radiography during an orthodontic assessment? *Br Dent J* 1995;179(10):377-81.
35. Tomar SL, Reeves AF. Changes in the oral health of U.S. children and adolescents and dental public health infrastructure since the release of the Healthy People 2010 Objectives. *Acad Pediatr* 2009;9(6):388-95.
36. Albandar JM, Tinoco EM. Global epidemiology of periodontal diseases in children and young persons. *Periodontol 2000* 2002;29:153-76.

37. Atieh MA. Diagnostic accuracy of panoramic radiography in determining relationship between inferior alveolar nerve and mandibular third molar. *J Oral Maxillofac Surg* 2010;68(1):74-82.
38. Le T, Nassery K, Kahlert B, Heithersay G. A comparative diagnostic assessment of anterior tooth and bone status using panoramic and periapical radiography. *Aust Orthod J* 2011;27(2):162-8.
39. Nohadani N, Ruf S. Assessment of vertical facial and dentoalveolar changes using panoramic radiography. *EurJ Orthod* 2008;30(3):262-8.
40. Garvey MT, Barry HJ, Blake M. Supernumerary teeth--an overview of classification, diagnosis and management. *J Can Dent Assoc* 1999;65(11):612-6.
41. Tsai HH. Panoramic radiographic findings of the mandibular growth from deciduous dentition to early permanent dentition. *J Clin Pediatr Dent* 2002;26(3):279-84.
42. Anthonappa RP, King NM, Rabie AB, Mallineni SK. Reliability of panoramic radiographs for identifying supernumerary teeth in children. *Inter J Paediatr Dent* 2012;22(1):37-43.
43. National Institute for Dental and Craniofacial Research. Dental Caries (Tooth Decay) in Adults (Age 20 to 64). http://www.nidcr.nih.gov/DataStatistics/FindDataByTopic/DentalCaries/DentalCariesAdults20to64 (accessed March 21, 2012).
44. Centers for Disease Control and Prevention. Recommendations for using fluoride to prevent and control dental caries in the United States. *MMWR* 2001;50(No. RR-14).
45. Ritter AV, Shugars DA, Bader JD. Root caries risk indicators: a systematic review of risk models. *Community Dent Oral Epidemiol* 2010;38(5):383-97.
46. Topping GVA, Pitts NB. Clinical Visual Caries Detection. *Monogr Oral Sci* 2009;21:15-41.
47. Hugoson A, Sjodin B, Norderyd O. Trends over 30 years, 1973-2003, in the prevalence and severity of periodontal disease. *J Clin Periodontol* 2008;35:405-14.
48. Rushton VE, Horner K, Worthington HV. Screening panoramic radiography of new adult patients: diagnostic yield when combined with bitewing radiography and identification of selection criteria. *Br Dent J* 2002;192(5):275-9.
49. Rushton MN, Rushton VE. A study to determine the added value of 740 screening panoramic radiographs compared to intraoral radiography in the management of adult (>18 years) dentate patients in a primary care setting. *J Dent* 2012;40(8)661-9.
50. Rushton VE, Horner K, Worthington HV. Routine panoramic radiography of new adult patients in general dental practice: relevance of diagnostic yield to treatment and identification of radiographic selection criteria. *Oral Surg Oral Med Oral Pathol Oral Radiol Endod* 2002;93(4):488-95.
51. Jindal SK, Sheikh S, Kulkarni S, Singla A. Significance of pre-treatment panoramic radiographic assessment of edentulous patients--a survey. Med Oral Patol Oral Cir Bucal. Jul 2011;16(4):e600-6.
52. Edgerton M, Clark P. Location of abnormalities in panoramic radiographs of edentulous patients. *Oral Surg Oral Med Oral Pathol* 1991;71(1):106-9.
53. Sumer AP, Sumer M, Guler AU, Bicer I. Panoramic radiographic examination of edentulous mouths. *Quintessence Int* 2007;38(7):e399-403.
54. Masood F, Robinson W, Beavers KS, Haney KL. Findings from panoramic radiographs of the edentulous population and review of the literature. *Quintessence Int* 2007;38(6):e298-305.

55. Awad EA, Al-Dharrab A. Panoramic radiographic examination: a survey of 271 edentulous patients. *Int J Prosthodont* 2011;24(1):55-7.
56. Bohay RN, Stephens RG, Kogon SL. A study of the impact of screening or selective radiography on the treatment and postdelivery outcome for edentulous patients. *Oral Surg Oral Med Oral Pathol Oral Radiol Endod* 1998;86(3):353-9.
57. Feine JS, Carlsson GE, Awad MA, et al. The McGill consensus statement on overdentures. Mandibular two-implant overdentures as first choice standard of care for edentulous patients. Montreal, Quebec, May 24-25, 2002. *Int J Oral Maxillofac Implants* 2002;17(4):601-2.
58. da Silva RP, Assaf AV, Pereira SM, et al. Validity of caries-detection methods under epidemiological setting. *Am J Dent* 2011;24(6):363-6.
59. Steiner M, Buhlmann S, Menghini G, Imfeld C, Imfeld T. Caries risks and appropriate intervals between bitewing x-ray examinations in schoolchildren. *Schweiz Monatsschr Zahnmed* 2011;121(1):12-24.
60. Patel S, Bay RC, Glick M. A systematic review of dental recall intervals and incidence of dental caries. *J Am Dent Assoc* 2010;141(5):527-39.
61. Pitts NB. The use of bitewing radiographs in the management of dental caries: scientific and practical considerations. *Dentomaxillofac Radiol* 1996;25(1):5-16.
62. Garcia RI, Valachovic RW, Chauncey HH. Longitudinal study of the diagnostic yield of panoramic radiographs in aging edentulous men. *Oral Surg Oral Med Oral Pathol* 1987;63(4):494-7.
63. Dye BA, Thornton-Evans G. Trends in oral health by poverty status as measured by Healthy People 2010 objectives. *Public Health Rep* 2010;125(6):817-30.
64. Dye BA, Arevalo O, Vargas CM. Trends in paediatric dental caries by poverty status in the United States, 1988-1994 and 1999-2004. *Int J Paediatr Dent* 2010;20(2):132-43.
65. Shwartz M, Grondahl HG, Pliskin JS, Boffa J. A longitudinal analysis from bite-wing radiographs of the rate of progression of approximal carious lesions through human dental enamel. *Arch Oral Biol* 1984;29(7):529-36.
66. Berkey CS, Douglass CW, Valachovic RW, Chauncey HH. Longitudinal radiographic analysis of carious lesion progression. *Community Dent Oral Epidemiol* 1988;16(2):83-90.
67. Mejare I, Kallest l C, Stenlund H. Incidence and progression of approximal caries from 11 to 22 years of age in Sweden: A prospective radiographic study. *Caries Res* 1999;33(2):93-100.
68. Sheiham A, Sabbah W. Using universal patterns of caries for planning and evaluating dental care. *Caries Research* 2010;44(2):141-50.
69. Chankanka O, Marshall TA, Levy SM, et al. Mixed dentition cavitated caries incidence and dietary intake frequencies. *Pediatr Dent* 2011;33(3):233-40.
70. Gruythuysen RJ, van der Linden LW, Woltgens JH, Geraets WG. Differences between primary and permanent teeth in posteruptive age dependency of radiological changes in enamel during the development of approximal caries. *J Biol Buccale* 1992;20(1):59-62.
71. Kotsanos N, Darling AI. Influence of posteruptive age of enamel on its susceptibility to artificial caries. *Caries Res* 1991;25(4):241-50.
72. Woltgens JH, Etty EJ, Geraets WG. Posteruptive age dependency of cariogenic changes in enamel of permanent teeth of children. *J Biol Buccale* 1990;18(1):49-53.

73. Cardoso CA, Magalhaes AC, Rios D, Lima JE. Cross-sectional hardness of enamel from human teeth at different posteruptive ages. *Caries Res* 2009;43(6):491-4.
74. Gutteridge DL. The use of radiographic techniques in the diagnosis and management of periodontal diseases. *Dentomaxillofac Radiol* 1995;24(2):107-13.
75. National Council on Radiation Protection and Measurements, ed *NCRP Report No. 160 - Ionizing Radiation Exposure of the Population of the United States*. Bethesda: National Council on Radiation Protection and Measurements; 2009.
76. American National Standards Institute. Photography - Intra-oral dental radiographic film - Specification. *New York: American National Standards Institute.* 1997;ANSI/NAPM IT2.49-1997. ANSI/ISO 3665:1996.
77. American National Standards Institute. Photography - Direct-exposing medical and dental radiographic film/process systems - Determination of ISO speed and ISO average gradient. *New York: American National Standards Institute.* 1983;ISO 5799:1991. ANSI PH2.50-1983.
78. U.S. Food and Drug Administration. Dental Radiography: Doses and Film Speed. *http://www.fda.gov/Radiation-EmittingProducts/RadiationSafety/NationwideEvaluationofX-RayTrendsNEXT/ucm116524.htm.* (accessed August 2011).
79. Farman TT, Farman AG. Evaluation of a new F speed dental X-ray film. The effect of processing solutions and a comparison with D and E speed films. *Dentomaxillofac Radiol* 2000;29(1):41-5.
80. Hadley DL, Replogle KJ, Kirkam JC, Best AM. A comparison of five radiographic systems to D-speed film in the detection of artificial bone lesions. *J Endod* 2008;34(9):1111-4.
81. Alkurt MT, Peker I, Bala O, Altunkaynak B. In vitro comparison of four different dental X-ray films and direct digital radiography for proximal caries detection. *Oper Dent* 2007;32(5):504-9.
82. Schulze RK, Nackat D, D'Hoedt B. In vitro carious lesion detection on D-, E-, and F-speed radiographic films. *Oral Surg Oral Med Oral Pathol Oral Radiol Endod* 2004;97(4):529-34.
83. Sheaffer JC, Eleazer PD, Scheetz JP, Clark SJ, Farman AG. Endodontic measurement accuracy and perceived radiograph quality: effects of film speed and density. *Oral Surg Oral Med Oral Pathol Oral Radiol Endod* 2003;96(4):441-8.
84. Syriopoulos K, Velders XL, Sanderink GC, van Der Stelt PF. Sensitometric and clinical evaluation of a new F-speed dental X-ray film. *Dentomaxillofac Radiol* 2001;30(1):40-4.
85. Woolhiser GA, Brand JW, Hoen MM, et al. Accuracy of film-based, digital, and enhanced digital images for endodontic length determination. *Oral Surg Oral Med Oral Pathol Oral Radiol Endod* 2005;99(4):499-504.
86. National Council for Radiation Protection & Measurements, ed. *NCRP Report No. 145 - Radiation Protection in Dentistry*. Bethesda: National Council on Radiation Protection and Measurement; 2003.
87. Gratt BM, White SC, Packard FL, Petersson AR. An evaluation of rare-earth imaging systems in panoramic radiography. *Oral Surg Oral Med Oral Pathol* 1984;58(4):475-82.
88. Kaugars GE, Fatouros P. Clinical comparison of conventional and rare earth screen-film systems for cephalometric radiographs. *Oral Surg Oral Med Oral Pathol* 1982;53(3):322-5.

89. Goren AD, Lundeen RC, Deahl II ST, et al. Updated quality assurance self-assessment exercise in intraoral and panoramic radiography. *Oral Surg Oral Med Oral Pathol Oral Radiol Endod* 2000;89(3):369-74.
90. Gavala S, Donta C, Tsiklakis K, et al. Radiation dose reduction in direct digital panoramic radiography. *Eur J Radiol* 2009;71(1):42-8.
91. Alcaraz M, Parra C, Martinez Beneyto Y, Velasco E, Canteras M. Is it true that the radiation dose to which patients are exposed has decreased with modern radiographic films? *Dentomaxillofac Radiol* 2009;38(2):92-7.
92. Dannewitz B, Hassfeld S, Eickholz P, Muhling J. Effect of dose reduction in digital dental panoramic radiography on image quality. *Dentomaxillofac Radiol* 2002;31(1):50-5.
93. Kaeppler G, Dietz K, Herz K, Reinert S. Factors influencing the absorbed dose in intraoral radiography. *Dentomaxillofac Radiol* 2007;36(8):506-13.
94. Centers for Disease Control and Prevention. Guidelines for Infection Control in Dental Health-Care Settings - 2003. *MMWR* 2003;52(No. RR-17):31.
95. Freeman JP, Brand JW. Radiation doses of commonly used dental radiographic surveys. *Oral Surg Oral Med Oral Pathol* 1994;77(3):285-9.
96. Gibbs SJ. Effective dose equivalent and effective dose: comparison for common projections in oral and maxillofacial radiology. *Oral Surgery Oral Med Oral Pathol Oral RadiolEendod* 2000;90(4):538-45.
97. Gibbs SJ, Pujol A, Jr., Chen TS, James A, Jr. Patient risk from intraoral dental radiography. *Dentomaxillofac Radiol* 1988;17(1):15-23.
98. Gibbs SJ. Biological effects of radiation from dental radiography. Council on Dental Materials, Instruments, and Equipment. *J Am Dent Assoc* 1982;105(2):275-81.
99. Hujoel P, Hollender L, Bollen AM, et al. Head-and-neck organ doses from an episode of orthodontic care. *Am J Orthod Dentofacial Orthop* 2008;133(2):210-7.
100. Ohman A, Kull L, Andersson J, Flygare L. Radiation doses in examination of lower third molars with computed tomography and conventional radiography. *Dentomaxillofac Radiol* 2008;37(8):445-52.
101. Kircos LT, Angin LL, Lorton L. Order of magnitude dose reduction in intraoral radiography. *J Am Dent Assoc* 1987;114(3):344-7.
102. Sinnott B, Ron E, Schneider AB. Exposing the thyroid to radiation: a review of its current extent, risks, and implications. *Endocr Rev* 2010;31(5):756-73.
103. Lambert K, McKeon T. Inspection of lead aprons: criteria for rejection. *Health Phys* 2001;80(5 Suppl):S67-9.
104. Michel R, Zorn MJ. Implementation of an X-ray radiation protective equipment inspection program. *Health Phys* 2002;82(2 Suppl):S51-3.
105. U.S. Food and Drug Administration. Pediatric X-ray Imaging. 2012 *http://www.fda.gov/Radiation-EmittingProducts/RadiationEmittingProductsandProcedures/MedicalImaging/ucm298899.htm.* (accessed August 2012).
106. Alliance for Radiation Safety in Pediatric Imaging in partnership with the American Academy of Oral and Maxillofacial Radiology. What Parents Should Know about the Safety of Dental Radiology. 2011 *http://www.pedrad.org/associations/5364/files/What%20Parents%20Should%20Know%20aboutthe%20Safety%20of%20Dental%20Radiology.pdf.* (accessed August 2012).

107. International Atomic Energy Agency. Diagnostic and Interventional Radiology. 2012 *https://rpop.iaea.org/RPOP/RPoP/Content/AdditionalResources/Training/1_TrainingMaterial/Radiology.htm.* (accessed August 2012).

Oregon
Tina Kotek, Governor

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

Clarification on Radiographs

The Oregon Board of Dentistry (Board) regularly receives questions about the requirement for radiographs/X-rays and how often they are required.

The decision about whether and/or when to take radiographs is the responsibility of Oregon licensed dental professionals, including Dentists, Dental Therapists, or an Expanded Practice Permit Dental Hygienist. It should be based on factors including the patient's oral health, patient's age, the risk for disease, and any sign or symptoms of oral disease that a patient may be experiencing.

The Oregon Board of Dentistry does not have a time requirement for how often radiographs or X-rays are to be taken. So, if your Dentist says we (the Board) require X-rays every six months or every year, that is not true.

The dental professional uses their professional judgment to decide when radiographic imaging is clinically indicated, not the patient.

Dental radiographs are an important diagnostic tool to assist your dental professional in treatment planning, and it is the responsibility of the treating dental professional to determine how often they are needed.

The Board takes the following into consideration when it reviews care provided by our licensees:

> **Oregon Revised Statute (ORS) 679.140(4) states:**
> "In determining what constitutes unacceptable patient care, the board may take into account all relevant factors and practices, including but not limited to the practices generally and currently followed and accepted by persons licensed to practice Dentistry in this state, the current teachings at accredited dental schools, relevant technical reports published in recognized dental journals, and the desirability of reasonable experimentation in the furtherance of the dental arts."

In order to diagnose dental pathology and complete an adequate examination on a new or existing patient, the dental professional must have adequate dental radiographs, periodontal probings (if appropriate), and a current medical history. If pathology is diagnosed during the dental examination, the dental professional is obligated to explain the problem, the treatment options, the risks of providing or not providing the treatment, and answer questions. The dental professional is also required to document in the patient's records any dental pathology that is diagnosed during the examination.

When treatment is provided, the dental professional is expected to have obtained the patient's informed consent prior to providing the treatment. **Patients may choose to refuse diagnostic tests, dental radiographs, or recommended treatment. A dentist is not obligated to treat a patient who does not agree with a treatment plan, including X-rays.** The Board cannot mandate that dental professionals provide unacceptable patient care, and the Board cannot force a licensee to provide treatment for a patient if, in their professional judgement, they do not have the ability to obtain an accurate dental diagnosis or dental justification for treatment.

OTHER ISSUES

MEMORANDUM OF AGREEMENT

Between the Oregon Dental Board and The Foundation for Medical Excellence on behalf of the Oregon Wellness Program

I. INTRODUCTION

THIS MEMORANDUM OF AGREEMENT ("MOA"), dated July 21, 2023, is between Oregon Board of Dentistry ("OBD") a state agency established under the laws of Oregon with its offices in Portland, Oregon, represented by Stephen Prisby, Executive Director; and The Foundation for Medical Excellence ("Foundation"), an Oregon public non-profit foundation with its principal place of business in Portland, Oregon, represented by Timothy Goldfarb, MHSA, President. The OBD and the Foundation are collectively referred to as the "Partners".

The Partners wish to work together and in compliance with the following clauses:

II. GOAL

Provide leadership, core services, and funding to continue to develop OBD licensees and enhance the Oregon Wellness Program that delivers support services for OBD licensees (dentists, dental therapists, and dental hygienists, i.e., the "Program"). The services should be accessible statewide, confidential, and help OBD licensees in dealing with the stresses of their profession.

III. AREAS OF COLLABARATION

Program protocols and organizational goals include, but are not limited to:

- Program transparency and accountability.
- Covenants for patient safety.
- Program elements that include counseling and coaching services tailored to dentists, dental therapists, and dental hygienists' needs.
- Confidentiality for OBD licensees seeking assistance. Individuals utilizing Program services are assured that their identity will not be known to the OBD.
- Removal of financial barriers for OBD licensees seeking assistance.
- Program development and implementation.
    - Advance outreach to rural areas.
    - Identification and expansion of ongoing Program funding sources.
    - Research and development of outcome measures to make sure that Program is effectively promoting wellness.
    - Development of improved methods for prevention.
    - Education of physicians and stakeholders about Program.
    - Statewide service delivery, utilizing telemedicine as necessary to serve the rural areas of the state.

IV. ROLES AND RESPONSIBILITIES OF PARTNERS

The OBD will provide funding to the Foundation in an amount not to exceed $40,000 per fiscal year: July 1, 2023 - June 30, 2024 & July 1, 2024 – June 30, 2025.

The Foundation, in collaboration with the OBD, shall be responsible for Program development, ongoing administration, and reporting to the OBD on the areas of joint collaboration identified in section III of this MOA. The Foundation shall develop Program business and strategic plans and a budget for use of funding provided by the OBD and report on the expenditure of funds provided by the OBD under section IX of this MOA.

V. PRINCIPAL CONTACTS

The principal contact for each organization is:

Oregon Board of Dentistry:	The Foundation for Medical Excellence:
Stephen Prisby	Timothy Goldfarb, MHSA
Executive Director	President
1500 SW 1st Avenue, Suite 770	11740 SW 68th Parkway, Suite 125
Portland, OR 97201	Portland, OR 97223
(971) 673-3200	(503) 222-1960

Such principal contacts may be changed via written notification to the other party.

VI. USE OF INTELLECTUAL PROPERTY

The parties agree that any intellectual property that is jointly developed through activities covered under this MOA, may be use by either party for healthcare provider wellness purposes without obtaining consent from the other and without any need to account to the other. Intellectual property developed under this MOA will become the property of the Program.

All other intellectual property used in the implementation of the MOA will remain the property of the party that provided it. This property may be used by either party for purposes covered by the MOA but consent will be obtained from the owner of the property before using it for purposes not covered by the MOA.

If any third-party intellectual property is used in the implementation of the MOA, the party obtaining the third-party intellectual property shall obtain a license from the third party appropriate to the use of the third-party intellectual property.

VII. EFFECTIVE DATES AND AMENDMENTS

This MOA shall take effect upon signing by both Parties and shall remain in effect until June 30, 2025 unless earlier terminated. Neither party may assign or transfer all or any portion of the obligations described in this MOA without the prior written consent of the other party.

The MOA may be renewed at the end of this period by written agreement. Such subsequent agreements supersede all prior agreements, and are subject to funding being specifically available for the purposes outlined therein.

The provisions of this MOA may only be amended or waived by written agreement.

The individuals signing this MOA on behalf of their respective entities represent and warrant (without personal liability therefor) that upon the signature of each, this MOA shall have been duly executed by the entity each represents.

VIII. TERMINATION

Any party may terminate this MOA and any related agreement, work plan and budget at any time and for any reason by giving 30 days prior written notice to the other party; provided, however, that in the event the Foundation fails to perform any of its obligations under this MOA, the OBD shall have the right to terminate this MOA and any related agreement, work plan and budget immediately upon written notice.

IX. ANNUAL REPORTING

The Foundation will provide annual reports to the OBD BY February 1 of each year. Reports will be reviewed at each April OBD Board meeting. Reports must include, but are not limited to:

- Program utilization:
    - Number of individuals and counseling sessions served by geographic region during the reporting period.
        - Total number or percentage of licensees being serviced in-person and via telehealth
        - Historical and cumulative number of individuals and counseling sessions served by geographic region.
    - Identification of any barriers to service provision encounters by licensees.
    - Efforts underway or planned to increase number of individuals served in the coming period. This should include updates on Program marketing and education of physicians and stakeholders since the prior report and goals for the coming period.
- Program effectiveness:
    - Outcome measures collected and their results.
        - Provide specific details on new efforts and methods that are underway to gather outcome data from licensees who have used the service.
        - Identify improvements that need to be made.
    - Updates on Program strategic planning goals and accomplishments since the prior report. Strategic plan goals for the coming period.
- Financial reports:
    - A detailed accounting of OBD funds utilization since the prior report.
    - A detailed accounting of Program funds received from all source sand all Program expenses since the prior report, including but not limited to expenses for administration, services, marketing, research, and technology.
    - Detailed financial statements, including funding sources and utilization, for the Foundation, which is responsible for Program administration and development.
- A funding request and budget for requested OBD funds with expected outcomes, including the number of counseling sessions to be made available with the proposed funding.

X. TRANSFER OF FUNDS

The parties acknowledge and agree that this MOA creates a funding obligation for the Program only as approved by the Oregon Legislature and that any funding will be provided only in accordance with this MOA. The OBD will provide funding to the Foundation in an amount not to exceed $40,000 per fiscal year.

The Foundation will submit funding requests to the OBD for review and approval. The OBD will determine whether the most recently reported utilization rates, outcome measures, and the proposed allocation of the additional funds are in line with the purposes outlined in this MOA, Section III, Areas of Collaboration.

Within 45 days of the OBD's approval of the funding request, the OBD will transfer funds to the Foundation pursuant to this MOA and in the amounts approved by the Board.

XI. COMPLIANCE WITH TAX LAWS

The Foundation is not, to the best of its principal contact's knowledge, in violation of any Oregon Tax Laws. For purposes of this certification, "Oregon Tax Laws" means all tax laws of this state, including but not limited to those included in: ORS 320.005 to 320.150 and 403.200 to 403.250 and ORS chapters 118, 314, 316, 317, 318, 321 and 323 and local taxes administered by the Department of Revenue; (ii) any tax provisions imposed by a political subdivision of this state that applied to Foundation, to Foundation's property, operations, receipts, or income, or to Foundation's performance of or compensation for any work performed by Foundation; (iii) any tax provisions imposed by a political subdivision of this state that applied to Foundation, or to goods, services, or property, whether tangible or intangible, provided by Foundation; and (iv) any rules, regulations, charter provisions, or ordinances that implemented or enforced any of the foregoing tax laws or provisions.

XII. NO JOINT VENTURE

Notwithstanding the terms "Partners" and "partnership," the Partners agree that they are not entering into a legal partnership, joint venture or other such business arrangement, nor are the Partners entering into a commercial undertaking for monetary gain. Neither party will refer to or treat the arrangements under this MOA as a legal partnership or take any action inconsistent with such intention.

XIII. DISPUTE RESOLUTION

The Partners hereby agree that, in the event of any dispute between the Partners relating to this MOA, the Partners shall first seek to resolve the dispute through informal discussions. In the event any dispute cannot be resolved informally within 180 consecutive calendar days, the Partners agree that the dispute may be negotiated between the Partners through mediation, if Partners can agree on a mediator. The costs of mediation shall be shared equally by the Partners. Neither Partner waves its legal rights to adjudicate this Agreement in a legal forum.

XIV. CHOICE OF LAW: DESIGNATION OF FORUM: FEDERAL FORUM

Choice of Law. The laws of the State of Oregon (without giving effect to its conflicts of law principles) govern all matters arising out of or relating to this MOA, including, without limitation, its validity, interpretation, construction, performance, and enforcement.

Designation of Forum. Any party brining a legal action or proceeding against any other party arising out of or relating to this MOA shall bring the legal action or proceeding in the Circuit Court of the State of Oregon for Marion County. Each party hereby consents to the exclusive jurisdiction of such courts, waives any objection to venue, and waives any claim that such forum is an inconvenient forum.

Federal Forum. Notwithstanding the Forum requirement above, if a claim must be brought in a federal forum, then it must be brought and adjudicated solely and exclusively within the United States District Court for the district of Oregon. This section applies to a claim brought against the State of Oregon only to the extent Congress has appropriately abrogated the State of Oregon's sovereign immunity and is not consent by the State of Oregon to be sued in federal court. This section is also not a waiver by the State of Oregon of any form of immunity, including but not limited to sovereign immunity and immunity based on the Eleventh Amendment to the constitution of the United States.

XV. ENTIRETY: COUNTERPARTS

This Agreement, including all Annexes, embodies the entire and complete understanding and agreement between the Partners and no amendment will be effective unless signed by both Partners. This MOA maybe be executed in serval counterparts, all of which when taken together constitute on agreement binding on all parties, notwithstanding that all parties are not signatories to the same counterpart. Each cop of the MOA so executed constitutes an original.

XVI. SIGNATURES

FOR OREGON BOARD OF DENTISTRY

_____ _____

Stephen Prisby
Executive Director

Date

FOR THE FOUNDATION FOR MEDICAL EXCELLENCE

_____ _____

Timothy Goldfarb, MHSA
President

Date

THE FOUNDATION FOR MEDICAL EXCELLENCE
11740 SW 68th Parkway, Suite 125, Portland, Oregon 97223-9014
PH: (503) 222-1960 ● FX: (503) 619-0609 ● EMAIL: info@tfme.org ● WEB: www.tfme.org

Oregon Wellness Program
Annual Report for 2023 Activities
Presented to the Oregon Board of Dentistry
February 7, 2024

The purpose of this document is to respond to the requirements of the agreement between The Foundation for Medical Excellence (TFME) and the Oregon Board of Dentistry (OBD) concerning the Oregon Wellness Program (OWP).

Introduction and OWP Overview

The OWP is a key element of a broad-based effort by the health care community and Oregon health care policy leaders to promote the wellbeing of health care professionals through education, coordinated counseling services, and research. The community believes that improved provider wellbeing has a direct link to retaining health care professionals and therefore improved public access to health care services.

In 2023, the OWP served 22 OBD clients and provided 93 hours of counseling. This compares to 7 OBD clients and 41 hours of counseling in the same 12 months of 2022. A dedicated team of 34 mental health professionals uphold the OWP's standards of confidential services offered within 3 working days of a client's request. In 2023, the OWP provided 3,437 hours of counseling to 642 clients, *a 62% increase in clients and 74% increase in sessions overall from the year prior.*

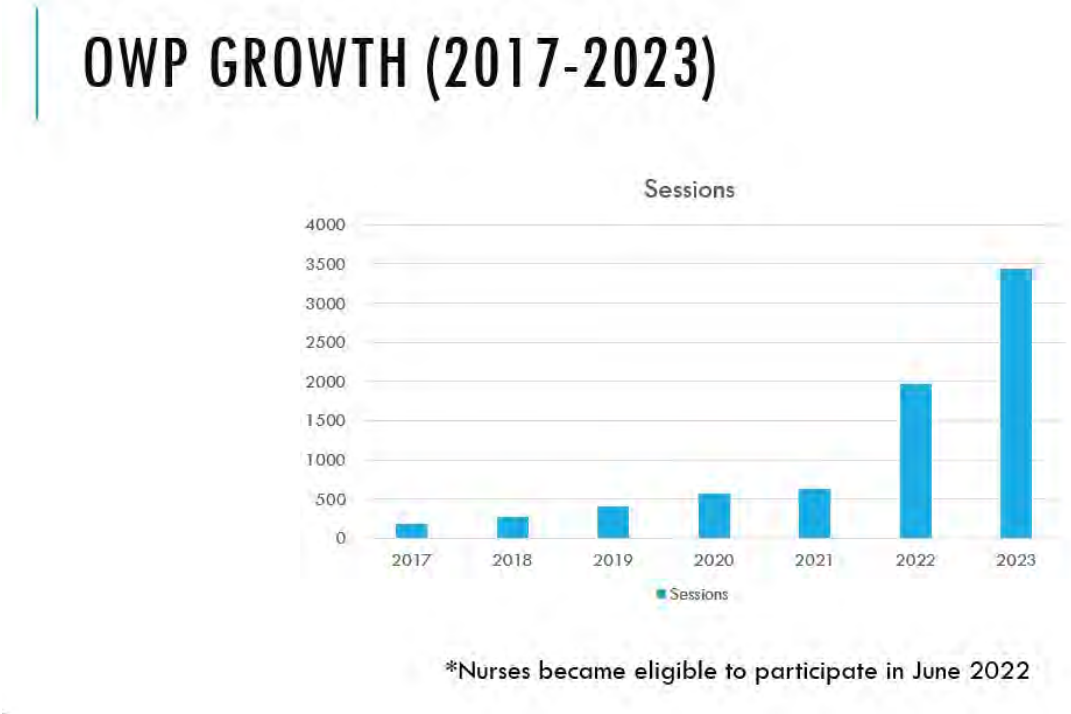
OWP leadership attributes the modest, but steady OBD licensee utilization to two factors:

1. The impact of the pandemic continues to reverberate throughout the health care system, especially in terms of the staffing of key elements of the industry (private practices and clinics have been affected in the same manner as other elements of the delivery system). In many cases, there are more patients that need services than there is staff and/or space to accommodate them. Limited staff and space in many of Oregon's health care practices and organizations generates even more pressure on our health care professionals to perform in an environment with scarce resources. Health care practices, systems and clinics have responded by increasing compensation levels and hiring temporary staff. Patient access to hospital services is illustrative of the overall problem. While more inpatient hospital beds and emergency room spaces are needed, their solutions are longer-term and, in the meantime, health care professionals remain under pressure to serve more patients in the same physical space.

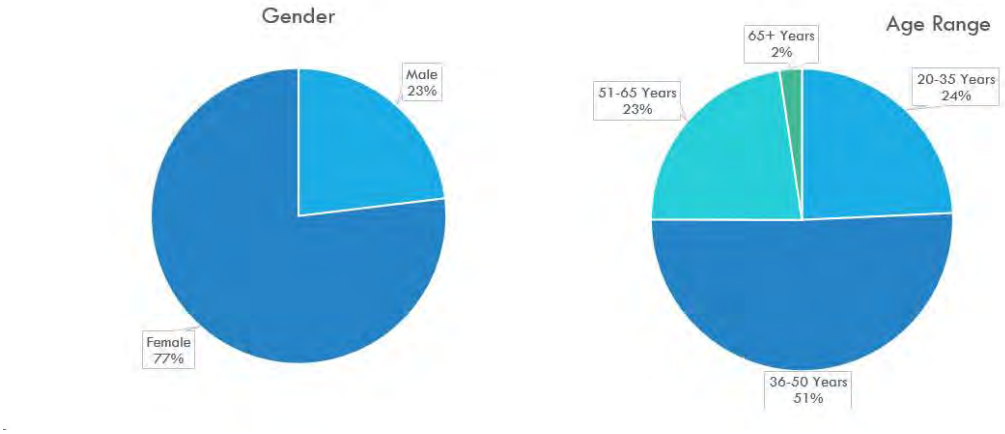
2. Despite the aforementioned increase in demand for OWP services, the OWP mental health professionals have continued to meet the access needs of OBD, OSBN, and OMB licensees without an impact to OWP performance standards. We believe an increased awareness of the OWP amongst OBD licensees has been the result of collegial word-of mouth, and the program's incorporation of nurse professionals, dentists, dental hygienists, and dental therapists across the last two years. As noted below, OWP experience is that utilization of counseling services grows as health care professionals become aware of the program and gain confidence in the confidentiality of the services provided.

Program Utilization

Between January and December 2023, OWP mental health care professionals provided 3,437 one-hour counseling sessions to 642 clients. As noted above, 93 of those sessions and 22 clients were OBD licensees. The first table below depicts program growth since the inception of OWP as a coordinated state-wide effort, and the second table shows the breakdown of clients by gender and age.



OWP CLIENT DEMOGRAPHICS – GENDER AND AGE



Barriers to Access and Care and Our Strategy to Increase Volumes

The primary "barrier" to program utilization is health care professional awareness of the program's availability and the program's strict adherence to client confidentiality. The increasing utilization of OWP services by OBD licensees appears to follow the pattern the OWP has experienced with other health care professionals.

Although the OWP has historically heavily relied on "word of mouth" between health care professionals, in 2022 the OWP temporarily contracted with a Portland-based professional marketing and communications team to revamp our web site and explore the use of social media. We are considering engaging the firm once again to review our marketing and communications effort and ensure that we are maximizing program exposure to the licensees of the OBD, the OSBN, and the OMB.

Outcome Measures

The Oregon Wellness Program (OWP) is conducting a prospective longitudinal study to assess its impact on the professional quality of life of Oregon healthcare professionals. Although the results are preliminary, they are important. This section briefly summarizes those findings.

Participants: 306 Oregon healthcare professionals from various healthcare fields have completed surveys. These numbers allow that the final evaluations will be sufficient to verify the results.

Data Provided: Healthcare professional data on 1) professional demographics, 2) professional quality of life (using the ProQOL measure), 3) duration of OWP use, and 4) Adverse Childhood Experiences (ACEs) scores have all been collected. Demographics include specialty, duration of work, gender, age, etc. The ProQOL survey evaluates individual themes such as compassion fatigue, satisfaction, and burnout. The ACEs score, ranging from 0-10, assesses the level of childhood trauma, with higher scores indicating more trauma.

Demographics: The majority of study participants are registered nurses (65%), followed by advanced practice nurses (7%) and physicians (12%). Approximately 26% of all the participants are current OWP users, averaging around 8 visits per year.

Professional Quality of Life (ProQOL): While completed results will be available shortly, initial findings support the value of OWP use for decreased burnout, increased professional satisfaction, and decreased anxiety and depression.

Adverse Childhood Experience Scores (ACE): A unique chapter of the study includes an assessment of ACEs scores. National findings report that individuals with ACEs scores of 4 or more face significantly increased risks of serious health issues such as cardiovascular and lung diseases, depression, and a notably higher likelihood of attempted suicide. While 17.3% of the national population scores 4 or more on ACEs, nearly twice that number (32%) of Oregon's healthcare professionals score 4 or more. These findings underscore the critical need for programs like the OWP.

Summary: The ongoing analyses of data includes correlations between ProQOL and the number of OWP visits; comparison of burnout between OWP users and non-users; and correlation of retrieved data from two time points, which to date align with the hypothesis that the OWP plays a crucial role in reducing burnout among healthcare professionals.

Program Financials (2023)

We have included copies of the latest TFME Statement of Financial Position and a display of OWP dedicated accounts. The reports are prepared by Susan Matlack Jones and Associates, LLC, a Portland Oregon firm that specializes in financial accounting for not-for-profit organizations.

The OWP only uses OBD funds to support services provided to OBD licensees. In addition, any OWP administrative costs are distributed proportionally to the OBD, OMB and the OSBN. Prior to the deposit of OBD funds in September 2023, dentists were paid for using funds provided by Permanente Dental ($10,600 expended in 2023). As a result, there is a balance in the OBD account of $32,000.

OWP Strategic Planning

Overall, the primary strategic challenge to the OWP is long term financial stability surrounding the dramatic increase in services provided to licensees of the OMB and increasingly, the OSBN. The OWP is meeting a need and these licensees are accessing counseling services at ever increasing rates. The OWP has historically relied on its funding from three sources: the licensee fees from the respective professional boards, gifts from health systems and insurers and periodic support from health care related foundations. As utilization has grown, it has become apparent that the current financial model is not sustainable. Licensee fees are limited. Health systems are under increasing financial pressure and their gifts are more difficult to obtain and foundation investments are unpredictable. Accordingly, the OWP and key stakeholders (the Oregon Dental Association, the Oregon Nursing Association and the Oregon Medical Association) have approached the Legislature about an appropriation aimed at supporting the access of Oregon’s health care professionals to OWP counseling services. The request is intended to add support to that provided by the licensing boards and health system gifts.

The Foundation for Medical Excellence
Statement of Activities - Oregon Wellness Program
12 Months Ending December 31, 2023

Prepared by Susan Matlack Jones & Associates
From TFME Records/For TFME Use Only
Unaudited

	YTD Total	General Oregon Wellness Fund 7100	Central OR Medical Society Fund 7110	Oregon Board of Dentistry Fund 7120	OMB Fund 7130	OHSU Fund 7140	Legacy Health Fund 7150	OWP Research Fund 7160	OWP Providence Fund 7170	OWP Asante Fund 7180	OWP PacificSource Fund 7190	OWP IPA Fund 7200	OWP Virginia Garcia Fund 7210	OWP St. Charles Fund 7220	OWP Permanente Dental Fund 7230	OWP EOCCO Fund 7240	OWP OSBN Fund 7250	COMP NW Fund 7260	CareOregon Fund 7270
Revenue:																			
Contributions	262,000	2,000	-	-	-	10,000	-	-	-	-	-	-	-	-	-	-	250,000	-	-
Program Income	655,000	-	-	40,000	170,000	-	75,000	-	-	10,000	-	-	-	-	10,000	-	250,000	-	100,000
Total Revenue	917,000	2,000	-	40,000	170,000	10,000	75,000	-	-	10,000	-	-	-	-	10,000	-	500,000	-	100,000
Expenses:																			
Salaries	26,667	-	-	-	10,667	-	-	-	-	-	-	-	-	-	-	-	16,000	-	-
Payroll Taxes	2,796	-	-	-	1,119	-	-	-	-	-	-	-	-	-	-	-	1,678	-	-
Contract Services	750,995	-	-	8,000	174,300	50,400	85,300	-	47,200	19,200	-	-	-	6,000	10,600	200	274,095	-	75,700
Computer Services	490	290	-	-	200	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Honoraria	400	-	-	-	-	-	-	-	400	-	-	-	-	-	-	-	-	-	-
Miscellaneous Expense	5,364	-	-	-	5,364	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Allocation of Shared Costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Expenses	786,711	290	-	8,000	191,649	50,400	85,300	-	47,600	19,200	-	-	-	6,000	10,600	200	291,773	-	75,700
Change in Net Assets	130,289	1,710	-	32,000	(21,649)	(40,400)	(10,300)	-	(47,600)	(9,200)	-	-	-	(6,000)	(600)	(200)	208,227	-	24,300
Beginning Funds	187,864	2,474	2,500	-	5,573	19,371	77,950	17,500	(45,000)	(3,500)	233	10,614	2,000	11,200	(3,400)	21,600	68,750	-	-
Ending Funds	318,152	4,184	2,500	32,000	(16,076)	(21,029)	67,650	17,500	(92,600)	(12,700)	233	10,614	2,000	5,200	(4,000)	21,400	276,977	-	24,300

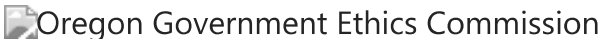
The Foundation for Medical Excellence
Statement of Financial Position
12/31/2023

Prepared by Susan Matlack Jones & Associates
From TFME Records/For TFME Use Only
Unaudited

	12/31/2023	12/31/2022	Change
Assets:			
Northwest Bank Checking	301,720	143,689	158,031
Paypal Account	20,668	9,570	11,098
Northwest Bank History of Medicine	46,461	46,322	139
Beneficial Interest in Assets Held by Oregon	79,397	76,127	3,270
J Bloom Life Insurance Policy	23,486	23,486	-
Schwab/General Account	2,589,111	2,631,388	(42,277)
Prepaid Expenses	1,514	1,514	-
Fixed Assets	17,083	17,083	-
Accumulated Depreciation	(17,083)	(17,083)	-
Total Assets	3,062,356	2,932,096	130,261
Liabilities:			
Accounts Payable	56,639	46,714	9,924
Total Liabilities	56,639	46,714	9,924
Net Assets:			
Net Assets Without Donor Restrictions:			
Unrestricted and Available for Operations	1,983,279	1,993,231	(9,952)
Oregon Wellness General Fund	4,184	2,474	1,710
OWP - COMS	2,500	2,500	-
OWP - Oregon Board of Dentistry	32,000	-	32,000
OWP - OMB	(16,076)	5,573	(21,649)
OWP - OHSU	(21,029)	19,371	(40,400)
OWP - Legacy	67,650	77,950	(10,300)
OWP - Research	17,500	17,500	-
OWP - Providence	(92,600)	(45,000)	(47,600)
OWP - Asante	(12,700)	(3,500)	(9,200)
OWP - PacificSource	233	233	-
OWP - IPA	10,614	10,614	-
OWP - Virginia Garcia	2,000	2,000	-
OWP - St. Charles	5,200	11,200	(6,000)
OWP - Permanente Dental	(4,000)	(3,400)	(600)
OWP - EOCCO	21,400	21,600	(200)
OWP - OSBN	276,977	68,750	208,227
OWP - CareOregon	24,300	-	24,300
Total Net Assets Without Donor Restrictions	2,301,431	2,181,095	120,336
Net Assets With Donor Restrictions:			
Soul of Medicine	131,683	131,683	-
TFME Scholarship Fund	436,253	436,253	-
Org. Professional Charter Grant	16,416	16,416	-
History of Medicine	41,224	41,224	-
Permanently Restricted	78,710	78,710	-
Total Net Assets With Donor Restrictions	704,287	704,287	-
Total Net Assets	3,005,718	2,885,381	120,336
Total Liabilities and Net Assets	3,062,356	2,932,096	130,261

Public Meetings Law Update: Advice

Oregon Government Ethics Commission - OGEC <OGEC@public.govdelivery.com>
Tue 3/26/2024 2:57 PM
To:PRISBY Stephen * OBD <stephen.prisby@OBD.oregon.gov>



March 26, 2024

Public Meetings Law Advice

The Oregon Government Ethics Commission (OGEC) now has statutory authority to provide advice and guidance on Public Meetings Law. The Governor signed HB 4117 on March 20, 2024, which went into immediate effect. This is in addition to OGEC's existing authority to provide advice and guidance on Oregon Government Ethics Law and Lobby Law.

OGEC can provide guidance on future or hypothetical events. The advice is provided in a variety of formats: Commission Advisory Opinion, Staff Advisory Opinion, Informational Letter of Advice, and Staff Advice. You can find out more information about the advice OGEC offers, request advice, and search previously issued advice on our website www.oregon.gov/ogec.

Advice Information

Oregon Government Ethics Commission
3218 Pringle Road SE, Suite 220
Salem, OR 97302
(503) 378-5105 | mail@ogec.oregon.gov | www.oregon.gov/OGEC

Enrolled
House Bill 4117

Sponsored by Representative SOSA, Senator CAMPOS, Representative NERON, Senator MANNING JR; Representatives FAHEY, HUDSON, Senator HAYDEN (Presession filed.)

CHAPTER .....

AN ACT

Relating to public meetings; creating new provisions; amending ORS 192.660, 244.280, 244.282 and 244.284; and declaring an emergency.

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

SECTION 1. Section 2 of this 2024 Act and ORS 192.672 are added to and made a part of ORS 192.610 to 192.705.

SECTION 2. Any person may submit to the Oregon Government Ethics Commission:

(1) A written request for the commission to issue and publish a commission advisory opinion under ORS 244.280 on the application of ORS 192.610 to 192.705 to any actual or hypothetical circumstance;

(2) A written request for the executive director of the Oregon Government Ethics Commission to issue and publish a staff advisory opinion under ORS 244.282 on the application of ORS 192.610 to 192.705 to any actual or hypothetical circumstance; or

(3) A written or oral request for the executive director or other staff of the commission to issue written or oral staff advice under ORS 244.284 on the application of ORS 192.610 to 192.705 to any actual or hypothetical circumstance.

SECTION 3. ORS 244.280 is amended to read:

244.280. (1) Upon the written request of any person, or upon its own motion, the Oregon Government Ethics Commission, under signature of the chairperson, may issue and publish written commission advisory opinions on the application of ORS [*192.660*] **192.610 to 192.705** or any provision of this chapter to any proposed transaction or action or any actual or hypothetical circumstance. A commission advisory opinion, and a decision by the commission to issue an advisory opinion on its own motion, must be approved by a majority of the members of the commission. Legal counsel to the commission shall review a proposed commission advisory opinion before the opinion is considered by the commission.

(2) Not later than 60 days after the date the commission receives the written request for a commission advisory opinion, the commission shall issue either the opinion or a written denial of the request. The written denial shall explain the reasons for the denial. The commission may ask the person requesting the advisory opinion to supply additional information the commission considers necessary to render the opinion. The commission, by vote of a majority of the members of the commission, may extend the 60-day deadline by one period not to exceed 60 days.

(3) Except as provided in this subsection, unless the commission advisory opinion is revised or revoked, the commission may not impose a penalty under ORS 244.350 or 244.360 on a person for any good faith action the person takes in reliance on an advisory opinion issued under this section.

The commission may impose a penalty under ORS 244.350 or 244.360 on the person who requested the advisory opinion if the commission determines that the person omitted or misstated material facts in making the request.

SECTION 4. ORS 244.282 is amended to read:

244.282. (1) Upon the written request of any person, the executive director of the Oregon Government Ethics Commission may issue and publish written staff advisory opinions on the application of ORS [*192.660*] **192.610 to 192.705** or any provision of this chapter to any proposed transaction or action or any actual or hypothetical circumstance.

(2) Not later than 30 days after the date the executive director receives the written request for a staff advisory opinion, the executive director shall issue either the opinion or a written denial of the request. The written denial shall explain the reasons for the denial. The executive director may ask the person requesting the advisory opinion to supply additional information the executive director considers necessary to render the opinion. The executive director may extend the 30-day deadline by one period not to exceed 30 days. The executive director shall clearly designate an opinion issued under this section as a staff advisory opinion.

(3)(a) Except as provided in paragraph (b) of this subsection, unless the staff advisory opinion is revised or revoked, the commission may only issue a written letter of reprimand, explanation or education for any good faith action a person takes in reliance on a staff advisory opinion issued under this section.

(b) The commission may impose, for an action that is subject to a penalty and that is taken in reliance on a staff advisory opinion issued under this section, a penalty under ORS 244.350 or 244.360 on the person who requested the opinion if the commission determines that the person omitted or misstated material facts in making the request.

(4) At each regular meeting of the commission, the executive director shall report to the commission on all staff advisory opinions issued since the last regular meeting of the commission. The commission on its own motion may issue a commission advisory opinion under ORS 244.280 on the same facts or circumstances that form the basis for any staff advisory opinion.

SECTION 5. ORS 244.284 is amended to read:

244.284. (1) Upon the written or oral request of any person, the executive director or other staff of the Oregon Government Ethics Commission may issue written or oral staff advice on the application of ORS [*192.660*] **192.610 to 192.705** or any provision of this chapter to any proposed transaction or action or any actual or hypothetical circumstance. Any written advice not designated as a staff advisory opinion under ORS 244.282 is considered staff advice issued under this section.

(2) Before imposing any penalty under ORS 244.350 or 244.360, the commission may consider whether the action that may be subject to penalty was taken in reliance on staff advice issued under this section.

SECTION 6. ORS 192.660 is amended to read:

192.660. (1) ORS 192.610 to 192.705 do not prevent the governing body of a public body from holding executive session during a regular, special or emergency meeting, after the presiding officer has identified the authorization under ORS 192.610 to 192.705 for holding the executive session.

(2) The governing body of a public body may hold an executive session:

(a) To consider the employment of a public officer, employee, staff member or individual agent.

(b) To consider the dismissal or disciplining of, or to hear complaints or charges brought against, a public officer, employee, staff member or individual agent who does not request an open hearing.

(c) To consider matters pertaining to the function of the medical staff of a public hospital licensed pursuant to ORS 441.015 to 441.119 and 441.993 including, but not limited to, all clinical committees, executive, credentials, utilization review, peer review committees and all other matters relating to medical competency in the hospital.

(d) To conduct deliberations with persons designated by the governing body to carry on labor negotiations.

(e) To conduct deliberations with persons designated by the governing body to negotiate real property transactions.

(f) To consider information or records that are exempt by law from public inspection.

(g) To consider preliminary negotiations involving matters of trade or commerce in which the governing body is in competition with governing bodies in other states or nations.

(h) To consult with counsel concerning the legal rights and duties of a public body with regard to current litigation or litigation likely to be filed.

(i) To review and evaluate the employment-related performance of the chief executive officer of any public body, a public officer, employee or staff member who does not request an open hearing.

(j) To carry on negotiations under ORS chapter 293 with private persons or businesses regarding proposed acquisition, exchange or liquidation of public investments.

(k) To consider matters relating to school safety or a plan that responds to safety threats made toward a school.

(L) If the governing body is a health professional regulatory board, to consider information obtained as part of an investigation of licensee or applicant conduct.

(m) If the governing body is the State Landscape Architect Board, or an advisory committee to the board, to consider information obtained as part of an investigation of registrant or applicant conduct.

(n) To discuss information about review or approval of programs relating to the security of any of the following:

(A) A nuclear-powered thermal power plant or nuclear installation.

(B) Transportation of radioactive material derived from or destined for a nuclear-fueled thermal power plant or nuclear installation.

(C) Generation, storage or conveyance of:

(i) Electricity;

(ii) Gas in liquefied or gaseous form;

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

(iv) Petroleum products;

(v) Sewage; or

(vi) Water.

(D) Telecommunication systems, including cellular, wireless or radio systems.

(E) Data transmissions by whatever means provided.

(o) To consider matters relating to the safety of the governing body and of public body staff and volunteers and the security of public body facilities and meeting spaces.

(p) To consider matters relating to cyber security infrastructure and responses to cyber security threats.

(3) Labor negotiations shall be conducted in open meetings unless negotiators for both sides request that negotiations be conducted in executive session. Labor negotiations conducted in executive session are not subject to the notification requirements of ORS 192.640.

(4) Representatives of the news media shall be allowed to attend executive sessions other than those held under subsection (2)(d) of this section relating to labor negotiations or executive session held pursuant to ORS 332.061 (2) but the governing body may require that specified information be undisclosed.

(5) When a governing body convenes an executive session under subsection (2)(h) of this section relating to conferring with counsel on current litigation or litigation likely to be filed, the governing body shall bar any member of the news media from attending the executive session if the member of the news media is a party to the litigation or is an employee, agent or contractor of a news media organization that is a party to the litigation.

(6) No executive session may be held for the purpose of taking any final action or making any final decision.

(7) The exception granted by subsection (2)(a) of this section does not apply to:

(a) The filling of a vacancy in an elective office.

(b) The filling of a vacancy on any public committee, commission or other advisory group.

(c) The consideration of general employment policies.

(d) The employment of the chief executive officer, other public officers, employees and staff members of a public body unless:

(A) The public body has advertised the vacancy;

(B) The public body has adopted regular hiring procedures;

(C) In the case of an officer, the public has had the opportunity to comment on the employment of the officer; and

(D) In the case of a chief executive officer, the governing body has adopted hiring standards, criteria and policy directives in meetings open to the public in which the public has had the opportunity to comment on the standards, criteria and policy directives.

(8) A governing body may not use an executive session for purposes of evaluating a chief executive officer or other officer, employee or staff member to conduct a general evaluation of an agency goal, objective or operation or any directive to personnel concerning agency goals, objectives, operations or programs.

(9) Notwithstanding subsections (2) and (6) of this section and ORS 192.650:

(a) ORS 676.175 governs the public disclosure of minutes, transcripts or recordings relating to the substance and disposition of licensee or applicant conduct investigated by a health professional regulatory board.

(b) ORS 671.338 governs the public disclosure of minutes, transcripts or recordings relating to the substance and disposition of registrant or applicant conduct investigated by the State Landscape Architect Board or an advisory committee to the board.

[*(10) Any person may submit to the Oregon Government Ethics Commission:*]

[*(a) A written request for the commission to issue and publish a commission advisory opinion under ORS 244.280 on the application of this section to any actual or hypothetical circumstance;*]

[*(b) A written request for the executive director of the Oregon Government Ethics Commission to issue and publish a staff advisory opinion under ORS 244.282 on the application of this section to any actual or hypothetical circumstance; or*]

[*(c) A written or oral request for the executive director or other staff of the commission to issue written or oral staff advice under ORS 244.284 on the application of this section to any actual or hypothetical circumstance.*]

[*(11)*] **(10)** Notwithstanding ORS 244.290, the Oregon Government Ethics Commission may not adopt rules that establish what entities are considered representatives of the news media that are entitled to attend executive sessions under subsection (4) of this section.

SECTION 7. This 2024 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2024 Act takes effect on its passage.

Passed by House February 15, 2024

.....
Timothy G. Sekerak, Chief Clerk of House

.....
Dan Rayfield, Speaker of House

Passed by Senate March 4, 2024

.....
Rob Wagner, President of Senate

Received by Governor:

.....M.,....., 2024

Approved:

.....M.,....., 2024

.....
Tina Kotek, Governor

Filed in Office of Secretary of State:

.....M.,....., 2024

.....
LaVonne Griffin-Valade, Secretary of State

Oregon
Tina Kotek, Governor

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

DATE: April 16, 2024

TO: OBD Board Members

FROM: OBD Executive Director, Stephen Prisby

SUBJECT: Election of Officers

Annually at every April Board Meeting you are directed to elect a new President, and historically also have elected a Vice-President. Point of reference, in recent modern times you have chosen the officers based on seniority.

ORS 679.250 Powers and duties of board; rules. The powers and duties of the Oregon Board of Dentistry are as follows: (1) To, during the month of April of each year, organize and elect from its membership a president who shall hold office for one year, or until the election and qualification of a successor.

One of the President's duties is to select the Chairs of the OBD's Committees. I have emailed you a survey so you can share your preferences for what Committees you have an interest in chairing or being a member on. I have also reached out to the three professional associations and representatives of the Dental Therapy Community for names as well. The new committee assignments will be shared after they are finalized with our new President. The new assignments would cover the May 2024 - April 2025 timeframe.

NEWSLETTERS & ARTICLES OF INTEREST

Dental Assisting Professional Model Workgroup to hold first meeting

February 13, 2024

A group of nearly 20 dental professionals representing numerous leading dental organizations have joined together to form the Dental Assisting Professional Model Workgroup, which will hold its first meeting later this month.

Dentistry is experiencing significant challenges related to the dental assisting workforce, including insufficient numbers of qualified dental assistants, which has resulted in dental practices facing reduced capacity, efficiency, and productivity. The goal of the workgroup is to address a fundamental element underlying these challenges — the inconsistency in dental assisting requirements and scope of practice from state to state.

“State definitions of dental assistants’ scopes of practice and exam, education, and credential requirements shape the careers of dental assistants,” said Katherine Landsberg, DANB’s Director of Government Relations. “Because these elements vary significantly from state to state, there is no shared national understanding of what dental assistants do and how they can advance, which makes it difficult to attract and retain candidates looking for a long-term career. The workgroup will lay the foundation for solutions that will support dental assistant workforce recruitment, retention, development and progression, while also enhancing patient care and public protection.”

The workgroup will develop a framework that aims to:

- Elevate the dental assisting profession and attract more candidates to the field
- Provide a road map for career growth that will support recruitment and retention of dental assistants over the long term
- Improve professional mobility of dental assistants from state to state
- Increase practice efficiency and enhance access to care
- Provide states with a straightforward framework for regulation that reflects the needs of dentistry

The framework will contain definitions of dental assisting levels and scope of duties, proposed standards for the education and training of dental assistants, model legislation and regulations that can serve as a template for state legislators and regulators, and guidance and resources for implementation.

The workgroup includes dental assistants, dentists, educators, dental hygienists, and regulators. Members of the workgroup were nominated by these organizations:

- American Dental Association
- American Association of Dental Administrators
- American Association of Dental Boards
- American Dental Assistants Association
- American Dental Education Association
- American Dental Hygienists' Association
- Association of Dental Support Organizations
- Dental Assisting National Board
- The DALE Foundation
- Hispanic Dental Association
- National Network for Oral Health Access

"By bringing together a diverse and comprehensive array of perspectives and expertise, the workgroup will be positioned to develop a framework that not only reflects the dynamic nature of dental assisting, but also aligns with the evolving needs of the oral healthcare profession," Landsberg added.

Prior to forming the workgroup, which will be led by third-party facilitators, DANB commissioned a series of listening sessions and surveys to better understand the dental industry's perspectives on

the current landscape of dental assisting laws, regulations, and scope of practice. The results of these surveys will be released in the coming weeks on DANB's website.

Have questions or need assistance?

Give us a call or send us an email to let us know how we can help.

Need a form? View all forms.

CONTACT US

Support

444 N. Michigan Ave., Suite 900

Chicago, IL 60611

Representatives are available M-F,

8:00 a.m. to 4:30 p.m. CT.

Email Us

800-367-3262

CHAT

Exams

Apply for Exams
Prepare for Exams
Online Proctored Exams
Test Center Exams
State Exams
Digital Badges
For Educators
Exams in Spanish

Forms and Policies
Volunteer

Certification

Earn Certification
Maintain Certification
Renew Certification
CPR Providers
Which Certification Is Right For You?

Career Resources

Become a Dental Assistant
Become an EFDA
Salary and Career Report
Dental Assistant Salary
Dental Assistant Jobs
Search Dental Assistant Schools
Selecting a Dental Assisting School
Scholarships

State Requirements

News & Blog

View News & Blog
Certified Press Newsletter
Credential Verification

About DANB

Forms and Policies

Reports

Privacy Policy

Terms & Conditions

Sitemap

CHAT

LICENSE RATIFICATION

RATIFICATION OF LICENSES

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

DENTAL HYGIENISTS

H8765	VANDOMELEN, HANNAH	02/06/2024	RDH
H8766	RIEKE MARTINEZ, PHARADEE	02/06/2024	RDH
H8767	REDDY, BRANDON	02/07/2024	RDH
H8768	PEREZ, CEDAR	02/07/2024	RDH
H8769	NGOC DO, STEPHANIE	02/09/2024	RDH
H8770	GODOY, ALEXIS JULIANA	02/14/2024	RDH
H8771	WARNINGHOFF, ALYSSA JEANNE	02/29/2024	RDH
H8772	MERRILL, JENNIFER	03/04/2024	RDH
H8773	MCCOURT, ROBIN	03/04/2024	RDH
H8774	RUTHERFORD, ASHLEY	03/13/2024	RDH
H8775	ZELLER, HOLLYCE	03/25/2024	RDH
H8776	HEBERT, NICO	03/28/2024	RDH
H8777	EGGERS, SYDNEY MICHELLE	03/28/2024	RDH
H8778	BLUEMMEL, MADELYNE	03/29/2024	RDH
H8779	CASTAING, SYDNEY	03/29/2024	RDH
H8780	CORSINI, BRITNEY	03/29/2024	RDH
H8781	MOREMAN, AMBER	04/03/2024	RDH
H8782	MATHEWS, SARAH	04/03/2024	RDH
H8783	GAMBOA, MIA	04/03/2024	RDH
H8784	OAKS, JESSICA	04/03/2024	RDH
H8785	STRAND, DENISE	04/03/2024	RDH
H8786	DAUPHINAIS, CARLIANNE	04/03/2024	RDH
H8787	FAIRCHILD, MICHELLE	04/03/2024	RDH
H8788	LOPEZ, ISABEL	04/03/2024	RDH
H8789	HENSON, ELLEE	04/03/2024	RDH
H8790	RIVAS, REBECA	04/03/2024	RDH
H8791	WALTER, JORDAN	04/03/2024	RDH
H8792	WOLF, JESSICA	04/03/2024	RDH
H8793	COWAN, COURTNEY	04/03/2024	RDH
H8794	PETERSON, MACIE	04/03/2024	RDH
H8795	O'SULLIVAN, CHASE	04/05/2024	RDH
H8796	SEEGRAVES, ERIN	04/05/2024	RDH
H8797	WILSON, ABIGAYLE	04/05/2024	RDH
H8798	CANENGUEZ, JENIFER	04/08/2024	RDH
H8799	NAGODE, KYLI	04/08/2024	RDH

H8800	WILSON, ANGELI	04/09/2024	RDH
H8801	BUTSCH, CATHERINE	04/09/2024	RDH
H8802	LEE, JUHEE	04/10/2024	RDH
H8803	COLLINS, KELSIE	04/10/2024	RDH
H8804	MOY, DAPHNE	04/10/2024	RDH
H8805	VIERIA, TRISHA	04/10/2024	RDH
H8806	DUFFY, SYONA	04/16/2024	RDH
H8807	BAKER, ANA	04/16/2024	RDH
H8808	LINDSEY, KAELA	04/16/2024	RDH
H8809	RECENDIZ, DAHLIA	04/16/2024	RDH
H8810	MULL, KYRA	04/16/2024	RDH
H8811	CRISOSTOMO, MERCY	04/16/2024	RDH
H8812	CANENGUEZ, JASMIN	04/16/2024	RDH
H8813	MORLAN, LISA	04/16/2024	RDH

DENTISTS

D11939	HEARN, GRAHAM	02/06/2024	DDS
D11940	NOOMEN, MELANIE JILL	02/06/2024	DMD
D11941	LLOYD, ADAM	02/06/2024	
D11942	FISSELIER, FRANCOIS-MARIE ALAIN PAUL	02/08/2024	DMD
D11943	LIM, ALICE	02/13/2024	DDS
D11944	ARAKAKI, ISAAC ANDREW	02/13/2024	DDS
D11945	FAGAN, SUSAN MILLIE	02/14/2024	DDS
D11946	SARRAMI, SHAYDA	02/22/2024	DDS
D11947	SHORT, JEFFREY ALLEN	03/04/2024	DDS
D11948	KOSA, DAVID A	03/07/2024	DDS
D11949	SEYDEL, ANNA LAURA	03/07/2024	DDS
D11950	SCHULTE, CONRAD MAX	03/08/2024	DMD
D11951	LIM, JANNY	03/11/2024	DDS
D11952	YANG, FEI	03/13/2024	DMD
D11953	OBASEKI, JOSEPHINE	03/13/2024	DDS
D11954	BHANDARI, ASHISH	03/13/2024	DMD
D11955	PETERSON, JANELLE CHRISTINE	03/20/2024	DDS
D11956	SRIVASTAVA, PRIYANKA	03/21/2024	DDS
D11957	PENG, LIN	04/03/2024	DMD
D11958	KRIEGER, AMANDA	04/09/2024	DDS
D11959	MICHAEL, MARINA	04/10/2024	DDS
D11960	ABDULLAH, SAMMY	04/16/2024	DDS
D11961	HAN. YIXUE	04/16/2024	DDS
D11962	ALLERT, DEVEN	04/16/2024	DMD
D11963	NGUYEN, JOHLASON	04/17/2024	DMD
D11964	MARTIN, ADAM	04/17/2024	DDS

DENTAL THERAPISTS

DT0020	JONES, ALEXANDRIA	03/21/2024	DT

LICENSE, PERMIT & CERTIFICATION

Nothing to report under this tab