PUBLIC PACKET

OREGON BOARD OF DENTISTRY

BOARD MEETING
AUGUST 25, 2023

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: **VIRTUAL & VIA ZOOM**

DATE: **August 25, 2023**

TIME: **8:00 a.m. – 1:30 p.m.**

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

OPEN SESSION (Zoom option available)
https://us02web.zoom.us/j/89050344472?pwd=U0lPVFhMQ1FkQm1WR05qQTVLd0lHUT09
Dial-In Phone #: 1-253-215-8782 ● Meeting ID: 890 5034 4472 ● Passcode: 553303

Review Agenda

1. Approval of Minutes
   - June 16, 2023 Board Meeting Minutes

NEW BUSINESS

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

3. Committee and Liaison Reports
   - Licensing, Standards and Competency Committee Meeting 7/12/2023, Chair Dunn
   - Draft Minutes – Action Requested
     - ODA: Dental Assistants Performing Local Anesthesia Letter
     - Oregon Society of Anesthesiologists: Dental Assistants Performing Local Anesthesia Letter
   - Draft - New Advisory Committee to be established – Action Requested
     - HB 3223
     - Document – DAWSAC
   - American Board of Dental Examiners (ADEX) 2023 Meeting
     - Report provided by Dr. Patricia Parker
   - Committee & Liaison Assignments

4 Executive Director's Report
   - Board Member and Staff Updates
   - OBD Budget Status Report
   - OBD 2023- 2025 Budget
   - Customer Service Survey – FY 2023 Results
   - Staff Speaking Engagements
   - Dental Hygiene License Renewal
   - Agency Head Financial Transactions Report July 1, 2022 – June 30, 2023
   - Tri Met 2023-2024 Contract
   - OBD Draft DEI Policy
   - OBD 2022-2025 Strategic Plan Summary of Work

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.

- Board Best Practices Self-Assessment & Score Card
- 2023 Legislative Session
- AADA & AADB Annual Meetings
- OBD Newsletter

5. Unfinished Business and Rules
   - Memo - Review and establish Oregon Wellness Program relationship with OBD
     - Overview of OWP with Timothy Goldfarb – Q & A
     - MOA for review and Board approval
   - Sec of State Filing - the Board amended 13 rules, repealing 3 rules and creating 1 new rule.- effective July 1, 2023
   - Sec of State Filing – the Board amended the fee rule, incorporating the fee increases effective August 1, 2023
   - Memo – Proposed Public Rulemaking Hearing to make Temporary Rule Permanent
   - Memo – Review OBD-DANB Agreement and proposed amendment
   - Updated Board Protocols

6. Correspondence
   - Request from Paula Hendrix, RDH to be a test examiner for CRDTS
   - Letter from American Academy of Dental Sleep Medicine – New Models of OSA Treatment
   - ODA and ODHA Addresses Concerns Regarding Mental Health Questions
     - OMB Adopting Mental Health Attestation Model for Licensure and Renewal Applications
     - OBD Initial Application and Renewal Example
     - APA calls for removal of mental health questions on applications to practice law
7. Other
   - OHA update from Sarah Kowalski, Dental Pilot Projects: Oral Health Program
     - DPP #100 Closing Report Letter and Advisory Committee Conclusion
   - Tribes
     - OBD Tribal Relationship & Cooperation Policy
     - HB 3173 (2023) Task Force on Tribal Consultation
   - Other Public Comment

8. Articles & Newsletters (No Action Necessary)
   - CRDTS Newsletter
   - DANB State Updates for Dental Assistants
   - SmileDirectClub to release customers from NDAs in settlement
   - ADA Evidence-based clinical practice guideline on restorative treatments for caries lesions
   - OBD Summer Newsletter

EXECUTIVE SESSION **10:30 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. The Board will also meet in Executive Session pursuant to ORS 192.660(2)(i), to conduct the annual review and performance evaluation of the Executive Director. 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

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LUNCH **11:30 a.m.**

OPEN SESSION (Zoom option available) **1:00 p.m.**
https://us02web.zoom.us/j/89050344472?pwd=U0lPVFhMQ1FkQm1WR05qQTVLd0lHUT09
Dial-In Phone #: 1-253-215-8782 ● Meeting ID: 890 5034 4472 ● Passcode: 553303

Enforcement Actions (vote on cases reviewed in Executive Session)
LICENSURE AND EXAMINATION
16. Ratification of Licenses Issued
17. License and Examination Issues

Performance Review Executive Director
18. Conduct performance evaluation of Executive Director

ADJOURN **1:30 p.m.**

Notes:
(1) A working lunch will be served for Board members at approximately 11:30 a.m.
(2) The meeting location is accessible to persons with disabilities. A request for an interpreter for the hearing impaired or for other accommodations for persons with disabilities should be made at least 48 hours before the meeting to Haley Robinson at (971) 673-3200.
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APPROVAL OF MINUTES

DRAFT

OREGON BOARD OF DENTISTRY
MINUTES
JUNE 16, 2023

MEMBERS PRESENT:	Chip Dunn, President Jennifer Brixey, Vice President Alicia Riedman, R.D.H., E.P.P. Reza Sharifi, D.M.D. Sheena Kansal, D.D.S. Aarati Kalluri, D.D.S. Jose Javier, D.D.S. Terrence Clark, D.M.D. Sharity Ludwig, R.D.H., E.P.P.
STAFF PRESENT:	Stephen Prisby, Executive Director Winthrop "Bernie" Carter, D.D.S., Dental Director/ Chief Investigator Angela Smorra, D.M.D., Dental Investigator Haley Robinson, Office Manager (portion of meeting) Samantha VandeBerg, Examination and Licensing Manager (portion of meeting) Ingrid Nye, Investigator (portion of the meeting) Kathleen McNeal, Office Specialist (portion of the meeting) Teresa Haynes, Project Manager (portion of the meeting)
ALSO PRESENT:	Lori Lindley, Sr. Assistant Attorney General
VISITORS PRESENT:	Ronald Sakaguchi, D.D.S., M.S., PhD, M.B.A, OSHU School of Dentistry Dean; Mary Harrison, Oregon Dental Assistants Association; Ginny Jorgensen, Oregon Dental Assistants Association
VIA TELECONFERENCE*:	Olesya Salathe, D.M.D., Oregon Dental Association (ODA); Jen Lewis-Goff, ODA; Lisa Rowley, Oregon Dental Hygienist Association (ODHA); Karen Hall, ODHA; Jen Hawley-Price, DALE Foundation; Katherine Landsberg, Dental Assisting National Board; Katy Adishian, ODA, Teresa Haynes

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

Call to Order: The meeting was called to order by the President at 8:00 a.m. at the Board office; 1500 SW 1st Ave., Suite 770, Portland, Oregon.

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

NEW BUSINESS

Approval of Minutes

Dr. Sharifi moved and Ms. Ludwig seconded that the Board approve the minutes from the April 28, 2023 Board Meeting as presented. The motion passed unanimously.

ASSOCIATION REPORTS

Oregon Dental Association (ODA)

Dr. Olesya Salathe reported that the ODA is continuing to work on advancing legislative initiatives. The ODA is advocating for 20 million dollars to shore up the dental workforce shortage with HB 2979.

Oregon Dental Hygienists' Association (ODHA)

Karen Hall announced a September 9, 2023 Medical Emergencies Nitrous Oxide course with Dr. Beadnell. More information will be posted in the ODHA July newsletter.

Oregon Dental Assistants Association (ODAA)

Mary Harrison noted that this graduation season saw 'lots' of dental assistants pass their exams. Ms. Harrison added that the ODAA is proud of the time and work they put in at Salem. The ODAA is excited that their input was heard and that it affected some of the amendments to the bills in the legislature.

OHSU School of Dentistry

Special guest Dean of OHSU SOD, Ronald Sakaguchi, D.D.S., M.S., PhD, M.B.A. gave an overview on the School of Dentistry and its work and recent achievements.

COMMITTEE AND LIAISON REPORTS

The updated Committee and Liaison Assignments document was presented.

A memo acknowledged that there was been no feedback or comments received on the May 10, 2023 Public Rulemaking Hearing. Mr. Prisby also reported that no other comments were received on the 17 proposed rule changes.

Dr. Kansal moved and Dr. Sharifi seconded that the Board approve the 17 rule changes and make them permanent on July 1, 2023. The motion passed unanimously.

818-001-0002
Definitions
As used in OAR chapter 818:
(1) "Board" means the Oregon Board of Dentistry, the members of the Board, its employees, its agents, and its consultants.
(2) "Dental Practice Act" means ORS Chapter 679 and 680.010 to 680.170 and the rules adopted pursuant thereto.
(3) "Dentist" means a person licensed pursuant to ORS Chapter 679 to practice dentistry.
(4) "Dental Hygienist" means a person licensed pursuant to ORS 680.010 to 680.210 to practice dental hygiene.
(5) "Dental Therapist" means a person licensed to practice dental therapy under ORS 679.603.
(6) "Dental Therapy" means the provision of preventative dental care, restorative dental treatment and other educational, clinical and therapeutic patient services as part of a dental care team, including the services described under ORS 679.621.

(7) "Direct Supervision" means supervision requiring 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.
(8) "General Supervision" means supervision requiring 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.
(9) "Indirect Supervision" means supervision requiring that a dentist authorize the procedures and that a dentist be on the premises while the procedures are performed.
(10) "Informed Consent" means the consent obtained following a thorough and easily understood explanation to the patient, or patient's guardian, of the proposed procedures, any available alternative procedures and any risks associated with the procedures. Following the explanation, the licensee shall ask the patient, or the patient's guardian, if there are any questions. The licensee shall provide thorough and easily understood answers to all questions asked.
(11) "Licensee" means a dentist, hygienist or dental therapist.
(12) “Volunteer Licensee” is a dentist, hygienist or dental therapist licensed according to rule to provide
dental health care without receiving or expecting to receive compensation.
(13) "Limited Access Patient" means a patient who, due to age, infirmity, or handicap is unable to receive regular dental hygiene treatment in a dental office.
(14) "Specialty." The specialty definitions are added to more clearly define the scope of the practice as it pertains to the specialty areas of dentistry.
(a) “Dental Anesthesiology” is the specialty of dentistry that deals with the management of pain through the use of advanced local and general anesthesia techniques.
(b) "Dental Public Health" is the science and art of preventing and controlling dental diseases and promoting dental health through organized community efforts. It is that form of dental practice which serves the community as a patient rather than the individual. It is concerned with the dental health education of the public, with applied dental research, and with the administration of group dental care programs as well as the prevention and control of dental diseases on a community basis.
(c) "Endodontics" is the specialty of dentistry which is concerned with the morphology, physiology and pathology of the human dental pulp and periradicular tissues. Its study and practice encompass the basic and clinical sciences including biology of the normal pulp, the etiology, diagnosis, prevention and treatment of diseases and injuries of the pulp and associated periradicular conditions.
(d) "Oral and Maxillofacial Pathology" is the specialty of dentistry and discipline of pathology that deals with the nature, identification, and management of diseases affecting the oral and maxillofacial regions. It is a science that investigates the causes, processes, and effects of these diseases. The practice of oral pathology includes research and diagnosis of diseases using clinical, radiographic, microscopic, biochemical, or other examinations.
(e) “Oral and Maxillofacial Radiology” is the specialty of dentistry and discipline of radiology concerned with the production and interpretation of images and data produced by all modalities of radiant energy that are used for the diagnosis and management of diseases, disorders and conditions of the oral and maxillofacial region.
(f) "Oral and Maxillofacial Surgery" is the specialty of dentistry which includes the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region.

(g) "Oral Medicine" is the specialty of dentistry responsible for the oral health care of medically complex patients and for the diagnosis and management of medically-related diseases, disorders and conditions affecting the oral and maxillofacial region.
(h) "Orofacial Pain" Orofacial Pain is the specialty of dentistry that encompasses the diagnosis, management and treatment of pain disorders of the jaw, mouth, face, head and neck. The specialty of Orofacial Pain is dedicated to the evidenced-based understanding of the underlying pathophysiology, etiology, prevention, and treatment of these disorders and improving access to interdisciplinary patient care.
(i) "Orthodontics and Dentofacial Orthopedics" is the specialty of dentistry concerned with the supervision, guidance and correction of the growing or mature dentofacial structures, including those conditions that require movement of teeth or correction of malrelationships and malformations of their related structures and the adjustment of relationships between and among teeth and facial bones by the application of forces and/or the stimulation and redirection of functional forces within the craniofacial complex. Major responsibilities of orthodontic practice include the diagnosis, prevention, interception and treatment of all forms of malocclusion of the teeth and associated alterations in their surrounding structures; the design, application and control of functional and corrective appliances; and the guidance of the dentition and its supporting structures to attain and maintain optimum occlusal relations in physiologic and esthetic harmony among facial and cranial structures.
(j) "Pediatric Dentistry" is an age defined specialty that provides both primary and comprehensive preventive and therapeutic oral health care for infants and children through adolescence, including those with special health care needs.
(k) "Periodontics" is the specialty of dentistry which encompasses the prevention, diagnosis and treatment of diseases of the supporting and surrounding tissues of the teeth or their substitutes and the maintenance of the health, function and esthetics of these structures and tissues.
(l) "Prosthodontics" is the specialty of dentistry pertaining to the restoration and maintenance of oral functions, comfort, appearance and health of the patient by the restoration of natural teeth and/or the replacement of missing teeth and contiguous oral and maxillofacial tissues with artificial substitutes.
(15) “Full-time” as used in ORS 679.025 and 680.020 is defined by the Board as any student who is enrolled in an institution accredited by the Commission on Dental Accreditation of the American Dental Association or its successor agency in a course of study for dentistry, dental hygiene or dental therapy.
(16) For purposes of ORS 679.020(4)(h) the term “dentist of record” means a dentist that either authorized treatment for, supervised treatment of or provided treatment for the patient in clinical settings of the institution described in 679.020(3).
(17) “Dental Study Group” as used in ORS 679.050, OAR 818-021-0060 and OAR 818-021-0070 is defined as a group of licensees who come together for clinical and non-clinical educational study for the purpose of maintaining or increasing their competence. This is not meant to be a replacement for residency requirements.
(18) “Physical Harm” as used in OAR 818-001-0083(2) is defined as any physical injury that caused, partial or total physical disability, incapacity or disfigurement. In no event shall physical harm include mental pain, anguish, or suffering, or fear of injury.
(19) “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.
(20) “BLS for Healthcare Providers or its Equivalent” the BLS/CPR certification standard is the American Heart Association’s BLS Healthcare Providers Course or its equivalent, as determined by the Board. This initial BLS/CPR course must be a hands-on course; online BLS/CPR courses

will not be approved by the Board for initial BLS/CPR certification: After the initial BLS/CPR certification, the Board will accept a Board-approved BLS for Healthcare Providers or its equivalent Online Renewal course for license renewal. A BLS/CPR certification card with an expiration date must be received from the BLS/CPR provider as documentation of BLS/CPR certification. The Board considers the BLS/CPR expiration date to be the last day of the month that the BLS/CPR instructor indicates that the certification expires.

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 and dermal fillers to treat a condition**s** that is **are** within the **oral and maxillofacial region** scope of the practice of dentistry after completing a minimum of **10** 20 hours in a hands on clinical course(s), which includes both **in** Botulinum Toxin Type A and 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 (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 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 **a Commission on Dental Accreditation (CODA) accredited graduate 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 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 July 1, 2022 **January 1, 2024**).

818-012-0007
Procedures, Record Keeping and Reporting of Vaccines
(1) Prior to administering a vaccine to a patient of record, the dentist must follow the "Model Standing Orders" approved by the Oregon Health Authority (OHA) for administration of vaccines and the treatment of severe adverse events following administration of a vaccine.
(2) The dentist must maintain written policies and procedures for handling and disposal of used or contaminated equipment and supplies.
(3) The dentist or designated staff must give the appropriate Vaccine Information Statement (VIS) to the patient or legal representative with each dose of vaccine covered by these forms. The dentist or designated must ensure that the patient or legal representative is available and has read, or has had read to them, the information provided and has had their questions answered prior to the dentist administering the vaccine. The VIS given to the patient must be the most current statement.
(4) The dentist or designated staff must document in the patient record:
(a) The date and site of the administration of the vaccine;
(b) The brand name, or NDC number, or other acceptable standardized vaccine code set, dose, manufacturer, lot number, and expiration date of the vaccine;
(c) The name or identifiable initials of the administering dentist;
(d) The address of the office where the vaccine(s) was administered unless automatically embedded in the electronic report provided to the OHA ALERT Immunization System;
(e) The date of publication of the VIS; and
(f) The date the VIS was provided and the date when the VIS was published.
(5) If providing state or federal vaccines, the vaccine eligibility code as specified by the OHA must be reported to the ALERT system.
(6) A dentist who administers any vaccine must report, the elements of Section (3), and Section (4) of this rule if applicable, to the OHA ALERT Immunization System within 14 days of administration.
(7) The dentist must report adverse events as required by the Vaccine Adverse Events Reporting System (VAERS), to the Oregon Board of Dentistry within 10 business days and to the primary care provider as identified by the patient.
(8) A dentist who administers any vaccine will follow storage and handling guidance from the vaccine manufacturer and the Centers for Disease Control and Prevention (CDC).
(9) Dentists who do not follow this rule can be subject to discipline for failure to adhere to these requirements.

818-012-0030
Unprofessional Conduct

The Board finds that in addition to the conduct set forth in ORS 679.140(2), unprofessional conduct includes, but is not limited to, the following in which a licensee does or knowingly permits any person to:
(1) Attempt to obtain a fee by fraud, or misrepresentation.
(2) Obtain a fee by fraud, or misrepresentation.
(a) A licensee obtains a fee by fraud if the licensee knowingly makes, or permits any person to make, a material, false statement intending that a recipient, who is unaware of the truth, rely upon the statement.
(b) A licensee obtains a fee by misrepresentation if the licensee obtains a fee through making or permitting any person to make a material, false statement.
(c) Giving cash discounts and not disclosing them to third party payers is not fraud or misrepresentation.
(3) Offer rebates, split fees, or commissions for services rendered to a patient to any person other than a partner, employee, or employer.
(4) Accept rebates, split fees, or commissions for services rendered to a patient from any person other than a partner, employee, or employer.
(5) Initiate, or engage in, with a patient, any behavior with sexual connotations. The behavior can include but is not limited to, inappropriate physical touching; kissing of a sexual nature; gestures or expressions, any of which are sexualized or sexually demeaning to a patient; inappropriate procedures, including, but not limited to, disrobing and draping practices that reflect a lack of respect for the patient's privacy; or initiating inappropriate communication, verbal or written, including, but not limited to, references to a patient's body or clothing that are sexualized or sexually demeaning to a patient; and inappropriate comments or queries about the professional's or patient's sexual orientation, sexual performance, sexual fantasies, sexual problems, or sexual preferences.
(6) Engage in an unlawful trade practice as defined in ORS 646.605 to 646.608.
(7) Fail to present a treatment plan with estimated costs to a patient upon request of the patient or to a patient's guardian upon request of the patient's guardian.
(8) Misrepresent any facts to a patient concerning treatment or fees.
(9)(a) Fail to **release patient records pursuant to OAR 818-012-0032.** provide a patient or patient's guardian within 14 days of written request:
(A) Legible copies of records; and
(B) Duplicates of study models, radiographs of the same quality as the originals, and photographs if they have been paid for.
(b) The licensee may require the patient or guardian to pay in advance a fee reasonably calculated to cover the costs of making the copies or duplicates. The licensee may charge a fee not to exceed $30 for copying 10 or fewer pages of written material and no more than $0.50 per page for pages 11 through 50 and no more than $0.25 for each additional page (including records copied from microfilm), plus any postage costs to mail copies requested and actual costs of preparing an explanation or summary of information, if requested. The actual cost of duplicating radiographs may also be charged to the patient. Patient records or summaries may not be withheld from the patient because of any prior unpaid bills, except as provided in (9)(a)(B) of this rule.
(10) Fail to identify to a patient, patient's guardian, or the Board the name of an employee, employer, contractor, or agent who renders services.
(11) Use prescription forms pre-printed with any Drug Enforcement Administration number, name of controlled substances, or facsimile of a signature.
(12) Use a rubber stamp or like device to reproduce a signature on a prescription form or sign a blank prescription form.

(13) Order drugs listed on Schedule II of the Drug Abuse Prevention and Control Act, 21 U.S.C. Sec. 812, for office use on a prescription form.
(14) Violate any Federal or State law regarding controlled substances.
(15) Becomes addicted to, or dependent upon, or abuses alcohol, illegal or controlled drugs, or mind altering substances, or practice with an untreated substance use disorder diagnosis that renders the licensee unable to safely conduct the practice of dentistry, dental hygiene or dental therapy.
(16) Practice dentistry, dental hygiene or dental therapy in a dental office or clinic not owned by an Oregon licensed dentist(s), except for an entity described under ORS 679.020(3) and dental hygienists practicing pursuant to ORS 680.205(1)(2).
(17) Make an agreement with a patient or person, or any person or entity representing patients or persons, or provide any form of consideration that would prohibit, restrict, discourage or otherwise limit a person's ability to file a complaint with the Oregon Board of Dentistry; to truthfully and fully answer any questions posed by an agent or representative of the Board; or to participate as a witness in a Board proceeding.
(18) Fail to maintain at a minimum a current BLS for Healthcare Providers certificate or its equivalent.
(19) Conduct unbecoming a licensee or detrimental to the best interests of the public, including conduct contrary to the recognized standards of ethics of the licensee's profession or conduct that endangers the health, safety or welfare of a patient or the public.
(20) Knowingly deceiving or attempting to deceive the Board, an employee of the Board, or an agent of the Board in any application or renewal, or in reference to any matter under investigation by the Board. This includes but is not limited to the omission, alteration or destruction of any record in order to obstruct or delay an investigation by the Board, or to omit, alter or falsify any information in patient or business records.
(21) Knowingly practicing with a physical or mental impairment that renders the Licensee unable to safely conduct the practice of dentistry, dental hygiene or dental therapy.
(22) Take any action which could reasonably be interpreted to constitute harassment or retaliation towards a person whom the licensee believes to be a complainant or witness.
(23) Fail to register with the Prescription Drug Monitoring Program (PDMP) in order to have access to the Program's electronic system if the Licensee holds a Federal Drug Enforcement Administration registration.
(24) Fail to comply with ORS 413.550-413.558, regarding health care interpreters.

818-012-0032
Diagnostic Records
(1) Licensees shall provide duplicates of physical diagnostic records that have been paid for to patient or patient's guardian within 14 calendar days of receipt of written request.
(A) **(a)** Physical records include**:**
(A) Legible copies of paper charting and chart notes, and;
(B) Duplicates of silver emulsion radiographs **of the same quality as the originals**, **duplicates of** physical study models, paper charting and chart notes, **and photographs if they have been paid for**.
(B) **(b)** Licensees may require the patient or patient's guardian to pay in advance the fee reasonably
calculated to cover costs of making the copies or duplicates.
(1) **(2)** Licensee may charge a fee not to exceed $30 for copying 10 or fewer pages of written material and no more than $0.50 per page for 11-50 and no more than $0.25 for each additional page, including cost of microfilm plus any postage costs to mail copies requested and actual

costs of preparing an explanation or summary of information, if requested. The actual costs of duplicating radiographs may also be charged to the patient.
(2) **(3)** Licensees shall provide duplicates of digital patient records within 14 calendar days of receipt of written request by the patient or patient's guardian.
(A) **(a)** Digital records include any patient diagnostic image, study model, test result or chart record in digital form.
(B) **(b)** Licensees may require the patient or patient's guardian to pay for the typical retail cost of the digital storage device, such as a CD, thumb drive, or DVD as well as associated postage.
(C) **(c)** Licensees shall not charge any patient or patient's guardian to transmit requested digital records over email if total records do not exceed 25 Mb.
(D) A clinical day is defined as a day during which the dental clinic treated scheduled patients.
(E) **(d)** Licensees may charge up to $5 for duplication of digital records up to 25Mb and up to $30 for more than 25Mb.
(F) **(e)** Any transmission of patient records shall be in compliance with the Health Insurance Portability and Accountability Act (HIPAA Act) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act).
(G) **(f)** Duplicated digital records shall be of the same quality as the original digital file.
(3) **(4)** If a records summary is requested by patient or patient's guardian, the actual cost of creating this summary and its transmittal may be billed to the patient or patient's guardian.
(5) Patient records or summaries may not be withheld from the patient because of any prior unpaid bills, except as provided in (1)(a)(B) of this rule.

818-015-0005
General Provisions
(1) "To advertise" means to publicly communicate information about a licensee's professional services or qualifications for the purpose of soliciting business.
(2) Advertising shall not be false, deceptive, misleading or not readily subject to verification and shall not make claims of professional superiority which cannot be substantiated by the licensee, who shall have the burden of proof.
(3) Advertising shall not make a representation that is misleading as to the credentials, education, or the licensing status of a licensee. Licensee may not claim a degree, credential, or distinction granted by a professional organization or institution of higher learning that has not been earned.
(**4**3) A licensee who authorizes another to disseminate information about the licensee's professional services to the public is responsible for the content of that information unless the licensee can prove by clear and convincing evidence that the content of the advertisement is contrary to the licensee's specific directions.
(5) A dentist shall adhere to the Doctors' Title Act, ORS 676.110 (Use of title "doctor")

818-015-0007
Specialty Advertising
(1) A dentist may only advertise as a specialist in an area of dentistry which is recognized by the Board and in which the dentist is licensed or certified by the Board.
(2) The Board recognizes the following specialties:
(a) Endodontics;
(b) Oral and Maxillofacial Surgery;
(c) Oral and Maxillofacial Radiology;
(d) Oral and Maxillofacial Pathology;

(e) Orthodontics and Dentofacial Orthopedics;
(f) Pediatric Dentistry;
(g) Periodontics;
(h) Prosthodontics;
(i) Dental Public Health;
(j) Dental Anesthesiology**;**
(k) Oral Medicine;
(l) Orofacial Pain.
(3) A dentist whose license is not limited to the practice of a specialty under OAR 818-021-0017 may advertise that the dentist performs or limits practice to specialty services even if the dentist is not a specialist in the advertised area of practice so long as the dentist clearly discloses that the dentist is a general dentist or a specialist in a different specialty. For example, the following disclosures would be in compliance with this rule for dentists except those licensed pursuant to 818-021-0017: "Jane Doe, DDS, General Dentist, practice limited to pediatric dentistry." "John Doe, DMD, Endodontist, practice includes prosthodontics."

818-021-0012
Specialties Recognized
(1) A dentist may advertise that the dentist is a dentist anesthesiologist, endodontist, oral and maxillofacial pathologist, oral and maxillofacial surgeon, oral and maxillofacial radiologist, oral medicine dentist, orofacial pain dentist, orthodontist and dentofacial orthopedics, pediatric dentist, periodontist, prosthodontist or dental public health dentist, only if the dentist is licensed or certified by the Board in the specialty in accordance with Board rules.
(2) A dentist may advertise that the dentist specializes in or is a specialist in dental anesthesiology, endodontics, oral and maxillofacial pathology, oral and maxillofacial surgery, oral and maxillofacial radiology, oral medicine, orofacial pain, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, prosthodontics or dental public health only if the dentist is licensed or certified by the Board in the specialty in accordance with Board rules.
The Board recognizes the following specialties:
(a) Dental Anesthesiology;
(b) Dental Public Health;
(c) Endodontics;
(d) Oral and Maxillofacial Pathology;
(e) Oral and Maxillofacial Radiology;
(f) Oral and Maxillofacial Surgery;
(g) Oral Medicine;
(h) Orofacial Pain;
(i) Orthodontics and Dentofacial Orthopedics;
(j) Pediatric Dentistry;
(k) Periodontics;
(l) Prosthodontics.

818-021-0015
Certification as a Specialist
The Board may certify a dentist as a specialist if the dentist:
(1) Holds a current Oregon dental license;
(2) Is a diplomate of or a fellow in a specialty board accredited or recognized by the American Dental Association; or
(3) Has completed a post-graduate program approved by the Commission on Dental

Accreditation of the American Dental Association; or
(4) Was qualified to advertise as a specialist under former OAR 818-010-0061.

818-021-0017
Application to Practice as a Specialist
(1) A dentist who wishes to practice as a specialist in Oregon, who does not have a current Oregon license, in addition to meeting the requirements set forth in ORS 679.060 and 679.065, shall submit to the Board satisfactory evidence of:
(a) Having graduated from a school of dentistry accredited by the Commission on Dental Accreditation of the American Dental Association and active licensure as a general dentist in another state. Licensure as a general dentist must have been obtained as a result of the passage of any clinical Board examination administered by any state or regional testing agency;
(b) Certification of having passed the dental examination administered by the Joint Commission on National Dental Examinations or Canadian National Dental Examining Board Examination; and
(c) Proof of satisfactory completion of a post-graduate specialty program accredited by the Commission on Dental Accreditation of the American Dental Association.
(d) Passing the Board's jurisprudence examination.
(e) Completion of a one-hour pain management course specific to Oregon provided by the Pain Management Commission of the Oregon Health Authority (Effective July 1, 2022).
(2) A dentist who graduated from a dental school located outside the United States or Canada who wishes to practice as a specialist in Oregon, who does not have a current Oregon license, in addition to meeting the requirements set forth in ORS 679.060 and 679.065, shall submit to the Board satisfactory evidence of: (a) Completion of a post-graduate specialty program of not less than two years at a dental school accredited by the Commission on Dental Accreditation of the American Dental Association, proficiency in the English language, and evidence of active licensure as a general dentist in another state obtained as a result of the passage of any clinical Board examination administered by any state or regional testing agency; or
(b) Completion of a post-graduate specialty program of not less than two years at a dental school accredited by the Commission on Dental Accreditation of the American Dental Association, proficiency in the English language and certification of having successfully passed the clinical examination administered by any state or regional testing agency within the five years immediately preceding application; and
(c) Certification of having passed the dental examination administered by the Joint Commission on National Dental Examinations or Canadian National Dental Examining Board Examination; and
(d) Passing the Board's jurisprudence examination; and
(e) Completion of a one-hour pain management course specific to Oregon provided by the Pain Management Commission of the Oregon Health Authority (Effective July 1, 2022).
(3) An applicant who meets the above requirements shall be issued a specialty license upon:
(a) Passing a specialty examination approved by the Board within the five years immediately preceding application; or
(b) Passing a specialty examination approved by the Board greater than five years prior to application; and
(A) Having conducted licensed clinical practice in the applicant's postdoctoral dental specialty in Oregon, other states or in the Armed Forces of the United States, the United States Public Health Service or the United States Department of Veterans Affairs for a minimum of 3,500 hours in the five years immediately preceding application. Licensed clinical practice could

include hours devoted to teaching the applicant's dental specialty by dentists employed by a dental education program in a CODA-accredited dental school, with verification from the dean or appropriate administration of the institution documenting the length and terms of employment, the applicant's duties and responsibilities, the actual hours involved in teaching clinical dentistry in the specialty applicant is applying for, and any adverse actions or restrictions; and;
(B) Having completed 40 hours of continuing education in accordance with the Board's continuing education requirements contained in these rules within the two years immediately preceding application.
(4) Any applicant who does not pass the first examination for a specialty license may apply for a second and third regularly scheduled specialty examination. If the applicant fails to pass the third examination for the practice of a recognized specialty, the applicant will not be permitted to retake the particular specialty examination until he/she has attended and successfully passed a remedial program prescribed by a dental school accredited by the Commission on Dental Accreditation of the American Dental Association and approved by the Board.
(5) Licenses issued under this rule shall be limited to the practice of the specialty only.

818-021-0030
Dismissal from Examination
(1) The Board may dismiss any applicant from an examination whose conduct interferes with the examination and fail the applicant on the examination.
(2) Prohibited conduct includes but is not limited to:
(a) Giving or receiving aid, either directly or indirectly, during the examination process;
(b) Failing to follow directions relative to the conduct of the examination, including termination of procedures;
(c) Endangering the life or health of a patient;
(d) Exhibiting behavior which impedes the normal progress of the examination; or
(e) Consuming alcohol or controlled substances during the examination.
Statutory/Other Authority: ORS 679 & 680
Statutes/Other Implemented: ORS 679.070 & 680.060
History:
DE 1-1989, f. 1-27-89, cert. ef. 2-1-89, Renumbered from 818-020-0075
DE 1-1988, f. 12-28-88, cert. ef. 2-1-89
DE 10-1984, f. & ef. 5-17-84

818-021-0040
Examination Review Procedures
(1) An applicant may review the applicant's scores on each section of the examination.
(2) Examination material including test questions, scoring keys, and examiner's personal notes shall not be disclosed to any person.
(3) Any applicant who fails the examination may request the Chief Examiner to review the examination. The request must be in writing and must be postmarked within 45 days of the postmark on the notification of the examination results. The request must state the reason or reasons why the applicant feels the results of the examination should be changed.
(4) If the Chief Examiner finds an error in the examination results, the Chief Examiner may recommend to the Board that it modify the results.
Statutory/Other Authority: ORS 183 & 192
Statutes/Other Implemented: ORS 183.310(2)(b) & 192.501(4)
History:

DE 1-1989, f. 1-27-89, cert. ef. 2-1-89, Renumbered from 818-020-0080
DE 1-1988, f. 12-28-88, cert. ef. 2-1-89
DE 10-1984, f. & ef. 5-17-84

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 includes an examination and the dentist passes the examination. **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 implants must complete at least seven (7) hours of continuing education related to the placement of dental implants every licensure renewal period (Effective July 1, 2022**January 1, 2024**).

818-021-0070
Continuing Education — Dental Hygienists
(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.)
(c) Correspondence courses, videotapes, distance learning courses or similar self-study course, provided that the course includes an examination and the dentist passes the examination. **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.
(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).

818-021-0076
Continuing Education - Dental Therapists
(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.)

(c) Correspondence courses, videotapes, distance learning courses or similar self-study course, provided that the course includes an examination and the dentist passes the examination. **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.
(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.

OAR 818-021-0084
Temporary Voluntary Practice Approval
1) A dentist, dental therapist or dental hygienist may practice, without compensation and in connection with a coordinating organization or other entity, the health care profession that the health care practitioner is authorized to practice for a maximum of 30 days each calendar year without licensure requirement. Compensation is defined as something given or received as payment including but not limited to bartering, tips, monies, donations, or services.
2) A dentist, dental therapist or dental hygienist is not required to apply for licensure or other authorization from the Board in order to practice under this rule.
3) To practice under this rule, a dentist, dental therapist or dental hygienist shall submit, at least 10 days prior to commencing practice in this state, to the Board:
(a) Out-of-State volunteer application;
(b) Proof that the practitioner is in good standing and is not the subject of an active disciplinary action;
(c) An acknowledgement that the practitioner may provide services only within the scope of practice of the health care profession that the practitioner is authorized to practice and will provide services pursuant to the scope of practice of Oregon or the health care practitioner's licensing agency, whichever is more restrictive;
(d) An attestation from dentist, dental therapist or dental hygienist that the practitioner will not receive compensation for practice in this state;
(e) The name and contact information of the dental director of the coordinating organization or
other entity through which the practitioner will practice; and
(f) The dates on which the practitioner will practice in this state. Failure to submit (a)-(e) above will result in non-approval.
4) Misrepresentation as to information provided in the application for the temporary practice approval may be grounds to open a disciplinary investigation that may result in discipline under OAR 818-012-0060.

5) Practitioner acknowledges they are subject to the laws and rules governing the health care profession in Oregon and that the practitioner is authorized to practice and are subject to disciplinary action by the Board.
6) A practitioner who is authorized to practice in more than one other jurisdiction shall provide to the Board proof from the National Practitioner Data Bank and their other state licensing Board that the practitioner is in good standing and not subject to any active disciplinary actions in any jurisdiction in which the practitioner is authorized to practice.

818-042-0040
Prohibited Acts
No licensee may authorize any dental assistant to perform the following acts:
(1) Diagnose or plan treatment.
(2) Cut hard or soft tissue.
(3) Any Expanded Function duty (OAR 818-042-0070 and OAR 818-042-0090) or Expanded Orthodontic Function duty (OAR 818-042-0100) or Restorative Functions (OAR 818-042-0095 or Expanded Preventive Duty (OAR 818-042-0113 and OAR 818-042-0114) or Expanded Function Anesthesia (OAR 818-042-0115) without holding the appropriate certification.
(4) Correct or attempt to correct the malposition or malocclusion of teeth except as provided by OAR 818-042-0100.
(5) Adjust or attempt to adjust any orthodontic wire, fixed or removable appliance or other structure while it is in the patient's mouth.
(6) Administer any drug except **as allowed under the indirect supervision of a Licensee, such as** fluoride, topical anesthetic, desensitizing agents, **topical tooth whitening agents,** over the counter medications per package instructions or drugs administered pursuant to OAR 818-026-0050(5)(a), OAR 818-026-0060(12), OAR 818-026-0065(12), OAR 818-026-0070(12) and as provided in OAR 818-042- 0070, OAR 818-042-0090 and OAR 818-042-0115.
(7) Prescribe any drug.
(8) Place periodontal packs.
(9) Start nitrous oxide.
(10) Remove stains or deposits except as provided in OAR 818-042-0070.
(11) Use ultrasonic equipment intra-orally except as provided in OAR 818-042-0100.
(12) Use a high-speed handpiece or any device that is operated by a high-speed handpiece intra-orally except as provided in OAR 818-042-0095, and only for the purpose of adjusting occlusion, contouring, and polishing restorations on the tooth or teeth that are being restored.
(13) Use lasers, except laser-curing lights.
(14) Use air abrasion or air polishing.
(15) Remove teeth or parts of tooth structure.
(16) Cement or bond any fixed prosthesis or orthodontic appliance including bands, brackets, retainers, tooth moving devices, or orthopedic appliances except as provided in OAR 818-042-0100.
(17) Condense and carve permanent restorative material except as provided in OAR 818-042-0095.
(18) Place any type of retraction material subgingivally except as provided in OAR 818-042-0090.
(19) Apply denture relines except as provided in OAR 818-042-0090(2).
(20) Expose radiographs without holding a current Certificate of Radiologic Proficiency issued by the Board (OAR 818-042-0050 and OAR 818-042-0060) except while taking a course of instruction approved by the Oregon Health Authority, Oregon Public Health Division, Office of Environmental Public Health, Radiation Protection Services, or the Oregon Board of Dentistry.

(21) Use the behavior management techniques known as Hand Over Mouth (HOM) or Hand Over Mouth Airway Restriction (HOMAR) on any patient.
(22) Perform periodontal assessment.
(23) Place or remove healing caps or healing abutments, except under direct supervision.
(24) Place implant impression copings, except under direct supervision.
(25) Any act in violation of Board statute or rules.

EXECUTIVE DIRECTOR'S REPORT

Board and Staff Updates

Mr. Prisby reported that the Governor reappointed, and the Senate confirmed on April 20th Dr. Reza Sharifi to a second term of service on the OBD. Thank you to Dr. Sharifi for volunteering for four more years of service on the Board in addition to all your other professional responsibilities.

DENTISTRY, OREGON BOARD OF (ORS 679.230)

Sharifi, Reza - Portland - (Reappointment)
Term: 4 year
5-15-23 - 5-14-27

3-22-23	Governor's message read, referred to President's desk.
3-22-23	Referred to Rules.
4-18-23	Hearing held.
4-19-23	Recommendation: Be confirmed en bloc.
4-20-23	Confirmed en bloc.
	Ayes, 21; Nays, 6--Bonham, Boquist, Girod, Linthicum, Robinson, Thatcher; Excused, 3--Campos, Findley, Gorsek.

Mr. Prisby reported that OBD Investigator, Shane Rubio's last day was June 1, 2023. Mr. Prisby added the open investigator position will be posted on the state's employment website and we will follow the necessary steps to recruit and hire his replacement.

Mr. Prisby shared that Teresa Haynes first retired from the OBD on December 31, 2019. Now it will be official again on June 30, 2023. In 2020, Teresa graciously agreed to assist and oversee the database implementation at first in a limited contracted basis, then came back as an official OBD employee when policies changed to allow it. She also assisted in a smooth hand off of her previous job duties to OBD Office Manager, Haley Robinson.

Mr. Prisby added that Teresa has served the Board since November 2, 1987, and originally started working for the State of Oregon in June 1984 when she was in her early twenties. During her 35+ years of service to the Board she has helped thousands of Licensees navigate the licensing process and make sense of the many versions of the Dental Practice Act. She has been able to navigate changes to the office staff, leadership, systems, processes and state government bureaucracy with a positive attitude and a commitment to service. Teresa is the youngest of nine children and she was born and raised in Oregon. She started her state career with the Department of Commerce, and worked for the Corporation Commissioner, Jane Edwards. Ms. Edwards later become the Executive Director for the OBD. Ms. Edwards asked Teresa to come work with her when she became the Executive Director, which Teresa happily accepted. Teresa has worked with a colorful & interesting cast of Board Members, Executive Directors and staff over the past 35 years. Teresa has a daughter, Michelle, who is now in her

30s and is a veterinary technician. Teresa plans to be semi-retired for a few years, and she no doubt will have many opportunities available. She looks forward to more travels and volunteer work as well. We are doing all we can to absorb her institutional knowledge and experience before she says good bye to the OBD at the end of the month.

Mr. Prisby thanked Samantha Plumlee for her 5-year OBD Work Anniversary on March 5th.
Mr. Prisby thanked Haley Robinson for her 7-year OBD Work Anniversary on June 20th.

OBD Budget Status Report

Mr. Prisby shared the budget report for the 2021 - 2023 Biennium. This report, which is from July 1, 2021 through April 30, 2023, shows revenue of $3,383,441.51 and expenditures of $3,271,507.92.

OBD HB 5011 & 2023 – 2025 Budget Update

Mr. Prisby shared various budget documents regarding the OBD's budget bill which is still pending approval by the Legislature. The HB 5011 Measure Summary gives more specific information on the proposed 2023-2025 Budget. The OBD like most state agencies has approval to continue functioning through mid-September should the Legislature not approve the OBD's budget bill and others by end of session.

Customer Service Survey

Mr. Prisby included the legislatively mandated survey results from July 1, 2022 through May 31, 2023. The results of the survey show that the OBD continues to receive positive ratings from the majority of those that submit a survey.

Board and Staff Speaking Engagements

Mr. Prisby noted that he gave a "Board Updates – Part 1" presentation to the OHSU - School of Dentistry 3rd year students on Thursday, April 20, 2023.

Further, Mr. Prisby told of Dr. Angela Smorra and Dr. Bernie Carter giving a "Board Updates – Part 2 Rules and Enforcement" presentation to the OHSU - School of Dentistry 3rd year students on Thursday, April 27, 2023.

Mr. Prisby noted that Samantha Plumlee gave a License Application virtual presentation to the graduating Dental Hygiene Students at Mt. Hood Community College in Gresham on Monday, April 24, 2023

And that Samantha Plumlee gave a License Application virtual presentation to the graduating Dental Students at OHSU - School of Dentistry in Portland on Thursday, April 27, 2023.

Also added that Samantha Plumlee gave a License Application virtual presentation to the graduating Dental Hygiene Students at Lane Community College in Eugene on Monday, May 22, 2023.

And finally, that Samantha Plumlee gave a License Application virtual presentation to the graduating Dental Hygiene Students at Pacific University in Hillsboro on Wednesday, May 31, 2023.

Memo - Delegated Duties for Executive Director & Staff

Mr. Prisby described that every June the new President of the OBD takes the gavel for the first regular Board meeting after being voted President at the April Board Meeting for a 1-year term of office. And every June board meeting, Mr. Prisby submits to the Board for reauthorization, a memo outlining delegated duties to himself as executive director and OBD staff along with his job description.

Dr. Javier moved and Dr. Clark seconded that the Board approve the delegated duties as presented. The motion passed unanimously.

OBD Bylaws
Mr. Prisby shared the OBD Bylaws, originally adopted in 2018, included for review by the Board.

Agency Expectations – DEI Work & Draft
Mr. Prisby noted the OBD like all state agencies has been directed by the Governor to comply with her directives. One of those important directives is for each agency to implement a DEI plan. The Draft DEI plan was circulated to OBD Board & Staff Members on May 25 to review ahead of today's meeting.

SPOTS Forum
At the last board meeting Mr. Prisby shared a lot of information regarding the state issued credit card (SPOTS card) the OBD agency utilizes for reoccurring and miscellaneous expenses. Mr. Prisby added that Haley Robinson and he attended the SPOTS Forum and that presentation was attached for review.

2023 Legislative Session
Mr. Prisby shared a report dated 6.1.2023 showing bills being tracked for the OBD. At the time of this report it was unknown what the Legislature was going to do before the end of session.

OBD 2023 - 2024 Board Meeting Dates
Mr. Prisby showed a schedule of Board approved 2024 meeting dates for planning purposes.

Newsletter
And Mr. Prisby concluded with a note that the Summer OBD Newsletter is planned to be published in August.

UNFINISHED BUSINESS AND RULES
Mr. Prisby shared a fee schedule showing the proposed fee increases which have been included in the OBD's 2023-2025 budget via HB 5011.

Dr. Sharifi moved and Dr. Javier seconded that OAR 818-001-0087 be approved as amended, as a temporary rule change and be effective August 1, 2023, as long as the legislature approves HB 5011. The motion passed unanimously.

818-001-0087
Fees
(1) The Board adopts the following fees:
(a) Biennial License Fees:
(A) Dental —$390**440**;
(B) Dental — retired — $0;

(C) Dental Faculty — $335**385**;
(D) Volunteer Dentist — $0;
(E) Dental Hygiene —$230**255**;
(F) Dental Hygiene — retired — $0;
(G) Volunteer Dental Hygienist — $0;
(H) Dental Therapy - $230**255**;
(I) Dental Therapy - retired - $0;
(b) Biennial Permits, Endorsements or Certificates:
(A) Nitrous Oxide Permit — $40;
(B) Minimal Sedation Permit — $75;
(C) Moderate Sedation Permit — $75;
(D) Deep Sedation Permit — $75;
(E) General Anesthesia Permit — $140;
(F) Radiology — $75;
(G) Expanded Function Dental Assistant — $50;
(H) Expanded Function Orthodontic Assistant — $50;
(I) Instructor Permits — $40;
(J) Dental Hygiene Restorative Functions Endorsement — $50;
(K) Restorative Functions Dental Assistant — $50;
(L) Anesthesia Dental Assistant — $50;
(M) Dental Hygiene, Expanded Practice Permit — $75;
(N) Non-Resident Dental Background Check - $100.00;
(c) Applications for Licensure:
(A) Dental — General and Specialty — $345**445**;
(B) Dental Faculty — $305**405**;
(C) Dental Hygiene — $180**210**;
(D) Dental Therapy - $180**210**;
(E) Licensure Without Further Examination — Dental, Dental Hygiene and Dental Therapy — $790**890;**
(F) Licensure Without Further Examination — Dental Hygiene and Dental Therapy — $820.
(d) Examinations:
(e) Jurisprudence — $0;
(f) Duplicate Wall Certificates — $50.
(2) Fees must be paid at the time of application and are not refundable.
(3) The Board shall not refund moneys under $5.01 received in excess of amounts due or to which the Board has no legal interest unless the person who made the payment or the person's legal representative requests a refund in writing within one year of payment to the Board.

Memo from Ingrid Nye regarding ADA course 'Recognition and Management of Complications during Minimal and Moderate Sedation' is referenced in rule 818-026-0030, but this course is no longer available.

Dr. Sharifi moved and Ms. Ludwig seconded that the Board move discussion of memo on the sedation complication course to the Anesthesia Committee. The motion passed unanimously.

OTHER

An invitation to the JCNDE State Dental Board Forum on June 26, 2023 was presented.

A report on Child Abuse – Mandatory Reporting Information was shared.

ARTICLES AND NEWS

An article about how Oregon state Government workers struggling to deliver services amid staffing shortages was discussed.

CRDTS has introduced a new CARE Program.

May 19-21, in Chicago, DANB kicked off a review of Dental Assisting Roles to inform future programs.

Oregon Office of Rural Health Overview

Oregon Office of Rural Health 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 11:48 a.m.

CONSENT AGENDA

2023-0190, 2023-0194, 2023-0203

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

COMPLETED CASES

2023-0074, 2023-0088, 2023-0135, 2022-0098, 2023-0185, 2023-0129, 2023-0179, 2023-0096, 2023-0065, 2023-0150, 2023-0083, 2023-0122

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.

2023-0009
Dr. Sharifi moved and Dr. Javier seconded that the Board move to close the matter with a Letter of Concern reminding licensee of her statutory scope, and to seek legal counsel regarding appropriate formation of her business under ORS 679.020. The motion passed unanimously.

2023-0075
Dr. Kansal moved and Ms. Ludwig seconded a move to close the matter with a Letter of Concern reminding Licensee document the names and strengths of medications administered, including the preinjection topical anesthetic. The motion passed unanimously.

PREVIOUS CASES REQUIRING BOARD ACTION

Alpert, Todd Henry, D.D.S.; 2023-0030 & 2023-0051
Ms. Ludwig moved and Dr. Javier seconded that the Board move to reaffirm previous vote on April 28, 2023. The motion passed unanimously.

2023-0082
Dr. Javier moved and Ms. Ludwig seconded that the Board move to affirm the previous action taken by the Board on April 28, 2023. The motion passed unanimously.

LICENSE & EXAMINATION ISSUES

Request for reinstatement of an expired license – Laurel Young, R.D.H.
Dr. Kalluri moved and Dr. Clark seconded that the Board approve the reinstatement license for Laurel Young, R.D.H. The motion passed unanimously.

RATIFICATION OF LICENSES

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

ADJOURNMENT

The meeting was adjourned at 11:55 a.m. Mr. Dunn stated that the next Board Meeting would take place on August 25, 2023.

_____
Charles 'Chip' Dunn
President

ASSOCIATION REPORTS

COMMITTEE REPORTS

Draft

LICENSING, STANDARDS AND COMPETENCY COMMITTEE
Held as a Zoom Meeting

Minutes
July 12, 2023

MEMBERS PRESENT:	Chip Dunn, Chair Sheena Kansal, D.D.S. Terrence Clark, D.M.D. Sharity Ludwig, R.D.H., E.P.P. Olesya Salathe, D.M.D. – ODA Rep. Susan Kramer, R.D.H. – ODHA Rep. Ginny Jorgensen, CDA, EFDA, EFODA, AAS - ODAA Rep. Yadira Martinez, R.D.H., E.P.P. – DT Rep.
STAFF PRESENT:	Stephen Prisby, Executive Director Angela Smorra, D.M.D., Dental Director/Chief Investigator Haley Robinson, Office Manager Ingrid Nye, Investigator Samantha Plumlee, Licensing Manager Kathleen McNeal, Office Specialist
ALSO PRESENT:	Lori Lindley, Sr. Assistant Attorney General
VISITORS PRESENT:	Jenn Lewis-Goff – ODA, Susan Kramer – ODHA, Lisa Rowley, R.D.H. – ODHA, Jill Lomax, Jen Hawley Price, Katherine Landsberg – DANB, Tony Garcia – DANB, Mary Harrison – ODAA, Sarah Kowalski - OHA, Mary Ellen Murphy, Jessica Dusek, Vesna Grace Stone, Linda Kihs, Bonnie Marshall

**Note - Some visitors may not be reflected in the minutes because their identity was unknown during the meeting.*

Call to Order: The meeting was called to order by Chip Dunn at 5:02 p.m.

MINUTES

Ms. Jorgensen moved and Dr. Salathe seconded that the minutes of the November 16, 2022 Licensing, Standards and Competency meeting be approved as presented. The motion passed unanimously.

Dr. Clark moved and Dr. Kansal seconded the Committee recommend that the Board move OAR 818-012-0005 and OAR 818-021-0060 as amended to the Rules Oversight Committee. The motion passed unanimously.

OAR 818-012-0005 – Scope of Practice

(4) 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).
(5) 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 818-021-0060 – Continuing Education-Dentists
(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).

Ms. Lindley recommend that the committee wait for further direction before moving forward on the proposed rule below. The issue of federal supremacy over state rule and other issues was being looked at closely by the DOJ so this should be tabled at this time.

OAR 818-021-XXXX
Dental, Dental Therapy and Dental Hygiene Licensure for Active-Duty Members of the Uniformed Services and their Spouses Stationed in Oregon

(1) A license to practice dentistry, dental hygiene or dental therapy shall be issued to Active-Duty Members of the Uniformed Services or their spouse when the following requirements are met:
(a) Completed application and payment of fee is received by the Board; and
(b) Satisfactory evidence of having graduated from a dental, dental hygiene or dental therapy program accredited by the Commission on Dental Accreditation of the American Dental Association; or
(c) Satisfactory evidence of having graduated from a dental school located outside the United States or Canada, completion of a predoctoral dental education program of not less than two years at a dental school accredited by the Commission on Dental Accreditation of the American Dental Association, and proficiency in the English language; or
(d) Satisfactory evidence of having graduated from a dental hygiene program located outside the United States or Canada, completion of not less than one year in a program accredited by the Commission on Dental Accreditation of the American Dental Association, and proficiency in the English language; or
(e) Satisfactory evidence of having successfully completed or graduated from a Board approved dental therapy education program that includes the procedures outlined in OAR 818-038-0020, and includes at least 500 hours of didactic and hands-on clinical dental therapy practice.
(f) Submission of a copy of the military orders assigning the active-duty member to an assignment in Oregon; and
(g) The applicant holds a current license in another state to practice dentistry, dental hygiene or dental therapy at the level of application; and
(h) The license is unencumbered and verified as active and current through processes defined by the Board; and
(i) Satisfactory evidence of successfully passing a clinical examination administered

by any state, national testing agency or other Board-recognized testing agency; and
(j) Verification of completion of the Board's Continuing Education (CE) requirements in accordance with OAR 818-021-0060, OAR 818-021-0070 & OAR 818-021-0076.
(2) The temporary license shall remain active for the duration of the above-mentioned military orders.
(3) Once licensed, each biennium, the licensee shall submit to the Board a Biennial Uniformed Servicemember Status Confirmation Form. The confirmation form shall include the following:
(a) Licensee's full name;
(b) Licensee's mailing address;
(c) Licensees business address including street and number or if the licensee has no business address, licensee's home address including street and number;
(d) Licensee's business telephone number or if the licensee has no business telephone number, licensee's home telephone number;
(e) Licensee's employer or person with whom the licensee is on contract;
(f) Licensee's assumed business name;
(g) Licensee's type of practice or employment;
(h) A statement that the licensee has met the CE requirements for their specific license renewal set forth in OAR 818-021-0060 or OAR 818-021-0070 or OAR 818-021-0076;
(i) Identity of all jurisdictions in which the licensee has practiced during the two past years; and
(j) A statement that the licensee has not been disciplined by the licensing board of any other jurisdiction or convicted of a crime.
(k) Confirmation of current active-duty status of servicemember.
(l) The form will be provided, depending on licensure type, pursuant to ORS 679.120(6), 680.075(6) and 679.615(4)(b).
(4) If military orders are reassigned, notification to the Board is required within 30 days of receipt.
(5) Any Board permits held by Licensees are required to be renewed per rule requirements on permit types.
(6) Individuals who are licensed under this rule are required to adhere to the Dental Practice Act and are subject to the same requirements and standards of practice as any other licensee of the Board.

Ms. Jorgensen discussed a capstone project from Pacific University, offering instructions for expanded function dental assistants to be able to train, test for and be certified in providing local anesthesia, similar to the training for a dental hygienist.

Dr. Salathe provided an official response from the ODA concluding that expanding the scope of dental assistants to include local anesthesia via nerve blocks was inappropriate due to lack of reporting on individual dental assistants, rather incidents would be reported under the supervising dentist or dental hygienist. The ODA does not feel that the available training would be adequate to provide competency. Further, the ODA cited that no other state allows an unregulated group to administer local anesthesia via nerve blocks.

Ms. Jorgensen responded, pointing out that dental assistants do have rules and training similar to dental hygienists in the area of restorative functions. Further, this project was in response to a survey of dentists asking for dental assistants to be able to provide local anesthesia under indirect supervision. Ms. Jorgensen thinks this new certification would help to alleviate the

workforce shortage of dental assistants.

Dr. Clark pointed out that he was bothered by the ODA stance because the ODA recently supported the loosening of dental assistant testing and credentials in a recent legislative bill. Dr. Clark supports additional credentialing for dental assistants and notes that dental assistants are regulated and adverse reports can be tracked through the supervising dentist. Dr. Clark stated that a rigorous curriculum can be created to provide a standard of care to benefit the public, the dental assistants and the entire dental team.

Ms. Martinez recommended this project be moved forward for other committees to discuss.

Ms. Kramer moved and Dr. Kansal seconded the Committee recommend that the Board move OAR 818-042-00XX as presented to the Rules Oversight Committee. The motion passed with Dr. Kansal, Dr. Clark, Ms. Jorgensen, Ms. Kramer, Ms. Ludwig, and Ms. Martinez voting aye. Dr. Salathe voted no.

OAR 818-042-00XX
Local Anesthesia Functions of Dental Assistants
(1) The Board shall issue a Local Anesthesia Functions Certificate (LAFC) to a dental assistant who holds an Oregon EFDA Certificate, and has successfully completed a Board approved curriculum from a program accredited by the Commission on Dental Accreditation of the American Dental Association or other course of instruction approved by the Board.
(2) A dental assistant may administer local anesthetic agents and local anesthetic reversal agents under the indirect supervision of a licensed dentist. Local anesthetic reversal agents shall not be used on children less than 6 years of age or weighing less than 33 pounds.

The committee was directed to review the documents regarding a dental/dental hygiene licensing compact. Director Prisby referenced the documents and said it was important to have the committee looped in on this and it will probably be an issue for Oregon to address in the future. The Board of Dentistry would have similar issues and concerns with implementing it, that the Oregon Occupational Therapy Licensing referenced in the documents.

Lori Lindley added there were a number of legal issues as well. There was brief discussion with the ODA having no position on it at this time. Ms. Kramer went on record to say that the ODHA is in favor of a potential licensure compact.

The Committee reviewed and briefly discussed the rules regarding radiologic proficiency certification for dental assistants.

Ms. Jorgensen moved and Ms. Martinez seconded the Committee recommend that the Board keep OAR 818-042-0050 as presented. The motion passed unanimously.

OAR 818-042-0050
Taking of X-Rays — Exposing of Radiographic Images
(1) A Licensee may authorize the following persons to place films/sensors, adjust equipment preparatory to exposing films/sensors, and expose the films and create the images under general supervision:
(a) A dental assistant certified by the Board in radiologic proficiency; or

(b) A radiologic technologist licensed by the Oregon Board of Medical Imaging and certified by the Oregon Board of Dentistry (OBD) who has completed ten (10) clock hours in a Board approved dental radiology course.
(2) A licensee may authorize a dental assistant who has completed a course of instruction approved by the Oregon Board of Dentistry, and who has passed the written Dental Radiation Health and Safety Examination administered by the Dental Assisting National Board, or comparable exam administered by any other testing entity authorized by the Board, or other comparable requirements approved by the Oregon Board of Dentistry to place films/sensors, adjust equipment preparatory to exposing films/sensors, and expose the films and create the images under the indirect supervision of a dentist, dental therapist, dental hygienist, or dental assistant who holds an Oregon Radiologic Proficiency Certificate. The dental assistant must submit within six months, certification by an Oregon licensed dentist, dental therapist or dental hygienist that the assistant is proficient to take radiographic images.
(3) A dental therapist may not order a computerized tomography scan.

Ms. Jorgensen moved and Ms. Martinez seconded the Committee recommend that the Board keep OAR 818-042-0060 as presented. The motion passed unanimously.

OAR 818-042-0060
Certification — Radiologic Proficiency
(1) The Board may certify a dental assistant in radiologic proficiency by credential in accordance with OAR 818-042-0120, or if the assistant:
(2) Submits an application on a form approved by the Board, pays the application fee and:
(a) Completes a course of instruction approved by the Oregon Board of Dentistry, in accordance with OAR 333-106-0055 or submits evidence that the Oregon Health Authority, Center for Health Protection, Radiation Protection Services recognizes that the equivalent training has been successfully completed;
(b) Passes the written Dental Radiation Health and Safety Examination administered by the Dental Assisting National Board, Inc. (DANB), or comparable exam administered by any other testing entity authorized by the Board, or other comparable requirements approved by the Oregon Board of Dentistry; and
(c) Certification by an Oregon licensee that the assistant is proficient to take radiographs.

Ms. Martinez moved and Ms. Jorgensen seconded the Committee recommend that the Board move OAR 818-042-0080 as presented to the Rules Oversight Committee. The motion passed unanimously.

OAR 818-042-0080
Certification — Expanded Function Dental Assistant (EFDA)
The Board may certify a dental assistant as an expanded function assistant:
(1) By credential in accordance with OAR 818-042-0120, or
(2) If the assistant submits a completed application, pays the fee and provides evidence of;
(a) Certification of Radiologic Proficiency (OAR 818-042-0060); and satisfactory completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association; or
(b) Certification of Radiologic Proficiency (OAR 818-042-0060); and passage of the Oregon Basic, Infection Control or Certified Dental Assisting (CDA) examination, and the Expanded Function Dental Assistant examination, or equivalent successor examinations, administered by the Dental Assisting National Board, Inc. (DANB), or any other testing entity authorized

by the Board; and certification by **an Oregon** licensed dentist that the applicant has successfully polished six (6) amalgam or composite surfaces, removed supra-gingival excess cement from four (4) crowns and/or fixed partial dentures (bridges) with hand instruments; placed temporary restorative material in three (3) teeth; preliminarily fitted four (4) crowns to check contacts or to adjust occlusion outside the mouth; removed four (4) temporary crowns for final cementation and cleaned teeth for final cementation; fabricated four (4) temporary crowns and/or fixed partial dentures (bridges) and temporarily cemented the crowns and/or
fixed partial dentures (bridges); polished the coronal surfaces of teeth with a brush or rubber cup as part of oral prophylaxis in six (6) patients; placed matrix bands on four (4) teeth prepared for Class II restorations. **The dental assistant must submit within six months' certification by a licensed dentist that the dental assistant is proficient to perform all the expanded function duties in subsection (b). If no expanded function certificate is issued within the six months, the dental assistant is no longer able to continue to perform expanded function duties until EFDA certification is achieved.**

Ms. Martinez moved and Ms. Jorgensen seconded the Committee recommend that the Board move OAR 818-042-0110 as presented to the Rules Oversight Committee. The motion passed unanimously.

OAR 818-042-0110
Certification— Expanded Function Orthodontic Dental Assistant (EFODA)
The Board may certify a dental assistant as an expanded function orthodontic assistant:
(1) By credential in accordance with OAR 818-042-0120, or
(2) Completion of an application, payment of fee and satisfactory evidence of;
(a) Completion of a course of instruction in a program in dental assisting accredited by the American Dental Association Commission on Dental Accreditation; or
(b) Passage of the Oregon Basic, Infection Control, Certified Dental Assistant (CDA) or Certified Orthodontic Assistant (COA) examination, and Expanded Function Orthodontic Assistant examination, or equivalent successor examinations, administered by the Dental Assisting National Board, Inc. (DANB), or any other testing entity authorized by the Board; and certification by **an Oregon** licensed dentist that the applicant has successfully placed and ligated orthodontic wires on ten (10) patients and removed bands/brackets and remaining adhesive using an ultrasonic, hand scaler or a slow speed handpiece from teeth on four (4) patients. **The dental assistant must submit within six months' certification by a licensed dentist that the dental assistant is proficient to perform all the expanded function orthodontic duties in subsection (b). If no expanded function certificate is issued within the six months, the dental assistant is no longer able to continue to perform expanded function orthodontic duties until EFODA certification is achieved.**

Ms. Martinez moved and Ms. Jorgensen seconded the Committee recommend that the Board move OAR 818-042-0113 as presented amended to the Rules Oversight Committee. The motion passed unanimously.

OAR 818-042-0113 Certification — Expanded Function Preventive Dental Assistants (EFPDA) The Board may certify a dental assistant as an expanded function preventive dental assistant:
(1) By credential in accordance with OAR 818-042-0120, or
(2) If the assistant submits a completed application, pays the fee and provides evidence of;
(a) Certification of Radiologic Proficiency (OAR 818-042-0060); and satisfactory completion

of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association; or
(b) Certification of Radiologic Proficiency (OAR 818-042-0060); and passage of the Oregon Basic or Infection Control examination, and Certified Preventive Functions Dental Assistant (CPFDA) examination, or the Expanded Function Dental Assistant (EFDA) examination, or the Coronal Polish (CP) examination, or equivalent successor examinations, administered by the Dental Assisting National Board, Inc. (DANB), or any other testing entity authorized by the Board; and certification by an Oregon licensed dentist that the applicant has successfully polished the coronal surfaces of teeth with a brush or rubber cup as part of oral prophylaxis to remove stains on six **(6)** patients. **The dental assistant must submit within six months' certification by a licensed dentist that the dental assistant is proficient to perform all the expanded function preventive duties in subsection (b). If no expanded function preventive certificate is issued within the six months, the dental assistant is no longer able to continue to perform expanded function preventive duties until EFPDA certification is achieved.**

Ms. Jorgensen moved and Ms. Martinez seconded the Committee recommend that the Board move OARs 818-042-0115, 818-042-0117, 818-035-0030, and 818-038-00XX as amended to the Rules Oversight Committee. The motion passed unanimously.

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.

OAR 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.

OAR 818-038-00XX
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.

Ms. Martinez moved and Ms. Kramer seconded the Committee recommend that the Board move OAR 818-042-0114 as presented to the Rules Oversight Committee. The motion passed unanimously.

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.

Ms. Jorgensen moved and Ms. Martinez seconded the Committee recommend that the Board move OAR 818-042-0100 as presented to the Rules Oversight Committee. The motion passed unanimously.

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.

Ms. Martinez moved and Dr. Clark seconded the Committee recommend that the Board move OAR 818-042-0020 as presented to the Rules Oversight Committee. The motion passed unanimously.

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.

Chair Dunn thanked everyone for their attendance and contributions.

The meeting adjourned at 6:30 p.m.

oregon dental ASSOCIATION

Oregon Board of Dentistry
1500 SW 1st Avenue, Suite 770
Portland, OR 97201

August 13th, 2023

Dear members of the Board of Dentistry:

ODA is a membership association of over 2,000 dentists across the state. Our decisions to weigh in on policy proposals are made by members of various committees within our governance structure. On most regulatory issues, issues are discussed at our Regulatory Affairs Council and may be elevated to our Board of Trustees. Both groups are broad in representation and diverse in perspective. Both groups have reviewed the initial proposal for dental assistants to perform local anesthesia, and both groups strongly oppose the proposal. **We strongly urge the Board not to move this issue forward further.**

ODA has deep concerns with the proposal for the following primary reasons:

1) Dental assistants are not a regulated group (i.e. no licensure requirement) by the state of Oregon and as such, there is no reporting mechanism for tracking adverse outcomes for assistants. Regulation exists in order to ensure public safety and to maintain a certain standard. It allows not only for disciplinary action and remediation for those injured but also for identifying practitioners who need additional education.

ODA members voiced significant concern related to the ability of the Board of Dentistry, dentists in private practice or corporate settings who would be hiring dental assistants, or the general public, to track and/or access records of a dental assistant who may have experienced a significant adverse patient outcome such as death from overdose, seizure, inability to manage a medical emergency such as anaphylaxis or nerve injury under indirect supervision. Currently, if an adverse event occurs, due to a dental assistants' error, the dentist will be disciplined by the Oregon Board of Dentistry. With this proposal, there will not be a public record associated with the dental assistant who administered the regional anesthesia causing death or injury. There would be no opportunity to enforce additional education for that dental assistant to prevent another adverse outcome. A future hiring dentist would not necessarily have knowledge of the concerns; a patient would not have the ability to review their regional anesthesia provider's safety record.

For this primary reason, the ODA members concluded that expanding the scope of dental assistants to provide regional local anesthesia was inappropriate due to lack of reporting which could adversely affect patients throughout the state as a troubled assistant moved jobs without remediation.

2) Dental assistant curriculum is currently inadequate for the administration of regional nerve blocks using local anesthesia. ODA members discussed what education/course work could prepare an individual dental practitioner to be competent to safely deliver local anesthetic. As the necessary course work was described and discussed, it became clear that a single course, or even a series of few courses, could not cover sufficient pharmacology, anatomy (including dissection of cadavers), and emergency management training to ensure provider

competency. Ultimately, ODA members felt that the base knowledge necessary prior to course work specific to local regional anesthesia is so critical and broad that an individual should pursue a hygiene education to obtain this skill set.

3) Finally, no other state allows an unregulated group to administer local regional anesthesia via nerve blocks (e.g. epidural, Bier block or blocks of the trigeminal nerve). ODA believes that it is because of the issues outlined above that other states have declined this initiative.

Finally, there has been much reference made to a survey conducted where dentists indicate they would like dental assistants to have this expanded function. We have not seen any data about how many dentists were included in this survey, the method of data collection for this survey, or other metrics to determine if the results are representative of a larger opinion, or if the survey itself is scientifically sound. To the contrary, in our discussion with our volunteers, there is overwhelming opposition to the proposal. When pressed whether any changes could be made to the proposal to make it better, our leadership overwhelmingly reflects that the minimum education required for individuals to safely perform these procedures is most of a dental hygiene degree and that individuals performing this scope of practice should be licensed by the state.

We agree that there is a need to examine rules around dental assistants' credentialing, requirements, education standards and career pathways. We welcome those conversations.

Sincerely,

Mark Miller, DMD, MAGD, ODA President

Stacy Geisler, DDS, Phd, ODA Regulatory Affairs Committee Chair

Olesya Salathe, DMD, ODA BOT member, Board of Dentistry Liaison

Oregon Board of Dentistry
1500 SW 1st Avenue, Suite 770
Portland, OR 97201

Submitted electronically to: Stephen.PRISBY@obd.oregon.gov
August 14, 2023

Dear Members of the Oregon Board of Dentistry:

The Oregon Society of Anesthesiologists (OSA) is a membership organization representing physician anesthesiologists across the state. Our members are dedicated to patient safety and access to care. We write to express concerns over the proposal to allow dental assistants to administer local anesthesia. We respectfully urge the Board not to advance this proposal.

While dental assistants are critical members of the overall care team, the OSA has grave patient safety concerns with the proposal. Administration of local anesthetic requires a knowledge of anatomy, pharmacology and physiology (especially medical contraindications or how to respond to adverse events). Incorrect administration can cause significant—and even permanent—harm to patients. Risks include anaphylaxis, nerve injury, stroke or even death. Current dental assistant programs do not include the necessary level of training required to safely administer local anesthetic, and these skills cannot be taught in a condensed course, or even several courses.

There is also concern over record keeping, since dental assistants are not licensed and practice under the supervision of a dentist. If an adverse outcome were to occur at the hands of a dental assistant, there will be no public record associated with the assistant, which would make it difficult for the Board to enforce additional education to prevent another adverse outcome.

The Oregon Society of Anesthesiologists strongly urges the board not to advance this proposal. Thank you for your consideration.

John Meyer, MD
President
Oregon Society of Anesthesiologists
johnmeyer0814@gmail.com

At the August 25, 2023 Board Meeting the Oregon Board of Dentistry (OBD) established a new standing Advisory Committee named the "Dental Assistant Workforce Shortage Advisory Committee (DAWSAC)" per ORS 679.280, to review, discuss and make recommendations to the Board on addressing workforce shortages in accordance with HB 3223 (2023).

The section of HB 3223 relevant to this is included for reference:

SECTION 5. (1) The Oregon Board of Dentistry shall convene an advisory committee of at least seven members to study the dental assistant workforce shortage and to review the requirements for dental assistant certification in other states. The committee shall provide advice to the board on a quarterly basis on how to address the dental assistant workforce shortage in this state.

(2)(a) In appointing members to the advisory committee, the board shall prioritize diversity of geographic representation, background, culture and experience.

(b) A majority of the members appointed to the committee must have experience working as dental assistants.

SECTION 6. This 2023 Act takes effect on the 91st day after the date on which the 2023 regular session of the Eighty-second Legislative Assembly adjourns sine die.

This advisory committee will meet no less than four times per calendar year once established, and generally be scheduled concurrently with regular OBD Board Meetings. The OBD President will designate two Co-Chairs of the Committee whom will be OBD Board Members. Preference will be given to Board Members who have past experience working as a dental assistant.

The advisory committee shall include five representatives from the Oregon dental assistant community who are currently or have worked as an Oregon dental assistant. The OBD President will select the members, and utilize the legislative criteria, if more than five people volunteer to serve on this advisory committee.

The advisory committee will also include one representative from each of the professional associations: The Oregon Dental Association, The Oregon Dental Hygienists' Association and the Oregon Dental Assistants Association and eventually one from the Oregon Dental Therapy Association (should that be established).

The Advisory Committee members will bring relevant topics and agenda items to the meetings, be meaningfully engaged on the relevant issues, offer solutions and assist in gathering information.

The inaugural DAWSAC meeting is tentatively scheduled for October 27, 2023.

Enrolled
House Bill 3223

Sponsored by Representatives PHAM H, JAVADI, Senators GELSER BLOUIN, MANNING JR; Representative LEVY E, Senator CAMPOS

CHAPTER .....

AN ACT

Relating to dental assistants; and prescribing an effective date.

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

SECTION 1. Section 2 of this 2023 Act is added to and made a part of ORS chapter 679.

SECTION 2. (1) In adopting rules related to the requirements for certification as a dental assistant, including any type of expanded function dental assistant, the Oregon Board of Dentistry may require an applicant for certification to pass a written examination. If passage of a written examination is required for certification as a dental assistant, including any type of expanded function dental assistant, the board may accept the results of any examination that is:

(a)(A) Administered by a dental education program in this state that is accredited by the Commission on Dental Accreditation of the American Dental Association, or its successor organization, and approved by the board by rule;

(B) Administered by a dental education program in this state that is approved by the Commission for Continuing Education Provider Recognition of the American Dental Association, or its successor organization, and approved by the board by rule; or

(C) An examination comparable to an examination described in subparagraph (A) or (B) of this paragraph that is administered by a testing agency approved by the board by rule; and

(b) Offered in plain language in English, Spanish and Vietnamese.

(2) The board may not require an applicant for certification as a dental assistant, including any type of expanded function dental assistant, to complete more than one written examination for certification as that type of dental assistant.

SECTION 3. Section 2 of this 2023 Act applies to applications for certification as a dental assistant, including any type of expanded function dental assistant, submitted on or after the operative date specified in section 4 of this 2023 Act.

SECTION 4. (1) Section 2 of this 2023 Act becomes operative on July 1, 2025.

(2) The Oregon Board of Dentistry may take any action before the operative date specified in subsection (1) of this section that is necessary to enable the board to exercise, on and after the operative date specified in subsection (1) of this section, all of the duties, functions and powers conferred on the board by section 2 of this 2023 Act.

SECTION 5. (1) The Oregon Board of Dentistry shall convene an advisory committee of at least seven members to study the dental assistant workforce shortage and to review the requirements for dental assistant certification in other states. The committee shall provide

advice to the board on a quarterly basis on how to address the dental assistant workforce shortage in this state.

(2)(a) In appointing members to the advisory committee, the board shall prioritize diversity of geographic representation, background, culture and experience.

(b) A majority of the members appointed to the committee must have experience working as dental assistants.

SECTION 6. This 2023 Act takes effect on the 91st day after the date on which the 2023 regular session of the Eighty-second Legislative Assembly adjourns sine die.

Passed by House March 16, 2023

Repassed by House June 24, 2023

.....
Timothy G. Sekerak, Chief Clerk of House

.....
Dan Rayfield, Speaker of House

Passed by Senate June 24, 2023

.....
Rob Wagner, President of Senate

Received by Governor:

.....M.,....., 2023

Approved:

.....M.,....., 2023

.....
Tina Kotek, Governor

Filed in Office of Secretary of State:

.....M.,....., 2023

.....
Secretary of State

American Board of Dental Examiners (ADEX) 2023
19th Annual Meeting Attendees
Gaylord Rockies Resort- Aurora Colorado

You will find the anticipated meetings list below and current listings of Committee/Subcommittee appointments and other assigned roles in the Member section on our ADEX website: www.adexexams.org Please ensure you have registered on the new website for access to the Member Only Section.

ADEX Executive Committee, *ADEX Quality Assurance Committee* (only if you are a member), ADEX Dental Examination Committee, ADEX Dental Hygiene Examination Committee, ADEX House of Representatives, ADEX Reception

You are not required to attend every meeting; but should plan for those meetings in which you are an appointed member. Please RSVP to Renea Chapman to confirm your attendance to the meeting at office@adexexams.org

We would like to avoid additional charges for those unable to attend their scheduled Committee or Board meeting. Please note that some committees and subcommittees will not be meeting as meetings took place prior to the Annual Meeting or were not called. Here is our preliminary agenda:

AGENDA - ADEX 2023
19th ANNUAL MEETING
Gaylord Rockies Resort-Aurora Colorado

(All room assignment locations to be confirmed and schedule is subject to minor time changes)

Friday, July 21,2023

8:00 AM – 12:00 PM Registration – TBD
8:30 AM - 11:30 AM Executive Committee Meeting – Hogan Boardroom
Noon - 1:00 PM Lunch Buffet – Willow Lake 1-2
1:00 PM – 3: 30 PM ADEX Quality Assurance Committee Mtg.- Mitzner-Closed Meeting
3:45 PM- 5:00 PM ADEX Board of Directors Meeting –Homestead 3-4
6:00 PM - 8:00 PM ADEX Reception – Willow Lake 1-2

Saturday, July 22,2023

7:00 AM – 8:00 AM Registration – TBD
7:00 AM - 8:00 AM Breakfast Buffet – Willow Lake 1-2
8:00 AM – 9:00 AM ADEX Dental Examination Committee Meeting – Homestead 3-4
8:00 AM – 9:00 AM ADEX Dental Hygiene Examination Committee Meeting – TBD
9:15 AM – 12:15 PM ADEX House of Representatives Meeting – Homestead 3-4*
12:15 PM – 12:30 PM ADEX Board of Directors Meeting (Welcome New Directors)– Homestead 3-4
12:30 - 2:00 PM Lunch Buffet – Willow Lake 1-2

VERY IMPORTANT**: Hotel reservations using the link must be made as soon as possible.** Hotel link provided close June 1, 2023

*For House of Representatives Members, please be prepared for the meeting time to extend to address all matters brought to the body. For those intending to depart on Saturday, July 22, please make arrangements AFTER 4pm CDT to allow for any voting business to be brought to the House. We intend to conclude sooner; however, there may be matters to address and we ask your attention to this notice and request.

ADEX does not pay the expenses of guests, but you are encouraged to make your reservation through the ADEX room block to take advantage of the special rate. Here is the hotel link information to book your room(s):

https://book.passkey.com/gt/218991721?gtid=351315fd19a4528506acea5821b37ecd

The block rate is available July 20-23, 2023
Hotel: Gaylord Rockies Resort-Aurora Colorado

Phone: 1-800-429-5673

Give agent: American Board of Dental Examiners at the Gaylord Rockies to make reservation by phone

Airline reservations: ADEX will reimburse appointed members for airline reservations (form on the website).

When should I arrive?

Quality Assurance Committee Members and ***Board of Directors Members*** should arrive Thursday late afternoon/evening based on airline travel and work schedules.

Dental Examination Committee Members and Dental Hygiene Committee Members should plan to arrive on Friday afternoon so that they will be able to attend the reception and then be ready for the Examination Committee Meetings on Saturday morning. Any committee not listed for meeting does not require members' attendance at Annual Meeting if that is the only committee or assignment held by the member.

More e-mails and information will follow as the date gets closer – mark your calendars now and make the appropriate reservations.

Please contact Renea Chapman, Executive Director at the ADEX office via office@adexexams.org OR renea.chapman@adexexams.org with any questions or concerns. I look forward to seeing everyone for an exciting ADEX meeting this July!

Many thanks,

Renea Chapman, Executive Director
American Board of Dental Examiners, Inc., (ADEX)
503-724-1104

ADEX Annual Meeting House of Representatives

Meeting July 22, 2023

- President's Award

  $10,000 grant given yearly. First award given to Stan Kanna. George Kanna Scholarship Fund to receive the award. From now on this award will be called the Stan Kanna Award.

- Update

  President's Report – nothing shared

  Treasurer's Report – Maurice Miles gave updated report and revised report will be emailed

  Psychometrician – unable to attend due to family emergency

  Report on Compacts – Dr. Guy Shampaigne

    - Compacts are a legal agreement to allow states to come into collaboration with each other
    - Dental Compacts are being considered/developed
    - Three states have agreed to join already
    - Medical has adopted Compacts
    - Federal Law for military
    - Dental Compact Development
    - Cosmetology used as the model
    - Lots of disadvantages for states to join
    - Better model is the medical compact model
    - A video of the PPT presentation on dental compacts is being produced for distribution to parties of interest
- Report on ADEX Exam 2023 Cycle – Dr. Ben Wall
- New Business
    - Nomination of Officers
    - Election of Officers
        - All current officers were eligible for re-election
        - All officers were re-elected
    - District Appointee Reports
        - Email will go out in about two weeks about what districts are up for new appointees
- Old Business
    - 2023 Annual Meeting Items
- In memoriam of Dr. Bruce Barrette – Dr. Scott Houfek
- Future Meeting Dates
    - Annual Meeting ADEX – Tentative Date – September 24-25, 2024 (Kentucky)
    - Annual Meeting CDCA-WREB-CITA – September 25-28, 2024 (Kentucky)

Adjournment

Oregon Board of Dentistry Committee and Liaison Assignments

May 2023 - April 2024

STANDING COMMITTEES

Dental Therapy Rules Oversight

Purpose: To draft, refine and update dental therapy rules.

Committee:

Sheena Kansal, D.D.S., Chair
Alicia Riedman, R.D.H., E.P.P.
Jennifer Brixey
Sarah Kowalski, R.D.H., OHA Rep.
Brandon Schwindt, D.M.D., ODA Rep.
Amy Coplen, R.D.H., ODHA Rep.
Ginny Jorgensen, CDA, EFDA, ODAA Rep.
Jason Mecum, DT Rep.
Kari Kuntzelman, DT Rep.
Miranda Davis, D.D.S., DT Rep.

Communications

Purpose: To enhance communications to all constituencies

Committee:

Michelle Aldrich, D.M.D., Chair
Reza Sharifi, D.M.D.
Jennifer Brixey
Alayna Schoblaske, D.M.D., ODA Rep.
Lesley Harbison, R.D.H., ODHA Rep.
Linda Kihs, CDA, EFDA, OMSA, MADAA, ODAA Rep.
Kari Kuntzelman, DT Rep.

Subcommittees:

- Newsletter – Alicia Riedman, R.D.H., E.P.P., Editor

Dental Hygiene

Purpose: To review issues related to Dental Hygiene

Committee:

Alicia Riedman, R.D.H., E.P.P., Chair
Terrence Clark, D.M.D.
Sheena Kansal, D.D.S.
Jennifer Brixey
David J. Dowsett, D.M.D., ODA Rep.
Lisa Rowley, R.D.H., ODHA Rep.
Bonnie Marshall, CDA, EFDA, EFODA, MADAA, ODAA Rep.
Mark Kobylinsky, R.D.H., E.P.P., DT, DT Rep.

Enforcement and Discipline

Purpose: To improve the discipline process

Committee:

Reza Sharifi, D.M.D., Chair
Alicia Riedman, R.D.H., E.P.P.
Terrence Clark, D.M.D.
Chip Dunn
Jason Bajuscak, D.M.D., ODA Rep.
Jill Mason, R.D.H., ODHA Rep.
Mary Harrison, CDA, EFDA, EFODA, FADAA, ODAA Rep.
Kristen Thomas, R.D.H., E.P.P., DT Rep.

Subcommittees:

Evaluators

- Aarati Kalluri, D.D.S., Senior Evaluator
- Sheena Kansal, D.D.S., Evaluator

Licensing, Standards and Competency

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

Committee:

Chip Dunn, Chair
Sheena Kansal, D.D.S.
Sharity Ludwig, R.D.H., E.P.P.
Terrence Clark, D.M.D.
Olesya Salathe, D.M.D., ODA Rep.
Susan Kramer, R.D.H., ODHA Rep.
Ginny Jorgensen, CDA, EFDA, EFODA, AAS, ODAA Rep.
Yadira Martinez, R.D.H., E.P.P., DT, DT Rep.

Rules Oversight

Purpose: To review and refine OBD rules

Committee:

Jose Javier, D.D.S., Chair
Michelle Aldrich, D.M.D.
Sharity Ludwig, R.D.H., E.P.P.
Jennifer Brixey
Philip Marucha, D.D.S., ODA Rep.
Laura Vanderwerf, R.D.H., ODHA Rep.
Mary Harrison, CDA, EFDA, EFODA, FADAA, ODAA Rep.
Sandra Galloway, D.M.D., DT Rep.

Anesthesia

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

Committee:

Reza Sharifi, D.M.D., Chair
Sheena Kansal, D.D.S.
Julie Ann Smith, D.D.S., M.D., M.C.R.
Brandon Schwindt, D.M.D.
Mark Mutschler, D.D.S.
Normund Auzins, D.M.D.
Ryan Allred, D.M.D.
Jay Wylam, D.M.D.
Michael Doherty, D.D.S.
Eric Downey, D.D.S.

LIAISONS

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

- Administrator Liaison – Stephen Prisby, Executive Director
- Board Attorneys' Roundtable – Lori Lindley, SAAG - Board Counsel
- Dental Liaison – Chip Dunn
- Hygiene Liaison – Alicia Riedman, R.D.H., E.P.P.

American Board of Dental Examiners (ADEX)

- House of Representatives – Aarati Kalluri, D.D.S.
- Dental Exam Committee – Aarati Kalluri, D.D.S.

Oregon Dental Association – Terrence Clark, D.M.D.
Oregon Dental Hygienists' Association – Alicia Riedman, R.D.H., E.P.P.
Oregon Dental Assistants Association – Sharity Ludwig, R.D.H., E.P.P.

Administrative Workgroup

Purpose: To update Board and agency policies and guidelines. Consult with Executive Director on administrative issues. Conduct evaluation of Executive Director. Also to work on and make strategic planning recommendations to the Board.

Committee:

- Chip Dunn, Chair
- Sharity Ludwig, R.D.H., E.P.P.
- Reza Sharifi, D.M.D.

Subcommittee:

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

- Chip Dunn – President
- Jennifer Brixey – Vice President
- Jose Javier, D.D.S. – Past President

EXECUTIVE DIRECTOR'S REPORT

EXECUTIVE DIRECTOR'S REPORT
August 25, 2023

Board Member & Staff Updates

The recruitment for the open investigator position yielded over 40 applicants and we recently offered the top candidate the position. I will have an update on the recruitment at this meeting. The OBD has also been understaffed the last 4 weeks with one staff member out for personal reasons. We appreciate all who engage with the Board for their patience as we are operating at 75% of our regular staff level.

OBD Budget Status Report

Attached is the budget report for the 2021 - 2023 Biennium. This report, which is from July 1, 2021 through June 30, 2023, shows revenue of $3,485,225.82 and expenditures of $3,620,701.31. The final FY 2023 reports have not been reconciled yet but they usually do not change much besides some final misc expenses. The results for both revenue & expenses are in line with what was budgeted for the two year period. **Attachment #1**

OBD 2023-2025 Budget

The Legislature approved the OBD 2023 - 2025 Budget and the Governor signed off on it on July 18, 2023. The final legislatively adopted budget documents were recently made available and will be compiled into the final OBD 2023-2025 legislatively adopted budget and posted on the OBD Website (probably by mid-September). I make note below of the unique Policy Option Packages (POP) incorporated into the OBD budget beyond the typical budget adjustments made when finalizing the state enterprise-wide budget.

Package 100: Dental Therapy Fees Implementation. This is a revenue only package that increases revenue for the board by $30,000 Other Funds. House Bill 2528, from the 2021 Legislative Session, authorized the board to issue a new dental therapy license, which was implemented with a corresponding license fee, effective July 2022. This package includes the revenue garnered from the new licensee base and fees.

Package 200: Oregon Wellness Program. This package increases Services and Supplies by $80,000 Other Funds to establish funding and support for the inclusion of OBD into the Oregon Wellness Program. The program is designed to provide confidential urgent mental health services to active clinical providers who self-refer.

Package 801: LFO Analyst Adjustments. This package includes several revenue and expenditure adjustments totaling an Other Funds expenditure limitation increase of $46,024 and a reduction of 0.38 FTE. The expenditure adjustments include the elimination of one vacant Business Operations Manager 2 (1.00 FTE) position, establishes funding for one previously unbudgeted Health Care Investigator (1.00 FTE), and reduces one Health Care Investigator from 1.00 FTE to 0.50 FTE beginning on January 1, 2024 (a reduction of 0.38 FTE in the 2023-25 biennium). The package also increases Other Funds expenditure limitation by $84,065 to outsource Dental Assistant Certifications to the Dental Assistant National Board (DANB); and includes an increase of $123,255 of Other Funds revenue received from DANB for Dental Assistant Certifications; and an increase of $365,150 Other Funds revenue for a fee increase across all fee types, effective July 1, 2023, to help support Package 200 and allow for the board to maintain an ending balance equivalent to three months of operating funds.

Customer Service Survey

Attached are the legislatively mandated survey results for FY 2023, which is July 1, 2022 – June 30, 2023. The results of the survey show that the OBD continues to receive positive ratings from the majority of those that submit a survey. **Attachment #2**

Staff Speaking Engagements

Dr. Angela Smorra presented "OBD Update and Jurisprudence" to the Dental Hygiene students at Portland Community College in Portland on Friday, June 9, 2023.

Samantha Plumlee gave a License Application virtual presentation to the graduating Dental Hygiene Students at Portland Community College in Portland on Monday, August 14, 2023.

Dental Hygiene License Renewal
The dental hygiene license renewal period started on August 1, 2023 (to coincide with the new fee increases) and it is progressing well. A reminder that audits of Continuing Education are planned to be conducted after the renewal period closes, as it did for the dentists who renewed their licenses earlier in the year.

Agency Head Financial Transactions Report July 1, 2022 – June 30, 2023
Board Policy requires that at least annually the entire Board review agency head financial transactions for the last Fiscal Year and that acceptance of the report be recorded in the minutes. I request that the Board review and if there are no objections, approve this report, which follows the close of the recent fiscal year. I am happy to answer any questions regarding this report. **Attachment #3 ACTION REQUESTED**

TriMet 2023-2024 Contract
I am asking the Board to ratify my entering into a contract with TriMet, which will allow the OBD to provide transportation passes for employees that are eligible to receive such passes for transportation to and from work. **Attachment #4 ACTION REQUESTED**

OBD Draft DEI Plan
The Draft DEI plan was reviewed and discussed by the Board at the June Board meeting and for review today for additional feedback and input. **Attachment #5 ACTION REQUESTED**

OBD 2022 -2025 Strategic Plan – Summary of Work
A brief summary of work completed on the priorities in the OBD strategic plan. **Attachment #6**

Board Best Practices Self-Assessment & Score Card
As a part of the legislatively approved Performance Measures, the Board needs to complete the attached Best Practices Self-Assessment Score Card so that it can be included as a part of the FY 2023 annual progress report. I will provide the report at the October Board Meeting.
Attachment #7 ACTION REQUESTED

2023 Legislative Session
Attached are bills that passed and have some impact the OBD and/or its licensees.
Attachment #8

American Association of Dental Administrators (AADA) and American Association of Dental Boards (AADB) Annual Meetings
Both annual meetings will be in Los Angeles, Ca, between Oct 18 - 21, 2023. The preliminary agenda for the AADB meeting is attached for your review. President Dunn is planning on attending the AADB Meeting. Lori Lindley will once again lead the Attorney's Roundtable at the meeting as well. Apparently the AADB is considering revising their bylaws and a draft of the proposed changes is included. I would like to attend the AADA Meeting and ask for the Board to approve this for me. I am an Officer of the AADA, serving as the Immediate Past President.
Attachment #9 ACTION REQUESTED

Newsletter
The summer OBD Newsletter is in Tab 8 of this board meeting packet and is available on our website. Thank you to all that contributed and especially to our graphic artists, Kathleen McNeal and Haley Robinson, along with Alicia Riedman, RDH for her review of it.

Agency 834

Appn Year			2023		
			Monthly Activity	Biennium to Date	Budget
Fund	Budget Obj	Budget Obj Title			
3400	1000	REVENUES	58,496.79	3,485,225.82	3,452,000.00
	2500	TRANSFER OUT	4,077.00	179,617.00	226,800.00
	3000	PERSONAL SERVICES	107,392.42	2,328,392.34	2,187,917.00
	4000	SERVICES AND SUPPLIES	93,662.97	1,292,308.97	1,671,337.00
	5000	CAPITAL OUTLAY	(22,199.00)	(22,199.00)	0.00
3400 Total			**241,430.18**	**7,263,345.13**	**7,538,054.00**
Grand Total			**241,430.18**	**7,263,345.13**	**7,538,054.00**

Agency	834
Agency Title	BOARD OF DENTISTRY
Appn Year	2023
Rpt Fiscal Mm	12
Rpt Fiscal Mm Name	JUNE 2023
Load Date GI	7/14/2023

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	53,487.00	3,096,266.00	3,100,001.00
				0210	OTHER NONBUSINESS LICENSES AND FEES	550.00	22,230.00	10,000.00
				0410	CHARGES FOR SERVICES	246.00	25,635.00	18,000.00
				0505	FINES AND FORFEITS	0.00	285,128.22	250,000.00
				0605	INTEREST AND INVESTMENTS	4,193.79	49,114.59	60,000.00
				0975	OTHER REVENUE	20.00	6,852.01	13,999.00
			REVENUES Total			**58,496.79**	**3,485,225.82**	**3,452,000.00**
		2500	TRANSFER OUT	2443	TRANSFER OUT TO OREGON HEALTH AUTHORITY	4,077.00	179,617.00	226,800.00
			TRANSFER OUT Total			**4,077.00**	**179,617.00**	**226,800.00**
		3000	PERSONAL SERVICES	3110	CLASS/UNCLASS SALARY & PER DIEM	72,345.77	1,569,854.82	1,397,859.00
				3160	TEMPORARY APPOINTMENTS	0.00	0.00	4,400.00
				3170	OVERTIME PAYMENTS	161.82	591.60	6,400.00
				3190	ALL OTHER DIFFERENTIAL	591.25	16,099.05	39,836.00
				3210	ERB ASSESSMENT	16.80	432.00	464.00
				3220	PUBLIC EMPLOYES' RETIREMENT SYSTEM	13,765.37	264,504.47	236,896.00
				3221	PENSION BOND CONTRIBUTION	4,075.99	82,126.08	75,620.00
				3230	SOCIAL	5,558.15	120,069.45	111,384.00

Agency	834
Agency Title	BOARD OF DENTISTRY
Appn Year	2023
Rpt Fiscal Mm	12
Rpt Fiscal Mm Name	JUNE 2023
Load Date GI	7/14/2023

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		SECURITY TAX			
				3241	PAID FAMILY MEDICAL LEAVE INSURANCE	290.62	1,993.06	0.00
				3250	WORKERS' COMPENSATION ASSESSMENT	12.68	345.08	368.00
				3260	MASS TRANSIT	436.69	9,214.42	8,834.00
				3270	FLEXIBLE BENEFITS	10,137.28	263,162.31	305,856.00
			PERSONAL SERVICES Total			**107,392.42**	**2,328,392.34**	**2,187,917.00**
		4000	SERVICES AND SUPPLIES	4100	INSTATE TRAVEL	2,104.82	19,716.86	52,968.00
				4125	OUT-OF-STATE TRAVEL	0.00	0.00	7,888.00
				4150	EMPLOYEE TRAINING	0.00	18,881.20	56,553.00
				4175	OFFICE EXPENSES	10,474.51	53,767.03	95,153.00
				4200	TELECOMM/TECH SVC AND SUPPLIES	1,196.23	29,473.39	25,997.00
				4225	STATE GOVERNMENT SERVICE CHARGES	64.00	74,830.19	73,273.00
				4250	DATA PROCESSING	5,359.11	109,456.44	186,234.00
				4275	PUBLICITY & PUBLICATIONS	504.93	4,040.99	15,494.00
				4300	PROFESSIONAL SERVICES	15,329.20	287,372.11	270,498.00
				4315	IT PROFESSIONAL SERVICES	0.00	0.00	148,013.00
				4325	ATTORNEY GENERAL LEGAL FEES	16,735.40	271,621.39	306,725.00
				4375	EMPLOYEE RECRUITMENT AND DEVELOPMENT	0.00	0.00	735.00
				4400	DUES AND SUBSCRIPTIONS	3,635.00	13,102.78	10,874.00
				4425	LEASE PAYMENTS & TAXES	7,952.81	167,897.43	186,798.00
				4475	FACILITIES MAINTENANCE	0.00	0.00	608.00
				4575	AGENCY PROGRAM RELATED SVCS & SUPP	4,530.65	44,809.98	107,494.00

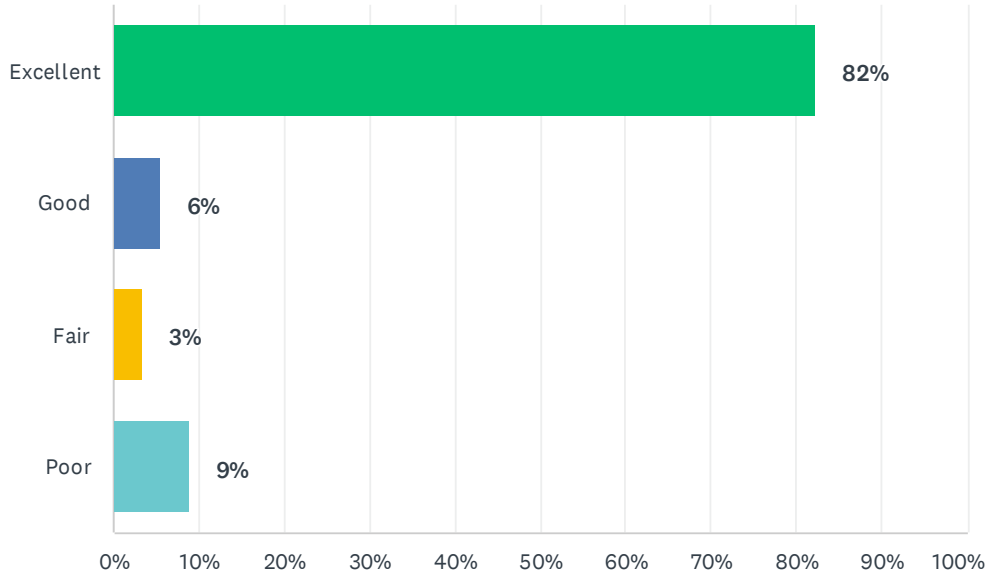
Agency	834
Agency Title	BOARD OF DENTISTRY
Appn Year	2023
Rpt Fiscal Mm	12
Rpt Fiscal Mm Name	JUNE 2023
Load Date GI	7/14/2023

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	4650	OTHER SERVICES AND SUPPLIES	3,577.31	111,408.36	95,453.00
				4700	EXPENDABLE PROPERTY $250-$5000	0.00	0.00	6,087.00
				4715	IT EXPENDABLE PROPERTY	22,199.00	85,930.82	24,492.00
			SERVICES AND SUPPLIES Total			**93,662.97**	**1,292,308.97**	**1,671,337.00**
		5000	CAPITAL OUTLAY	5550	DATA PROCESSING SOFTWARE	(22,199.00)	(22,199.00)	0.00
			CAPITAL OUTLAY Total			**(22,199.00)**	**(22,199.00)**	**0.00**

DAFR9210 Agency 834 - month end

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

Answered: 90 Skipped: 0

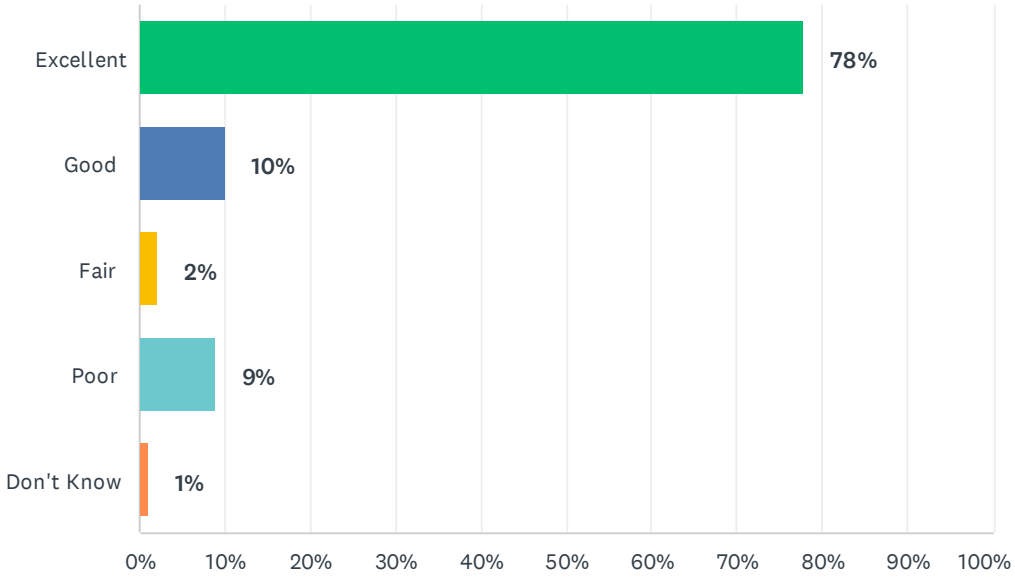


ANSWER CHOICES	RESPONSES	
Excellent	82%	74
Good	6%	5
Fair	3%	3
Poor	9%	8
TOTAL		90

Attachment #2

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

Answered: 90 Skipped: 0

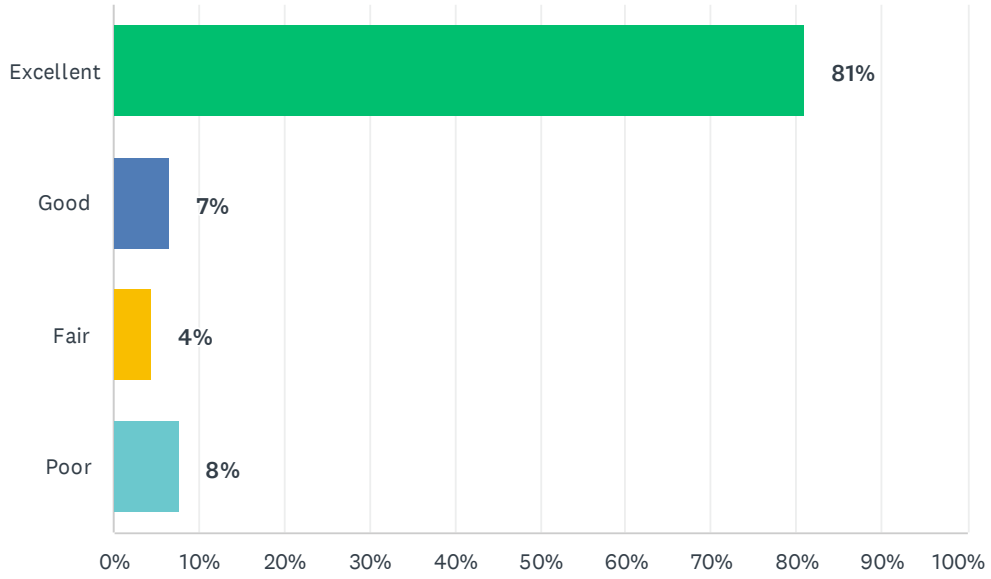


ANSWER CHOICES	RESPONSES	
Excellent	78%	70
Good	10%	9
Fair	2%	2
Poor	9%	8
Don't Know	1%	1
TOTAL		90

Attachment #2

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

Answered: 90 Skipped: 0

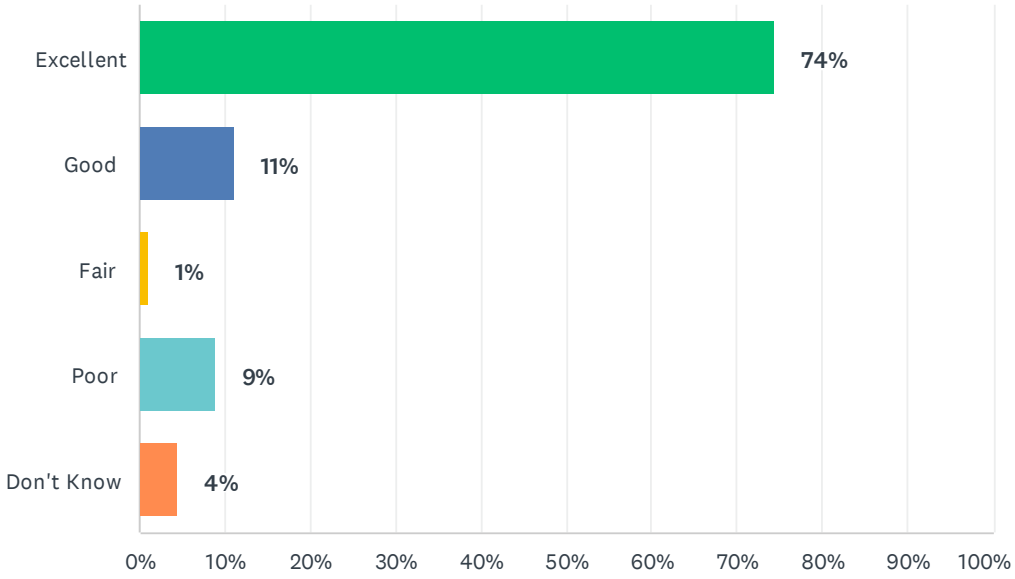


ANSWER CHOICES	RESPONSES	
Excellent	81%	73
Good	7%	6
Fair	4%	4
Poor	8%	7
TOTAL		90

Attachment #2

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

Answered: 90 Skipped: 0

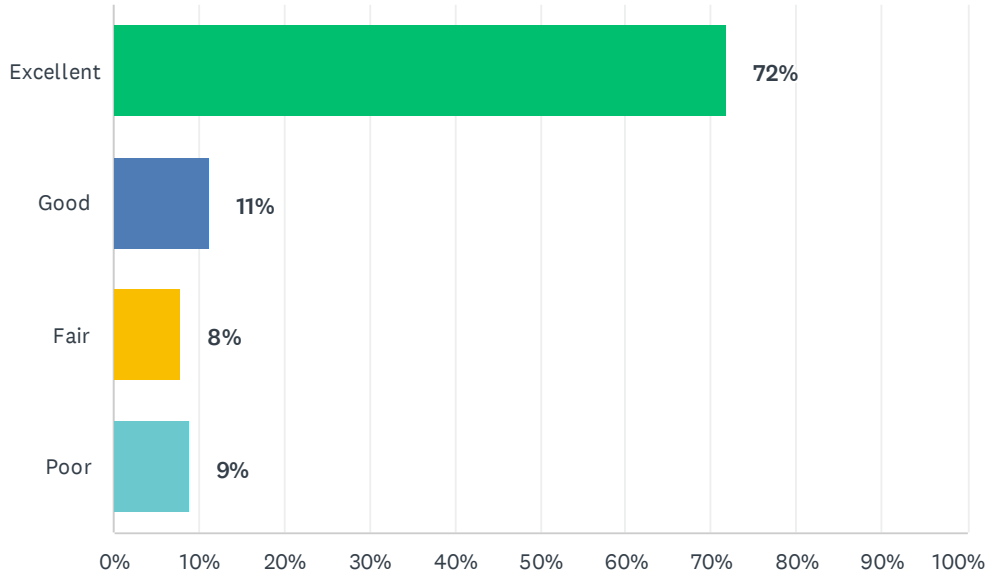


ANSWER CHOICES	RESPONSES	
Excellent	74%	67
Good	11%	10
Fair	1%	1
Poor	9%	8
Don't Know	4%	4
TOTAL		90

Attachment #2

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

Answered: 89 Skipped: 1

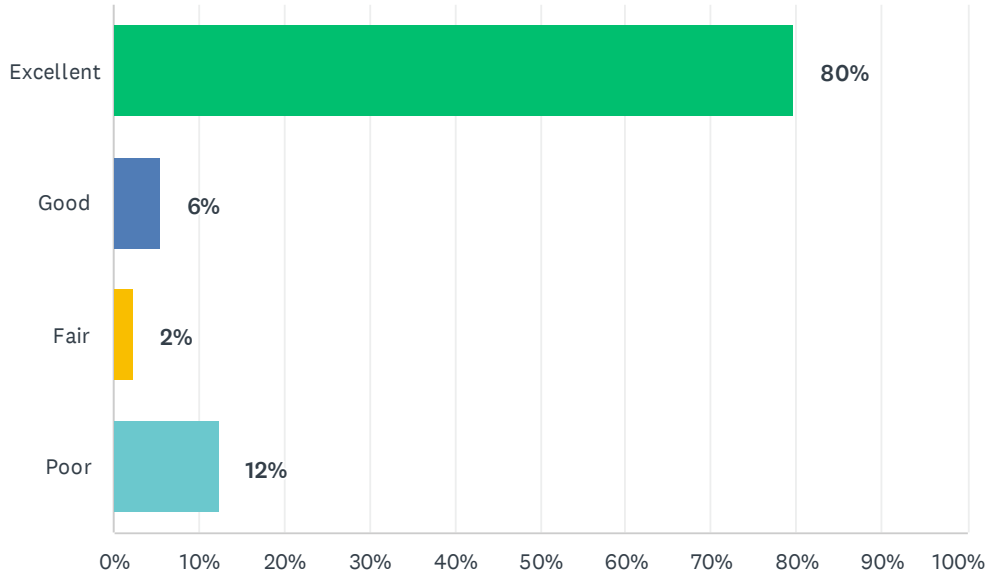


ANSWER CHOICES	RESPONSES	
Excellent	72%	64
Good	11%	10
Fair	8%	7
Poor	9%	8
TOTAL		89

Attachment #2

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

Answered: 89 Skipped: 1



ANSWER CHOICES	RESPONSES	
Excellent	80%	71
Good	6%	5
Fair	2%	2
Poor	12%	11
TOTAL		89

Attachment #2

Fiscal Year 2023 Agency Head Financial Transactions

Annual Leave Summary July 1, 2022 – June 30, 2023

Accrual or type of leave	Balance 7/1/2022	Accrual per month	Earned	Used	Balance 6/30/2023
Vacation	160	13.34	160	80	240
Vacation Payout	-	-	-	-	0
Sick Leave	744	8	96	32	808
Personal Business	24	-	-	24	0
Discretionary Governor's Leave	8	-	-	8	0
Misc Personal Leave	-	-	-	-	0

Unclassified Executive Service, Unclassified Excluded and Management Service

Months Worked	Accrual Rate
First month through 60th month	10.00 hours per month
61st month through 120th month	11.34 hours per month
121st month through 180th month	13.34 hours per month
181st month through 240th month	15.34 hours per month
241st month through 300th month	17.34 hours per month
After 300th month	19.34 hours per month

Annual Travel Summary July 1, 2022 – June 30, 2023

Total In State Travel Expenses	**$ 381.38**
DANB Stakeholder Forum in Chicago, Il July 2022	**$ 885.60**
AADA & AADB Annual Meetings in Asheville, NC October 2022	**$ 3,031.27**
Total Out of State Travel Expenses	**$ 3,916.87**
Total Agency Head Expenses Reimbursed to Employee:	**$ 2,452.67**

The expenses not reimbursed to employee, were covered or directly expensed to the state.

FY 2023 Spots Card Purchases (Agency credit card paid directly by state)

	Total
Registrations/Memberships	$ 5839
Office Equipment/Supplies	$ 20,451
Publications/Subscriptions	$ 1196
Board Meeting/Staff Training Food	$ 3358
Transportation	$ 502.64
	$ 31,346.64

Fiscal Year 2023 Agency Head Financial Transactions

Agency Head Financial Transactions
Spots Card and Travel Reimbursement
Fiscal Year 2023 by Quarter

SPOTS Card Purchases: (Agency credit card paid directly by state)	**sub-total**	**Total**
July – September		**$7393.29**
AT&T	$1301.50	
Clear Training	$290.00	
Board Meeting Food	$678.13	
FedEx	$14.49	
Parking	$46.35	
Quadient (Mail & Fold Machine Leases)	$2,881.98	
NPDB	$190.00	
Office Depot	$1002.68	
NIC	924.00	
Nameplates	$29.16	
Zipcar (annual membership fee)	$35.00	
October – December		**$8513.04**
AT&T	$1,301.66	
NPDB	$1006.00	
Board Meeting Food	$977.78	
FARB Conference Reg	$900.00	
Quadient (Mail & Fold Machine Leases)	$1,808.40	
Office Depot	$705.91	
NIC	$973.00	
Parking	$456.29	
Survey Monkey	$384.00	
January – March		**$6675.19**
AADB Mid-Year Meeting Reg	$595.00	
AT&T	$1,706.71	
Quadient (Mail & Fold Machine Leases)	$1,808.40	
Board Meeting Food	$371.56	
Office Depot	$1272.52	
NIC	$921.00	
April – June		**$8765.12**
AT&T	$829.58	
Quadient (Mail & Fold Machine Leases)	$1808.40	
Board Meeting Food	$1330.53	
AADB Membership Renewal	$3635.00	

Fiscal Year 2023 Agency Head Financial Transactions

Office Depot	$259.61
NIC	$902.00

TRI-COUNTY METROPOLITAN TRANSPORTATION DISTRICT OF OREGON

EMPLOYER CONTRACT FOR

TRIMET UNIVERSAL ANNUAL PASS FARE PROGRAM

This Contract is entered into **September 1, 2023** by and between the Tri-County Metropolitan Transportation District of Oregon ("TriMet") and **OREGON BOARD OF DENTISTRY** ("Employer") located at **1500 SW 1st Avenue, Suite 770**, **Portland, OR 97201**.

1. Universal Annual Pass Program
   Employer shall implement the Universal Annual Pass Program at Employer's work site(s) in accordance with the attached and incorporated Exhibit A, Universal Annual Pass Administrative Program Requirements (Program Requirements) as may be amended by TriMet. By signature hereto, Employer certifies that it has read and agrees to be bound by all of the Program Requirements, including but not limited to the Requirements initialed by Employer and those applicable to the Institutional Web Portal ("Services").

2. Term
   This Contract shall be in effect from the date listed above through August 31, 2024, unless terminated sooner by TriMet as provided in the Program Requirements. TriMet also may terminate this Contract upon 30 days advance written notice to Employer, and in such event where Employer is in compliance with this Contract, TriMet will reimburse Employer for all returned Universal Annual Passes based on the number of days remaining in the Contract term.

3. Employer Payment
   Employer's total payment due under this Contract is **$1,147.98**. Refer to the Exhibit C Schedule for calculation of Universal Annual Pass price. Employer's Universal Annual Pass price per employee per year under this Contract is **$191.33**. Additional fare instruments purchased during the contract year will be prorated based on this price, as set forth in section E.2) of Exhibit A of this Contract.

4. Universal Annual Pass Qualified Employees
   The total number of Employer's qualified employees, as defined in Exhibit A, Paragraph B, is **6**. The Employee Commute Options survey was performed **June 1, 2023**, the results of which are contained in the attached and incorporated Exhibit B.

5. Correspondence/Communications
   (a) TriMet's Representative and Employer's Transportation Coordinator shall be responsible for routine, day-to-day correspondence and communications regarding Employer's implementation of the Pass Program. Upon commencement of this Contract, TriMet and Employer shall provide written notice to each other of the name and address of their respective designated Representative and Transportation Coordinator, and shall provide prompt written notice of any change thereto.

(b) All notices required to be given by the terms of this Contract shall be provided in writing and signed by the person serving the notice, and shall be sufficient if given in person, mailed postage pre-paid certified return receipt or telefaxed (with confirmation record) to the persons at the signature addresses below, or to such other address as either Party may notify the other of in writing. Any notice given personally shall be deemed to have been given on the day that it is personally delivered or telefaxed (with confirmation record), and if mailed three days after the date of the postmark of such mailing.

6. Limitation of Liability

TO THE MAXIMUM EXTENT PERMITTED BY APPLICABLE LAW, TRIMET, ITS OFFICERS, DIRECTORS, EMPLOYEES, AGENTS, SERVICES PROVIDERS AND LICENSORS SHALL NOT BE LIABLE TO EMPLOYER OR ANYONE FOR ANY INDIRECT, INCIDENTAL, SPECIAL, CONSEQUENTIAL OR EXEMPLARY DAMAGES, INCLUDING BUT NOT LIMITED TO DAMAGES FOR LOST PROFITS, GOODWILL, USE, DATA OR OTHER INTANGIBLE LOSSES (REGARDLESS OF WHETHER WE HAVE BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES), HOWEVER CAUSED, WHETHER BASED UPON CONTRACT, NEGLIGENCE, STRICT LIABILITY IN TORT, WARRANTY OR ANY OTHER LEGAL THEORY. IN NO EVENT SHALL TRIMET'S TOTAL LIABILITY TO EMPLOYER IN CONNECTION WITH THE PASS PROGRAM AND THE SERVICES FOR ALL DAMAGES, LOSSES AND CAUSES OF ACTION EXCEED AMOUNTS PAID TO TRIMET UNDER THIS AGREEMENT DURING THE PRIOR 12 MONTHS.

7. Indemnity

EMPLOYER AGREES TO DEFEND, INDEMNIFY AND HOLD HARMLESS TRIMET AND ITS OFFICERS, DIRECTORS, EMPLOYEES, CONTRACTORS, AGENTS, LICENSORS, SUPPLIERS, SUCCESSORS AND ASSIGNS FROM AND AGAINST ANY CLAIMS, LIABILITIES, DAMAGES, JUDGMENTS, AWARDS, LOSSES, COSTS, EXPENSES OR FEES (INCLUDING REASONABLE ATTORNEYS' FEES) ARISING OUT OF OR RELATING TO VIOLATION OF THIS CONTRACT, INCLUDING WITHOUT LIMITATION EMPLOYER'S USE OF THE SERVICES OTHER THAN AS EXPRESSLY AUTHORIZED IN THIS CONTRACT.

8. No Third Party Beneficiary

Employer and TriMet are the only Parties to this Contract and as such are the only Parties entitled to enforce its terms. Nothing in this Agreement gives or shall be construed to create or provide any legal right or benefit, direct, indirect or otherwise to any other Party unless that Party is individually identified by name herein with the express and stated designation as an intended beneficiary of the terms of this Contract.

9. Authority

Each Party represents that the individual signing below is duly authorized by that Party to enter into this Contract and bind that Party to its terms.

10. Entire Agreement

This Contract and any attached exhibits constitute the entire agreement between the Parties on the subject matter hereof. There are no understandings, agreements, or representations, oral or written, regarding this Contract not specified herein. No waiver, consent, modification or change of terms of this Contract shall bind either Party unless in writing and signed by both Parties and all necessary approvals have been

obtained. Such waiver, consent, modification or change, if made shall be effective only in the specific instance and for the specific purpose given.

11. Execution of Contract

This Contract and any written modifications thereto, may be executed in two or more counterparts, each of which together shall be deemed an original, but all of which together shall constitute one and the same instrument. In the event that any signature is delivered by facsimile transmission or by e-mail delivery of a "pdf" format date file, such signature shall create a valid and binding obligation of the Party executing (or on whose behalf such signature is made) with the same force and effect as if such facsimile or "pdf" signature page were an original thereof.

OREGON BOARD OF DENTISTRY

By: _____
signature

Date: _____

Name: _____
please print

Title: _____

Address: _____
_____

Telephone Number: _____

THE TRI-COUNTY METROPOLITAN TRANSPORTATION DISTRICT OF OREGON

By: _____
signature

Date: _____

Name: JC Vannatta

Title: Executive Director of Public Affairs

Address: 101 SW Main Street, Suite 700
Portland, Oregon 97204

OREGON BOARD OF DENTISTRY
1500 SW 1st Ave., Suite 770
Portland, OR 97201
Telephone: 971-673-3200

Diversity, Equity, and Inclusion Plan

DRAFT

LAND RECOGNITION

We would like to acknowledge the many tribes and bands who call Oregon their ancestral and current territory, including: Burns Paiute, Confederated Tribes of Coos, Lower Umpqua and Siuslaw, Cow Creek Band of Umpqua Tribe of Indians, Confederated Tribes of Grand Ronde, Confederated Tribes of Siletz Indians, Confederated Tribes of Warm Springs, Confederated Tribes of Umatilla Indian Reservation, Coquille Tribe, and Klamath Tribes; and honor the ongoing relationship between the land, plants, animals, and people indigenous to this place we now call Oregon. We recognize the continued sovereignty of the nine federally recognized tribes who have ties to this land.

AGENCY MISSION

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.

AGENCY FUNCTION

The Oregon Board of Dentistry (OBD) is comprised of a ten member board and eight staff members. The Board Members are selected by the Governor and confirmed by the Senate. The staff members are state employees who were hired through the state of Oregon's HR employment system. The OBD utilizes outside HR support for all recruitment efforts. The authority and responsibilities of the Oregon Board of Dentistry (OBD) are contained in Oregon Revised Statutes Chapter 679 (Dentists & 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 by enforcing the standards of practice established in statute and rule. The primary program activities are Licensing, Enforcement and Monitoring, and Administration.

Diversity, Equity, and Inclusion Statement

OBD is committed to establishing, monitoring, and maintaining a diverse workforce, reflective of the population in the State of Oregon, where all employees are valued, treated fairly, and given opportunities to develop, thrive and feel that they truly belong. This is a commitment to an active program that provides equal opportunities for all persons regardless of race, color, religion, sex, sexual orientation, national origin, marital status, age, or disability. Every employee plays a part in our diverse workforce and inclusive work environment by being respectful and supportive, and by acting with integrity and respect to one another. Each person's skills, talents, knowledge, experiences, and personalities broaden the range of perspectives and approaches to conducting the work we do at the OBD.

OBD can best promote excellence by recruiting, retaining, and accommodating a diverse group of staff in an environment of respect that is supportive of their workplace success. This climate of diversity, inclusion and excellence is critical to successfully attaining our mission of contributing leadership and resources to increase the skills, knowledge and career opportunities of Oregonians.

The OBD is an equal-opportunity employer that is committed to a proactive role in the recruitment and selection process. The OBD will use diverse recruitment strategies to identify and attract candidates and establish interview panels that represent protected-class groups.

The OBD is committed to providing broad and culturally enriched training, career growth and developmental opportunities to all employees on an equal basis, enabling them to further advance and promote their knowledge, skills, and abilities and their value of diversity

The Affirmative Action Policy and Diversity & Inclusion Statement will appear on the OBD's webpage. Additionally, OBD's plan will be provided to all new employees, posted in the employees' common area, and linked in OBD's quarterly newsletter. All OBD employees, with a higher emphasis of responsibility placed on management employees, are responsible for the implementation of the Affirmative Action Policy and Diversity & Inclusion in the workplace. Employees and Board members are expected to ensure that they are aware of the Affirmative Action Policy and Diversity & Inclusion statement and follow the policy and statement guidelines as it pertains to their work, especially during the hiring process.

An individual who has interviewed for employment, who believes they were denied employment based on any of the aforementioned discriminatory factors, may file a complaint with the Executive Director on behalf of the Board. All reported incidents will be investigated promptly, thoroughly, impartially, and discreetly. The investigator will notify the complainant in writing of the results of the investigation. Formal appeals/complaints may also be filed with the state's Affirmative Action Office; the Bureau of Labor and Industries; the Equal Employment Opportunity Commission (909 First Avenue, Ste. 400, Seattle, WA 98104-1061); or the United States Department of Labor, Office of Civil Rights.

The purpose of this statement is to update and maintain the previously initiated affirmative action program for the OBD in keeping with the directive of the GO, State and Federal laws and regulations, and executive orders of the President of the United States of America concerning diversity and inclusion/affirmative action discrimination/non-discrimination guidelines appropriate under the Civil Rights Acts, equal employment opportunity (EEO) policies, and the Americans with Disabilities Act by which our good faith efforts must be directed. We support the work of the OCC and GO, both inside and outside of state government.

The OBD's 2022 -2025 Strategic plan aligns with our agency's goals based on the State of Oregon's 2023-2025 Affirmative Action Plan and the State of Oregon's Diversity, Equity, and Inclusion Action Plan.

While the OBD was created by state laws, we seek to ensure that the OBD builds an organization that uses the concepts of diversity, equity, and inclusion (DEI), such as problem-solving, innovation, and organizational development, to create a workplace that is stronger, better functioning, and more dynamic, and that can deliver the best possible service to the people of Oregon (see Appendix B).

2023-2025 Overview and Plan

During the 2023-2025 biennium, the OBD will work toward meeting its affirmative action, diversity, equity, inclusion, and altruistic goals.

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The Board members turned over due to the term limits on Board members. It welcomed five new Board members during the 2021-2023 Biennium. These five were chosen by Governor Kate Brown and confirmed by the Senate. There will at least 5 board member openings during the 2023-2025 Biennium due to board members terming out at various times.

All the basic tasks and mission of the Board to license, regulate and protect the public will remain the Board's highest priorities.

The OBD's 2022 – 2025 Strategic Plan defines priorities in alignment with its statutory obligations and its mission - to promote quality oral health care and protect all communities in the State of Oregon by equitably and ethically regulating dental professionals. The OBD is challenged to address a rapid and accelerating rate of change. Significant shifts are occurring in oral healthcare, dentistry practice, dental therapy services, organizational structures, business models and markets. The Strategic Plan is referenced in this document for its direct alignment with this affirmative action plan for 2023 – 2025.

The OBD sees its mission as elevating the standard of oral health care in Oregon, not solely though regulation but through information, outreach, and education. Additionally, new mandates from the Governor and the Legislature challenge all state agencies to address racial disparities and social determinants of health in the healthcare environment.

The OBD seeks to be an active partner with those that seek a better Oregon for everyone in ways that our small agency can make an impact.

The OBD Board Members and staff ratios have historically remained consistent in terms of the protected classes. At the time of this report, the Board is comprised of 10 Board members, of whom are: one Caucasian man, one Hispanic man, one African American man, one Middle Eastern man, two Asian women, three Caucasian women, and one Native American woman. There are currently eight OBD staff comprised of one Caucasian man, one Hispanic man, one Multiple Ethnicities man, and five Caucasian women. In the past biennium, there has been a noted shift in the classification of worker generation. In previous years, a significant portion of the staff was classified as Baby Boomers. As of June 1 2023, OBD staff include three Millennials, three Generation X, and two Baby Boomers, a much a wider range in the generations (See Organization Charts Appendix C).

Affirmative Action Report

Agency Affirmative Action Policy: The Board of Dentistry affirms and supports the Governor's Affirmative Action Plan and is dedicated to creating a work environment, which will attract and retain employees who represent the broadest possible spectrum of society including women, minorities and the disabled. The Board of Dentistry will not tolerate discrimination or harassment on the basis of race, color, sex, marital status, religion, national origin, age, mental or physical disability, or any reason prohibited by state or federal statute. The Board and its management further adopts and affirms the Governor's beliefs that the State has a commitment to the right of all persons to work and advance on the basis of merit, ability and potential.

The Board of Dentistry has seven positions budgeted at 8.0 FTE.

Status of 8 staff positions at July 1, 2022:

Official/Administrator	1.0 White/Male/over 40
Professional/Technical	1.0 Hispanic/Male/over 40
Administrative/Support	1.0 Multiple Ethnicities/Male/over 40
	2.0 White/Female/over 40
	3.0 White/Female/under 40

The ten members of the Board are appointed by the Governor and confirmed by the Senate to four-year terms. By statute, six members are licensed dentists, two are licensed hygienists and two are public members.
Status of 10 Board Members positions at July 1, 2022:

Board President	1.0 Hispanic/Male/over 40
Board Vice President	1.0 African American/Male/over 40
	3.0 White/Female/over 40
	2.0 Asian/Female over 40
	1.0 Native American/Female/under 40
	1.0 Middle Eastern/Male/over 40
	1.0 White/Male/over 40

Employees are urged to cross- train whenever possible so that they may take advantage of those opportunities when they occur. The OBD's Executive Director promotes and encourages professional development training. OBD Staff have annually attended the DEI Conference and found great value in it.

2023-2025 DEI Plan

We have finite resources and bandwidth to address and work meaningfully on all 10 strategies identified in the state's most recent Diversity, Equity and Inclusion Action Plan.

The OBD will focus on these 4 areas:

Strategy/Focus Area - Communications
Challenge: Staff and communities are unaware of programs and services available to them.
Actions: Engage the Racial Justice Commission and Office of Cultural Change.
Attend Meetings. Ensure all Executive Orders are being followed and implemented. Share employment opportunities with the Office of Cultural Change, Partners in Diversity, and other DEI minded organizations.
Timeline: By July 1, 2024

Strategy/Focus Area – Community Engagement
Challenge: Staff and communities are overburdened by engagement process. Time needs to be allocated to further engage in DEI actions to support community engagement with the OBD.
Actions: Review current outreach processes.
Connect with professional associations, dental school, dental hygiene schools and dental therapy programs. Educate staff and Board Members on DEI processes during staff and Board meetings.

- Increase ease of access to OBD services and information
- Ensure equity exists in investigation outcomes

Timeline: By July 1, 2025

Strategy/Focus Area – Diversifying Workforce

Challenge: The OBD has limited resources and its mission is not directly focused on workforce, growth, shortages or other. It can do its part with information, education and be a resource.

Actions: How to leverage and partner with organizations that have more resources and focus in the area of the oral healthcare work force.

- Dental Assisting education programs
- Dental Hygiene Programs
- Dental Therapy programs
- Tribes
- OHA
- OHAA
- ODHA
- ODA

Timeline: By July 1, 2025

Strategy/Focus Area – Increase Awareness of Diversity, Equity, and Inclusion within the Board

Challenge: There are a lot of hats that Board and Staff members wear and a lot of documents to read and review. Need to plan extra time for integration and awareness.

Actions: Share and encourage participation by OBD staff in all DEI events and educational opportunities, such as the Annual DEI Conference. Our strategy is to revise and update our current processes, while encouraging the awareness of the importance of diversity, equity, and inclusion within our Board and staff, will be implemented over the next biennium with the hopes of creating a more inclusive working environment and culture that supports the Governor's efforts and the OBD as well.

Timeline: By July 1, 2024

Strategy/Focus Area –Data

Challenge: There is very little data on communities we serve and where consumers look for information

Actions: Develop a data strategy that gathers where community members are looking for information about the OBD and the services we provide.

Timeline: By July 1, 2025

State of Oregon Diversity, Equity and Inclusion Action Plan, A Roadmap to Racial Equity and Belonging

Oregon
Tina Kotek, Governor

OBD Executive Director
Stephen Prisby

Board of Dentistry
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TO: OBD Board Members

FROM: Stephen Prisby, OBD Executive Director

DATE: August 14, 2023

SUBJECT: OBD 2022 – 2025 Strategic Plan Summary of Work

Strategic Priority A – Licensure Evolution
Dental Therapy Rules Oversight Committee had five meetings leading up to the inaugural rules and policies to regulate dental therapists in Oregon. Dental Therapy rules, license instructions and applications were in place and ready on July 1, 2022. The first application for licensure was received and issued in September 2022.
Engage dental therapy community and include in Board work.

Strategic Priority C – Community Interaction and Equity
Juliet Valdez Office of Cultural Change invited to Aug 2022 Board Meeting
Continue to share information and welcome our Tribal partners to every Board Meeting
Engage the dental therapy community and added a regular standing Dental Therapy Rules Oversight Committee
DEI Plan being reviewed by the board at multiple meetings before being finalized in October 2023
Recognized and accepted comments & feedback from the dental assistant community on legislative and other issues

Strategic Priority D – Workplace Environment
Hybrid Work Environment implemented successfully
Professional Development opportunities for staff – Investigator Specific Training, including AG Law Conference
Staff informed on timely announcements with Workday and Paid Leave Program implementation from the Oregon Employment Department
New State Holiday - Juneteenth adding to another day off
Regular Quarterly Check-ins with all staff

Strategic Priority E – Technology & Process
Modernization Efforts - Board Meetings, Teams Environment
Laptops distributed to Board members, emails, first Evaluator and Board Books distributed for October 2022 Board meeting
December 2022 Initial license applications able to be completed on line and complete transition away from paper applications
Updated & Streamlined Protocols, malpractice PLRs and Compliance Audit Project

OBD 2022-2025 Strategic Plan Attached

Oregon Board of Dentistry

Strategic Plan 2022-2025

Adopted February 25, 2022

Table of Contents

Oregon Board of Dentistry

2022-2025 Strategic Plan

Board members and staff of the Oregon Board of Dentistry who participated in the development of this strategic plan at the October 22-23, 2021 Planning Session:

Alicia Riedman, RDH - President
Jose Javier, DDS - Vice President
Amy B. Fine, DMD
Gary Underhill, DMD
Reza J. Sharifi, DMD
Charles "Chip" Dunn
Yadira Martinez, RDH
Jennifer Brixey
Aarati Kalluri, DDS
Sheena Kansal, DDS

Stephen Prisby - Executive Director
Haley Robinson - Office Manager
Winthrop "Bernie" Carter, DDS - Dental Director/Chief Investigator
Angela M. Smorra, DMD - Dental Investigator
Ingrid Nye - Investigator
Lori Lindley - Sr. Assistant Attorney General

Facilitators:
Jennifer Coyne - CEO, The PEAK Fleet
Theresa Trelstad - Contractor Consultant, The PEAK Fleet

Oregon Board of Dentistry
Strategic Plan Overview

The Oregon Board of Dentistry's (OBD) responsibilities and oversight authority is bestowed from the Oregon Revised Statutes Chapter 679 (Dentists), Chapter 680.10 to 680.205 (Dental Hygienists), Oregon Administrative Rules Chapter 818. In addition, direction for Dental Therapists is guided by HB 2528 (2021) and the addition of Interim Therapeutic Restorations, HB 2627 (2021) for Expanded Practice Dental Hygienists. These new statutes task the OBD with regulation and oversight of the practice of dentistry and dental hygiene by enforcing standards of practice established in the Oregon Legislature statutes and rule.

At the end of the previous 2017-2020 planning cycle and after hardships of the COVID 19 pandemic (which has persisted from 2020 into 2022), OBD had established transformative ways of addressing critical issues. Strong relationships with the Governor's office, Oregon Legislature, Oregon Health Authority, peer professional organizations, and national associations gave context and direction, and kept a finger on the pulse of rapid changes in the dental profession, business practices, and operating models.

In mid-2021 the Board and staff of OBD agreed to secure professional, external strategy and facilitation services in the creation of their next multi-year strategic plan, building upon the efforts of the 2017-2020 Plan.

During the planning process, the OBD Board and Staff agreed to update the mission statement to reflect a focus on access to care as well as on integrity. The OBD will implement the strategic plan, adaptively to rapidly changing circumstances, in support of its Mission: *to promote quality oral health care and protect all communities in the State of Oregon by equitably and ethically regulating dental professionals.*

Through external market research, initial discussions with the Board and Staff, and tabulation of the licensee surveys, a set of priorities emerged. Through the facilitated process between August and October 2021, five key strategic priorities were defined and goals established. Actions needed to meet the strategic goals were drafted and prioritized.

Covered in more detail in the subsequent pages, focus for the next 3-5 years will be on Licensure Evolution (including Dental Therapy legislation implementation),

Dental Practice Accountability, Workplace Environment, Technology & Processes, and Community Interaction & Equity.

This multi-year strategic plan outlines OBD's path and efforts to engage constituents on many levels to upscale practices and processes reflecting the changing environment and statutory responsibilities.

The new strategic plan is built upon a foundation of strength in Staff and Board expertise and experience, as well as positive Licensee sentiment, expressed as 78% positive, following a very tough year with the pandemic and other social impacts (especially on the healthcare industry). In addition, the Board and Staff defined and approved organizational core values of ***integrity***, ***fairness***, ***responsibility***, and ***community.*** Combined with a focus on mission, the newly defined core values are a visible lens through which to make decisions and set direction.

Oregon Board of Dentistry
Mission Statement & Core Values

Mission of the Oregon Board of Dentistry:

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 Core Values:

- Integrity
- Fairness
- Responsibility
- Community

Oregon Board of Dentistry

Organizational & External Influences Analysis

This organizational and external analysis covers the internal factors that will influence the ability to respond to operational needs as well as the external factors that may drive change. The Oregon Board of Dentistry analyzed the social, technological, economic, legal/regulatory, and environmental factors that might affect the practice of dentistry and the OBD's oversight. In addition, the current organizational status was analyzed primarily through staff interviews.

The most significant Strengths, Weaknesses, Opportunities, and Threats that affect the OBD are:

STRENGTHS	WEAKNESSES
• Foundation of known, common values: Integrity, Fairness, Responsibility, Community and commitment to the mission • Skilled, experienced, and dedicated staff • Successful migration and knowledge transfer as new Board and Staff onboarded during previous strategic period • Foresight and proactive succession and onboarding planning • Board composition provides a breadth of perspectives • Member survey shows support in OBD remains high at 78% after problematic pandemic year	• Lack of clear understanding for OBD scope and jurisdiction by public, patients and Licensees • Limited control over budget/funding impact ability to adjust staffing plans to meet overall strategic plan needs • Legislature changes can create significant increases in staff work that are not in alignment with staffing capacity • Low levels of Licensee participation in inputs/surveys. 2020 strategic priorities member survey had 265 responses • Board member turnover creates loss of continuity and historical knowledge
OPPORTUNITIES	**THREATS**
• Ability to implement Dental Therapy licensure process • Migration of technology to improve licensee experience, overall processes & efficiency, and provide workplace flexibility • Collaboration with Oregon Health Authority (OHA) to manage public engagement and expectations for language, cultural diversity, equity, and inclusion across OHA partners. (With guidance from the State Racial Justice Council.)	• Continued lagging technology infrastructure • Shifts in business operations and managed care pose challenges to dentistry practices and regulation • Insurance maximums dating to the 1960's influence patient care recommendations

In addition to the SWOT items called out above it is important to note that ability to address Opportunities, Threats, and Weaknesses will come from the areas of Strength. For instance, the Engaged Board and Staff expertise coupled with the learnings from the migration and knowledge transfer of the previous period is the key to implementing needed technology infrastructure which in turn drives the hybrid work environment. In a similar fashion, collaboration with OHA and the State Racial Justice Council recommendations will set standards for community engagement, helping clarify OBD scope and public expectations for interaction with the OBD.

STRATEGIC PRIORITY A

Licensure Evolution

In support of providing quality oral care equitably to all, the dental profession must address the issue of communities having access to dental care services. This access may be limited by lack of dental care professionals in certain community areas such as rural areas, lower socio-economic areas, or tribal communities. Solving this problem requires creativity and the evolution of types of licenses granted. As new legislation is created, the OBD must implement rules and standards to govern dental professionals in Oregon.

Goals

⟹ Develop and implement rules based on legislation changes

⟹ Successfully implement Dental Therapy license

Action Items

- Develop and implement rules in support of HB 2528 (2021) for newly created Dental Therapist license
- Develop and implement communication strategies with communities most impacted by Dental Therapy license implementation
- Engage interested parties to learn more and gather feedback about implementing Dental Therapy practice in Oregon

STRATEGIC PRIORITY B

Dental Practice Accountability

The landscape of dental practices continues to evolve further toward group dentistry practice including ownership by national corporate entities. This in turn, creates challenges and complexity in ensuring the public safety and high standards of practice are upheld. In addition, when complaints are made, establishing appropriate accountability and encouraging improvements to happen is more challenging than in the past.

Goals

⟹ Ensure Licensees dictate clinical care provided to patients (in contrast to corporate non-Licensees driving care decisions)

⟹ Increase OBD visibility into practice ownership models

⟹ OBD jurisdiction over Dental practices in Oregon, regardless of ownership and business operating model

⟹ Correlate patient care to level of competency required by practitioners (DT, DMD, DDS, DH); hold entities accountable to the level of licenses within their practice

Action Items

- Implement changes to Licensee Renewal form to capture multiple office/group affiliation
- Gather dental practice ownership and training information
- Analyze complaints by ownership types
- Receive OHSU updated curriculum and include in Board Book
- Evaluate options for strengthening statute related to accountability, ownership, and standards of care

STRATEGIC PRIORITY C

Community Interaction and Equity

The Oregon Board of Dentistry recognizes that systemic inequities exist in our society which have resulted in practices that have not always provided equitable access to dental care across our community.

Protecting the Community has always been at the center of the Oregon Board of Dentistry Mission. Fairness and equity are imbedded in the OBD Values. The OBD believes it can do more to address the systemic inequities that have existed and ensure more fully that our mission and values apply to everyone.

Goals

⟹ Communicate and market to reach the diverse communities within Oregon

⟹ Increase ease of access to OBD services

⟹ Ensure equity exists in Investigation outcomes

⟹ Increase OBD Licensee, patient, and community understanding of OBD roles, responsibilities, and services

Action Items

- Align Diversity, Equity, and Inclusion plans to guidance provided by the State of Oregon Racial Justice Council
- Include diversity analysis when developing Marketing or Communications materials; consider diversity in visual representations
- Enable OBD to take complaints in complainant's first language
- Create analysis of prior investigations, findings, and actions across Licensee demographics to frame equity-related data

STRATEGIC PRIORITY D

Workplace Environment

The COVID-19 pandemic, technology advances, talent supply/demand issues as well as numerous factors affecting employee expectations of the work environment are driving the need for changes to work environments worldwide. OBD has previously been limited in ability to offer more flexible work location options due to technological limitations. Those limitations are easing, allowing for secure and effective ways to access needed information while employees work from home or other remote locations. Offering this flexibility will likely increase employee satisfaction while at the same time enabling increased efficiency.

In addition to flexible work arrangements, employees also desire clear expectations and recognition for their work as well as fair and equitable processes for advancing their careers. OBD investments in these areas should result in increased employee retention.

Board succession planning is also critical. Several Board members have terms ending in this next plan horizon. The strategic resource plans extend to the Board as well as employees.

Goals

⟹ Establish succession plan for Board members, continuing to represent many viewpoints and experiences in Board composition

⟹ Increase workplace flexibility through a hybrid workplace guideline

⟹ Increase workplace satisfaction and career development conversations

Action Items

- Define and implement hybrid workplace guidelines
- Evaluate overall workload and staff workload balance, consider adjustments for upcoming fiscal cycles
- Develop succession plans for Board positions coming open and establish effective process for ongoing timely replacement

STRATEGIC PRIORITY E

Technology & Processes

All organizations are affected by technology developments, and Oregon Board of Dentistry and the dental profession is no exception. The OBD has the strategic opportunity to implement processes and tools that will improve efficiency, employee and Board member experience as well as improve the effectiveness of processes for dental professional engaged with OBD. In addition, growing advances in data collection and analysis will enable the ability to continue to ensure fair and equitable outcomes for applicants and Licensees.

Goals

⟹ Improve efficiency and resource utilization through online record keeping

⟹ Increase ability to complete analytics related to licensees and investigations

⟹ Improve investigation case management with archived files

Action Items

- Complete digitization and modernization process for Board Books
- Complete implementation of InLumon system
- Build working digital database of Licensee records
- Create digital archive of investigation files
- Pilot data analysis capabilities

Oregon Board of Dentistry Strategic Plan 2022-2025

Mission: *To promote quality oral health care and protect all communities in the State of Oregon by equitably and ethically regulating dental professionals.*

MISSION-CRITICAL PRIORITIES				
A. Licensure Evolution	B. Dental Practice Accountability	C. Community Interaction & Equity	D. Workplace Environment	E. Technology and Processes
GOALS				
• Develop and implement rules based on legislation changes	• Ensure licensees dictate clinical care provided to patients (in contrast to corporate non-licensees driving care decisions)	• Communicate and market to reach the all communities within Oregon	• Establish succession plan for Board members, continuing to represent many viewpoints and experiences in Board composition	• Improve efficiency and resource utilization through on-line records keeping
• Successfully implement Dental Therapy license	• Increase OBD visibility into practice ownership models	• Increase ease of access to OBD services	• Increase workplace flexibility through a hybrid workplace guideline	• Increase ability to complete analytics related to licensees and investigations
	• OBD jurisdiction over Dental practices in Oregon, regardless of ownership and business operating model	• Ensure equity exists in investigation outcomes	• Increase workplace satisfaction and career development conversations	• Improve investigation case management with archived files
	• Correlate patient care to level of competency required by practitioners (DT, DMD, DDS, DH); hold entities accountable to the level of licenses within their practice	• Increase OBD licensee, patient, and community understanding of OBD roles, responsibilities, and services		
ACTION ITEMS				
• Develop and implement rules in support of HB 2528 (2021) for newly created Dental Therapist license	• Implement changes to Licensee Renewal form to capture multiple office/group affiliation	• Align Diversity, Equity, and Inclusion plans to guidance provided by the State of Oregon Racial Justice Council	• Develop succession plans for Board positions coming open and establish effective process for ongoing timely replacement	• Complete digitization and modernization process for Board Books
• Develop and implement communication strategies with communities impacted by Dental Therapy license implementation	• Gather dental practice ownership and training information	• Enable OBD to take complaints in complaintant's first language	• Define and implement hybrid workplace guidelines	• Complete implementation of InLumon system
• Engage interested parties to learn more and gather feedback about implementing Dental Therapy Practice in Oregon	• Receive OHSU updated curriculum and include in Board Book	• Include diversity analysis when developing Marketing or Communications materials; consider diversity in visual representations	• Evaluate overall workload and staff workload balance, consider adjustment for upcoming fiscal cycles	• Build working digital database of Licensee records
	• Analyze complaints by ownership types	• Create analysis of prior investigations, findings, and actions across licensee demographics to frame equity-related data		• Pilot data analysis capabilities
	• Evaluate options for strengthening statute related to accountability, ownership, and standards of care	• Additional prioritized actions taken from recomendations and resources proivided by State Racial Justice Council		• Create digital archive of investigation files
	• Potential for proposed legislative changes			

Oregon Board of Dentistry 2022-2025 Strategic Plan

Roadmap and Goals

Strategic Priorities	2022-2023	2023 - 2024	2024-2025	Goals
Licensure Evolution	• Develop and implement rules in support of HB 2528 (2021) for newly created Dental Therapist license	• Engage interested parties to learn more and gather feedback about implementing Dental Therapy Practice in Oregon		• Develop and implement rules based on legislation changes
	• Develop and implement communication strategies with communities impacted by Dental Therapy license implementation			• Successfully implement Dental Therapy license
Dental Practice Accountability	• Implement changes to Licensee Renewal form to capture multiple office/group affiliation • Gather dental practice ownership and training information • Receive OHSU updated curriculum and include in Board Book	• Analyze complaints by ownership types • Evaluate options for strengthening statute related to accountability, ownership, and standards of care	• Potential for proposed legislative changes	• Ensure licensees dictate clinical care provided to patients (in contrast to corporate non-licensees driving care decisions) • Increase OBD visibility into practice ownership models • OBD jurisdiction over Dental practices in Oregon, regardless of ownership and business operating model • Correlate patient care to level of competency required by practitioners (DT, DMD, DDS, DH); hold entities accountable to the level of licenses within their practice
Community Interaction and Equity	• Align Diversity, Equity, and Inclusion plans to guidance provided by the State of Oregon Racial Justice Council	• Include diversity analysis when developing Marketing or Communications materials; consider diversity in visual representations	• Additional prioritized actions taken from recommendations and resources provided by State Racial Justice Council	• Communicate and market to reach the all communities within Oregon
	• Enable OBD to take complaints in complainant's first language	• Create analysis of prior investigations, findings, and actions across licensee demographics to frame equity-related data		• Increase ease of access to OBD services
				• Ensure equity exists in investigation outcomes
				• Increase OBD licensee, patient, and community understanding of OBD roles, responsibilities, and services
Workplace Environment	• Develop succession plans for Board positions coming open and establish effective process for ongoing timely replacement • Develop and implement hybrid workplace guidelines	• Evaluate overall workload and staff workload balance, consider adjustment for upcoming fiscal cycles		• Establish succession plan for Board members, continuing to represent many viewpoints and experiences in Board composition • Increase workplace flexibility through a hybrid workplace guideline • Increase workplace satisfaction and career development conversations
Technology and Processes	• Complete digitization and modernization process for Board Books • Complete implementation of InLumon system	• Build working digital database of Licensee records • Pilot data analysis capabilities	• Create digital archive of investigation files	• Improve efficiency and resource utilization through on-line records keeping • Increase ability to complete analytics related to licensees and investigations
				• Improve investigation case management with archived files

Best Practices Self-Assessment Guide:
Information in Support of Best Practices

Best Practices Criteria
1. Executive Director's performance expectations are current. • Goals and expectations for the Executive Director are reviewed annually.
2. Executive Director receives annual performance feedback. • The Administrative Workgroup reviews the Executive Director's performance annually and makes recommendations to the Board.
3. The agency's mission and high-level goals are current and applicable. • The OBD's 2022 -2025 Strategic Plan was ratified in Feb 2022. • Agency performance measures, as well as short and long term goals, are reviewed annually.
4. The Board reviews the Annual Performance Progress Report. • Performance measures are reviewed as a part of the budget.
5. The Board is appropriately involved in review of agency's key communications. • Board members are informed of relevant news and information. • Board members are updated on articles and ideas for inclusion in the newsletter.
6. The Board is appropriately involved in policy-making activities. • The Board's committees review rules and policy making issues. • The Board reviews legislative proposals that could impact the Board.
7. The agency's policy option budget packages are aligned with their mission and goals. • The Board reviews agency's proposed policy option packages. • The Board reviews the Agency Request Budget.
8. The Board reviews all proposed budgets. • The Board reviews the Agency Request Budget.
9. The Board periodically reviews key financial information and audit findings. • The Board reviews agency head financial and payroll transactions annually at a Board Meeting. • The Board reviews agency performance audits.
10. The Board is appropriately accounting for resources. • All Board revenue and expenditures are reviewed by the Board. • All Board expenditures are reviewed and approved by the Executive Director and Office Manager. • Physical inventory of all agency property is conducted annually.
11. The agency adheres to accounting rules and other relevant financial controls. • Board staff prepares all transaction entries in accordance with Oregon Statute, Oregon Administrative Rules, Oregon Accounting Manual and Generally Accepted Accounting principles. • The Board has annually received the Department of Administrative Services Comprehensive Annual Financial Report Gold Star Award for timely and complete financial data.
12. Board members act in accordance with their roles as public representatives. • Board members appropriately recuse themselves from cases which create an actual or potential conflict of interest. • The Board follows public meetings and records laws. • The Board uses good judgment in upholding the Board's Mission Statement of Protecting the Citizens of Oregon.

13. The Board coordinates with others where responsibilities and interest overlap.
    - Board members and staff participate in appropriate professional associations.
    - The OBD works with the OHSU School of Dentistry on certain issues.
    - The OBD works with the ODA, ODHA, ODAA, TDIC and others that request it- to present important practice related issues to members and licensees.
    - The OBD is actively involved in the American Association of Dental Boards (AADB), American Association of Dental Administrators (AADA) and regional testing agencies.

14. The Board members attend/complete relevant training sessions.
    - New Board members attend new Board member orientation presented by OBD Staff and assigned attorney.
    - Board members utilize the Governor's Board Training.

15. The Board reviews its management practices to ensure best practices are utilized.
    - On an annual basis, in regular board meetings and as needed.

Best Practices Self-Assessment

Annually, Board members are to self-evaluate their adherence to a set of best practices and report the percent total best practices met by the Board (percent of yes responses in the table below) in the Annual Performance Progress Report as specified in the agency Budget instructions.

Best Practices Assessment Score Card

Best Practices Criteria	Yes	No
1. Executive Director's performance expectations are current.		
2. Executive Director receives annual performance feedback.		
3. The agency's mission and high-level goals are current and applicable.		
4. The Board reviews the Annual Performance Progress Report.		
5. The Board is appropriately involved in review of agency's key communications.		
6. The Board is appropriately involved in policy-making activities.		
7. The agency's policy option budget packages are aligned with their mission and goals.		
8. The Board reviews all proposed budgets.		
9. The Board periodically reviews key financial information and audit findings.		
10. The Board is appropriately accounting for resources.		
11. The agency adheres to accounting rules and other relevant financial controls.		
12. Board members act in accordance with their roles as public representatives.		
13. The Board coordinates with others where responsibilities and interest overlap.		
14. The Board members identify and attend appropriate training sessions.		
15. The Board reviews its management practices to ensure best practices are utilized.		
Total Number		
Percentage of total:		

Enrolled
Senate Bill 11

Sponsored by Senator GORSEK; Senators HAYDEN, MANNING JR, THATCHER, Representatives FAHEY, HIEB (Presession filed.)

CHAPTER .....

AN ACT

Relating to public meetings of state government entities; amending ORS 192.672.

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

SECTION 1. ORS 192.672 is amended to read:

192.672. (1) A state board or commission may meet through telephone or other electronic means in accordance with ORS 192.610 to 192.690.

(2)(a) Notwithstanding ORS 171.072 or 292.495, a member of a state board or commission who attends a meeting through telephone or other electronic means is not entitled to compensation or reimbursement for expenses for attending the meeting.

(b) A state board or commission may compensate or reimburse a member, other than a member who is a member of the Legislative Assembly, who attends a meeting through telephone or other electronic means as provided in ORS 292.495 at the discretion of the board or commission.

(3)(a) A state board or commission that meets through telephone or other electronic means in accordance with ORS 192.610 to 192.690 shall record and promptly publish the meeting on a publicly accessible website or hosting service, so that members of the public may without charge:

(A) Observe a recording of the meeting if the meeting was conducted through videoconferencing technology; or

(B) Listen to a recording of the meeting if the meeting was conducted through teleconferencing technology that did not include video capabilities.

(b) The requirement that a meeting be published under this subsection does not apply to that portion of a state board or commission meeting that was lawfully held in executive session under ORS 192.660 or other law.

(c) The requirement to record and publish meetings under this subsection applies to any state board or commission that is within the executive department, as defined in ORS 174.112, and whose members are subject to Senate confirmation under ORS 171.562 and 171.565.

Passed by Senate April 11, 2023

Repassed by Senate June 15, 2023

.....
Lori L. Brocker, Secretary of Senate

.....
Rob Wagner, President of Senate

Passed by House May 23, 2023

.....
Dan Rayfield, Speaker of House

Received by Governor:

.....M.,....., 2023

Approved:

.....M.,....., 2023

.....
Tina Kotek, Governor

Filed in Office of Secretary of State:

.....M.,....., 2023

.....
Secretary of State

Enrolled
Senate Bill 450

Sponsored by Senator BONHAM; Representative HIEB (Presession filed.)

CHAPTER .....

AN ACT

Relating to opioids.

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

SECTION 1. Section 2 of this 2023 Act is added to and made a part of ORS chapter 689.

SECTION 2. (1) A requirement that a health care provider who is authorized to prescribe drugs in this state label a drug dispensed by the health care provider with the information described in subsection (2) of this section does not apply to a drug approved by the United States Food and Drug Administration for the reversal of an opioid overdose if the drug is:

(a) In the form of a nasal spray; and

(b) Personally dispensed by a health care provider described in this subsection at the location of practice of the health care provider.

(2) The information described in subsection (1) of this section includes:

(a) The name of the patient;

(b) The name and address of the dispensing health care provider;

(c) The date of dispensing;

(d)(A) The name of the drug or, if the dispensed drug does not have a brand name, the generic name of the drug along with the name of the drug distributor or manufacturer;

(B) The drug's quantity per unit, unless the drug is a compound; and

(C) The directions for the drug's use stated in the prescription;

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

(f) When applicable and as determined by the State Board of Pharmacy, an expiration date after which the patient should not use the drug.

SECTION 3. Section 2 of this 2023 Act applies to dispensations made on or after the effective date of this 2023 Act.

Passed by Senate March 28, 2023

Repassed by Senate June 15, 2023

.....
Lori L. Brocker, Secretary of Senate

.....
Rob Wagner, President of Senate

Passed by House May 25, 2023

.....
Dan Rayfield, Speaker of House

Received by Governor:

.....M.,....., 2023

Approved:

.....M.,....., 2023

.....
Tina Kotek, Governor

Filed in Office of Secretary of State:

.....M.,....., 2023

.....
Secretary of State

Enrolled
House Bill 2240

Sponsored by Representative NERON; Representative RUIZ (at the request of Oregon School Board Association, Coalition of School Administrators) (Presession filed.)

CHAPTER .....

AN ACT

Relating to requirements to use health care interpreters; amending ORS 413.550; and declaring an emergency.

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

SECTION 1. ORS 413.550, as amended by section 8, chapter 453, Oregon Laws 2021, is amended to read:

413.550. As used in ORS 413.550 to 413.559:

(1) "Certified health care interpreter" means an individual who has been approved and certified by the Oregon Health Authority under ORS 413.558.

(2) "Coordinated care organization" has the meaning given that term in ORS 414.025.

(3) "Health care" means medical, surgical, oral or hospital care or any other remedial care recognized by state law, including physical and behavioral health care.

(4)(a) "Health care interpreter" means an individual who is readily able to:

(A) Communicate in English and communicate with a person with limited English proficiency or who communicates in signed language;

(B) Accurately interpret the oral statements of a person with limited English proficiency, or the statements of a person who communicates in signed language, into English;

(C) Accurately interpret oral statements in English to a person with limited English proficiency or who communicates in signed language;

(D) Sight translate documents from a person with limited English proficiency; and

(E) Interpret the oral statements of other persons into the language of the person with limited English proficiency or into signed language.

(b) "Health care interpreter" also includes an individual who can provide the services described in paragraph (a) of this subsection using relay or indirect interpretation.

(5) "Health care interpreter registry" means the registry described in ORS 413.558 that is administered by the authority.

(6)**(a)** "Health care provider" means any of the following that are reimbursed with public funds, in whole or in part:

[*(a)*] **(A)** An individual licensed or certified by the:

[*(A)*] **(i)** State Board of Examiners for Speech-Language Pathology and Audiology;

[*(B)*] **(ii)** State Board of Chiropractic Examiners;

[*(C)*] **(iii)** State Board of Licensed Social Workers;

[*(D)*] **(iv)** Oregon Board of Licensed Professional Counselors and Therapists;

[*(E)*] **(v)** Oregon Board of Dentistry;

[*(F)*] **(vi)** State Board of Massage Therapists;
[*(G)*] **(vii)** Oregon Board of Naturopathic Medicine;
[*(H)*] **(viii)** Oregon State Board of Nursing;
[*(I)*] **(ix)** Oregon Board of Optometry;
[*(J)*] **(x)** State Board of Pharmacy;
[*(K)*] **(xi)** Oregon Medical Board;
[*(L)*] **(xii)** Occupational Therapy Licensing Board;
[*(M)*] **(xiii)** Oregon Board of Physical Therapy;
[*(N)*] **(xiv)** Oregon Board of Psychology;
[*(O)*] **(xv)** Board of Medical Imaging;
[*(P)*] **(xvi)** State Board of Direct Entry Midwifery;
[*(Q)*] **(xvii)** Respiratory Therapist and Polysomnographic Technologist Licensing Board;
[*(R)*] **(xviii)** Board of Registered Polysomnographic Technologists;
[*(S)*] **(xix)** Board of Licensed Dietitians; and
[*(T)*] **(xx)** State Mortuary and Cemetery Board;

[*(b)*] **(B)** An emergency medical services provider licensed by the Oregon Health Authority under ORS 682.216;

[*(c)*] **(C)** A clinical laboratory licensed under ORS 438.110;

[*(d)*] **(D)** A health care facility as defined in ORS 442.015;

[*(e)*] **(E)** A home health agency licensed under ORS 443.015;

[*(f)*] **(F)** A hospice program licensed under ORS 443.860; or

[*(g)*] **(G)** Any other person that provides health care or that bills for or is compensated for health care provided, in the normal course of business.

(b) "Health care provider" does not include any individual listed in paragraph (a) of this subsection when providing services as an employee of or under contract with:

(A) A school district, as defined in ORS 332.002;

(B) A public charter school, as defined in ORS 338.005; or

(C) An education service district, as defined in ORS 334.003.

(7) "Interpretation service company" means an entity, or a person acting on behalf of an entity, that is in the business of arranging for health care interpreters to work with health care providers in this state.

(8) "Person with limited English proficiency" means a person who, by reason of place of birth or culture, communicates in a language other than English and does not communicate in English with adequate ability to communicate effectively with a health care provider.

(9) "Prepaid managed care health services organization" has the meaning given that term in ORS 414.025.

(10) "Qualified health care interpreter" means an individual who has been issued a valid letter of qualification from the authority under ORS 413.558.

(11) "Sight translate" means to translate a written document into spoken or signed language.

SECTION 2. This 2023 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2023 Act takes effect on its passage.

Passed by House February 28, 2023

.....
Timothy G. Sekerak, Chief Clerk of House

.....
Dan Rayfield, Speaker of House

Passed by Senate June 21, 2023

.....
Rob Wagner, President of Senate

Received by Governor:

.....M.,....., 2023

Approved:

.....M.,....., 2023

.....
Tina Kotek, Governor

Filed in Office of Secretary of State:

.....M.,....., 2023

.....
Secretary of State

Enrolled
House Bill 2395

Sponsored by Representatives DEXTER, BYNUM, GRAYBER, HIEB, REYNOLDS, Senators HAYDEN, JAMA, PATTERSON, STEINER; Representatives ANDERSEN, BOWMAN, CHAICHI, EVANS, FAHEY, GAMBA, HARTMAN, HOLVEY, HUDSON, JAVADI, KROPF, MARSH, NELSON, NERON, NOSSE, PHAM H, PHAM K, RUIZ, TRAN, WALTERS, Senators FREDERICK, GELSER BLOUIN, KNOPP, LIEBER, SOLLMAN, TAYLOR (Presession filed.)

CHAPTER .....

AN ACT

Relating to substance use; creating new provisions; amending ORS 146.100, 339.867, 339.869, 339.870, 339.871, 430.389, 431A.855, 431A.865, 475.525, 475.744, 689.681, 689.682, 689.684 and 689.686; repealing section 7a, chapter ___, Oregon Laws 2023 (Enrolled House Bill 2421); and declaring an emergency.

Whereas the residents of the State of Oregon acknowledge that the opioid crisis in which we see ourselves is the result of a complex set of political, economic and societal factors emanating from policy and systemic decisions going back decades; and

Whereas the residents of this state acknowledge the need to act quickly to prevent more unnecessary loss of life; and

Whereas the residents of this state acknowledge that a multipronged approach focused on substance use prevention, harm reduction and treatment must be adopted; and

Whereas the residents of this state acknowledge the need to make data-driven and scientifically based decisions when possible; and

Whereas the residents of this state acknowledge that drug use does not define a person and we must remember to act courageously and compassionately; and

Whereas the residents of this state acknowledge that we must make conscious efforts to minimize and remove stigma around substance use treatment; and

Whereas the Legislative Assembly created the Opioid Settlement Prevention, Treatment and Recovery Board and tasked the board with allocating funds from the Opioid Settlement Prevention, Treatment and Recovery Fund to support access to harm reduction, drug treatment and opioid data; now, therefore,

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

SHORT-ACTING OPIOID ANTAGONISTS

SECTION 1. ORS 689.681 is amended to read:

689.681. (1) As used in this section:

(a) "Kit" means a [*dose of naloxone*] **package of one or more doses of a short-acting opioid antagonist** and the necessary medical supplies to administer the [*naloxone*] **short-acting opioid antagonist**.

[*(b) "Opiate" means a narcotic drug that contains:*]

[*(A) Opium;*]

[*(B) Any chemical derivative of opium; or*]

[*(C) Any synthetic or semisynthetic drug with opium-like effects.*]

[*(c) "Opiate overdose" means a medical condition that causes depressed consciousness and mental functioning, decreased movement, depressed respiratory function and the impairment of the vital functions as a result of ingesting opiates in an amount larger than can be physically tolerated.*]

(b) "Opioid" means a natural, synthetic or semisynthetic chemical that interacts with opioid receptors on nerve cells in the body and brain to reduce the intensity of pain signals and feelings of pain.

(c) "Opioid overdose" means a medical condition that causes depressed consciousness, depressed respiratory function or the impairment of vital bodily functions as a result of ingesting opioids.

(d) "Short-acting opioid antagonist" means any short-acting drug approved by the United States Food and Drug Administration for the complete or partial reversal of an opioid overdose.

(2) Notwithstanding any other provision of law, a pharmacy, a health care professional [*or*]**,** a pharmacist with prescription and dispensing privileges**, a law enforcement officer, a firefighter, an emergency medical services provider** or any other person designated by the State Board of Pharmacy by rule may**:**

(a) Distribute and administer [*naloxone*] **a short-acting opioid antagonist** and distribute the necessary medical supplies to administer the [*naloxone*] **short-acting opioid antagonist**[*.*]**;**

(b) Distribute multiple kits to:

(A) An individual who has experienced an opioid overdose or is likely to experience an opioid overdose;

(B) Family members of an individual described in subparagraph (A) of this paragraph; and

(C) Any other individual who requests one or more kits; and

(c) [*The pharmacy, health care professional or pharmacist may also*] Distribute multiple kits to social service agencies under ORS 689.684 or to other persons who work with individuals who have experienced an [*opiate overdose*] **opioid overdose**. The social services agencies or other persons may redistribute the kits to individuals likely to experience an [*opiate overdose*] **opioid overdose** or to family members of the individuals.

(3)**(a)** A person acting in good faith, if the act does not constitute wanton misconduct, is immune from **criminal and** civil liability for any act or omission of an act committed during the course of distributing and administering [*naloxone*] **a short-acting opioid antagonist** and distributing the necessary medical supplies to administer the [*naloxone*] **short-acting opioid antagonist** under this section.

(b) A person acting in good faith is immune from criminal and civil liability for the person's failure or refusal to distribute or administer a short-acting opioid antagonist or distribute the necessary medical supplies to administer a short-acting opioid antagonist under this section, if the person's failure or refusal does not constitute wanton misconduct.

SECTION 2. ORS 689.682 is amended to read:

689.682. **(1) As used in this section:**

(a) "Opioid" means a natural, synthetic or semisynthetic chemical that interacts with opioid receptors on nerve cells in the body and brain to reduce the intensity of pain signals and feelings of pain.

(b) "Opioid overdose" means a medical condition that causes depressed consciousness, depressed respiratory function or the impairment of vital bodily functions as a result of ingesting opioids.

(c) "Short-acting opioid antagonist" means any short-acting drug approved by the United States Food and Drug Administration for the complete or partial reversal of an opioid overdose.

[*(1)*] **(2)** In accordance with rules adopted by the State Board of Pharmacy under ORS 689.205, a pharmacist may prescribe [*naloxone*] **a short-acting opioid antagonist** and the necessary medical supplies to administer the [*naloxone*] **short-acting opioid antagonist**.

[*(2)*] **(3)** If a prescription is presented to a pharmacist for dispensing an opiate or opioid in excess of a morphine equivalent dose established by rule by the board, the pharmacist may offer to prescribe and provide, in addition to the prescribed opiate or opioid, a [*naloxone kit consisting of a dose of naloxone*] **short-acting opioid antagonist** and the necessary medical supplies to administer the [*naloxone*] **short-acting opioid antagonist**.

SECTION 3. ORS 689.684 is amended to read:

689.684. (1) For purposes of this section, "social services agency" includes, but is not limited to, homeless shelters and crisis centers.

(2) A person may administer to an individual [*naloxone*] **a short-acting opioid antagonist, as defined in ORS 689.681,** that was not distributed to the person if:

(a) The individual to whom the [*naloxone*] **short-acting opioid antagonist** is being administered appears to be experiencing an [*opiate overdose*] **opioid overdose** as defined in ORS 689.681; and

(b) The person who administers the [*naloxone*] **short-acting opioid antagonist** is an employee of a social services agency or is trained under rules adopted by the State Board of Education pursuant to ORS 339.869.

(3) For the purposes of protecting public health and safety, the Oregon Health Authority may adopt rules for the administration of [*naloxone*] **short-acting opioid antagonists** by employees of a social services agency under this section.

SECTION 4. ORS 689.686 is amended to read:

689.686. (1) A retail or hospital outpatient pharmacy shall provide written notice in a conspicuous manner that [*naloxone*] **a short-acting opioid antagonist, as defined in ORS 689.681,** and the necessary medical supplies to administer [*naloxone*] **the short-acting opioid antagonist** are available at the pharmacy.

(2) The State Board of Pharmacy may adopt rules to carry out this section.

SECTION 5. (1) The amendments to ORS 689.681, 689.682, 689.684 and 689.686 by sections 1 to 4 of this 2023 Act become operative on January 1, 2024.

(2) The State Board of Pharmacy may take any action before the operative date specified in subsection (1) of this section that is necessary to enable the board to exercise, on and after the operative date specified in subsection (1) of this section, all of the duties, functions and powers conferred on the board by the amendments to ORS 689.681, 689.682, 689.684 and 689.686 by sections 1 to 4 of this 2023 Act.

STANDING ORDERS

SECTION 6. Sections 7 and 8 of this 2023 Act are added to and made a part of ORS chapter 689.

SECTION 7. (1) As used in this section, "opioid," "opioid overdose" and "short-acting opioid antagonist" have the meanings given those terms in ORS 689.681.

(2)(a) The Public Health Officer appointed under ORS 431.045, or a physician licensed under ORS chapter 677 who is employed by the Oregon Health Authority, may issue a standing order to prescribe a short-acting opioid antagonist, and the necessary medical supplies to administer the short-acting opioid antagonist, to:

(A) An individual who is at risk of experiencing an opioid overdose;

(B) An individual who or entity that may encounter an individual who is likely to experience an opioid overdose; and

(C) The owner of a building or facility described in section 8 of this 2023 Act.

(b) The Public Health Officer or physician may issue a standing order within certain geographic areas of the state or statewide, and may withdraw a standing order at any time.

(3) Upon the request of an individual or entity, a pharmacist shall dispense a short-acting opioid antagonist and the necessary medical supplies to administer the short-acting opioid antagonist pursuant to a standing order issued under subsection (2) of this section.

(4) An individual or an entity may possess, store, deliver or distribute a short-acting opioid antagonist and the necessary medical supplies to administer the short-acting opioid antagonist, and may administer a short-acting opioid antagonist, pursuant to a standing order issued under subsection (2) of this section.

(5)(a) An individual acting in good faith, if the act does not constitute wanton misconduct, is immune from criminal and civil liability for any act or omission of an act committed during the course of possessing, storing, delivering or distributing a short-acting opioid antagonist and the necessary medical supplies to administer the short-acting opioid antagonist and during the course of administering a short-acting opioid antagonist.

(b) An individual is immune from criminal and civil liability for the individual's failure or refusal to possess, store, deliver or distribute a short-acting opioid antagonist and the necessary medical supplies to administer the short-acting opioid antagonist, or failure or refusal to administer a short-acting opioid antagonist.

(6) The State Board of Pharmacy and the authority, in consultation with one another, may adopt rules to carry out this section.

SECTION 8. (1) As used in this section, "kit," "opioid," "opioid overdose" and "short-acting opioid antagonist" have the meanings given those terms in ORS 689.681.

(2) The owner of any building or facility to which the public has legal access may have in the building or facility one or more kits stored in a location in the building or facility easily accessible by members of the public if the kit or kits are obtained pursuant to a standing order issued under section 7 of this 2023 Act.

(3)(a) A member of the public may administer the short-acting opioid antagonist contained in a kit described in subsection (2) of this section to an individual experiencing, or who appears to be experiencing, an opioid overdose. The member of the public acting in good faith, if the act does not constitute wanton misconduct, is immune from criminal and civil liability for:

(A) Any act or omission of an act committed during the course of administering the short-acting opioid antagonist under this section; and

(B) Not administering the short-acting opioid antagonist.

(b) The owner and any staff members of a building or facility described in subsection (2) of this section in which a kit, obtained pursuant to a standing order issued under section 7 of this 2023 Act, is located, are immune from criminal and civil liability for any act or omission of an act committed during the course of the administration of, or for the failure or refusal to administer, the short-acting opioid antagonist contained in the kit located in the building or facility.

(4) The Oregon Health Authority shall publish, on a website operated by or on behalf of the authority, a list of the types of buildings and facilities, and the locations of buildings and facilities, described in subsection (2) of this section, for which the authority prioritizes the provision of kits.

(5) The authority may adopt rules to carry out this section. In adopting rules under this subsection, the authority shall consult with the State Board of Pharmacy.

SECTION 9. (1) Sections 7 and 8 of this 2023 Act become operative on January 1, 2024.

(2) The Oregon Health Authority and State Board of Pharmacy may take any action before the operative date specified in subsection (1) of this section that is necessary to enable the authority and the board to exercise, on and after the operative date specified in subsection (1) of this section, all of the duties, functions and powers conferred on the authority and the board by sections 7 and 8 of this 2023 Act.

SCHOOLS

SECTION 10. ORS 339.867 is amended to read:

339.867. As used in ORS 339.869 and 339.870:

(1)**(a)** "Medication" means:

[*(a)*] **(A)** Medication that is not injected;

[*(b)*] **(B)** Premeasured doses of epinephrine that are injected;

[*(c)*] **(C)** Medication that is available for treating adrenal insufficiency; and

[*(d)*] **(D)** Naloxone or any similar medication that is in any form available for safe administration and that is designed to rapidly reverse an overdose of an opioid drug.

[*(2)*] **(b)** "Medication" does not include nonprescription sunscreen.

(2) "Opioid overdose" has the meaning given that term in ORS 689.681.

(3) "Short-acting opioid antagonist" has the meaning given that term in ORS 689.681.

SECTION 11. ORS 339.869 is amended to read:

339.869. (1) The State Board of Education, in consultation with the Oregon Health Authority, the Oregon State Board of Nursing and the State Board of Pharmacy, shall adopt:

(a) Rules for the administration of prescription and nonprescription medication to students by trained school personnel and for student self-medication. The rules shall include age appropriate guidelines and training requirements for school personnel.

(b) Rules for the administration of premeasured doses of epinephrine by school personnel trained as provided by ORS 433.815 to any student or other individual on school premises who the personnel believe in good faith is experiencing a severe allergic reaction, regardless of whether the student or individual has a prescription for epinephrine.

(c)(A) Rules for the administration of medication that treats adrenal insufficiency by school personnel trained as provided by ORS 433.815 to any student on school premises whose parent or guardian has provided for the personnel the medication as described in ORS 433.825 (3) and who the personnel believe in good faith is experiencing an adrenal crisis, as defined in ORS 433.800.

(B) Rules adopted under this paragraph must:

(i) Include guidelines on the designation and training of school personnel who will be responsible for administering medication; and

(ii) Specify that a school district is only required to train school personnel when the school district has been notified by a parent or guardian that a student enrolled in a school of the school district has been diagnosed with adrenal insufficiency.

(d) Guidelines for the management of students with life-threatening food allergies and adrenal insufficiency, which must include:

(A) Standards for the education and training of school personnel to manage students with life-threatening allergies or adrenal insufficiency.

(B) Procedures for responding to life-threatening allergic reactions or an adrenal crisis, as defined in ORS 433.800.

(C) A process for the development of individualized health care and allergy or adrenal insufficiency plans for every student with a known life-threatening allergy or adrenal insufficiency.

(D) Protocols for preventing exposures to allergens.

(e) Rules for the administration of [*naloxone or any similar medication that is in any form available for safe administration and that is designed to rapidly reverse an overdose of an opioid drug by trained school personnel*] **a short-acting opioid antagonist** to any student or other individual on school premises who the [*personnel believe*] **individual administering the short-acting opioid antagonist believes** in good faith is experiencing an **opioid** overdose [*of an opioid drug*].

(2)(a) School district boards shall adopt policies and procedures that provide for:

(A) The administration of prescription and nonprescription medication to students by trained school personnel, including the administration of medications that treat adrenal insufficiency;

(B) Student self-medication; and

(C) The administration of premeasured doses of epinephrine to students and other individuals.

(b) Policies and procedures adopted under paragraph (a) of this subsection shall be consistent with the rules adopted by the State Board of Education under subsection (1) of this section. A school

district board shall not require school personnel who have not received appropriate training to administer medication.

(3)(a) School district boards may adopt policies and procedures that provide for the administration of [*naloxone or any similar medication that is in any form available for safe administration and that is designed to rapidly reverse an overdose of an opioid drug*] **a short-acting opioid antagonist**.

(b) Policies and procedures adopted under paragraph (a) of this subsection shall be consistent with the rules adopted by the State Board of Education under subsection (1) of this section.

(4)(a) A school district board shall provide to the parent or legal guardian of each minor student enrolled in a school in the school district information regarding short-acting opioid antagonists. The information described in this subsection must include at least:

(A) A description of short-acting opioid antagonists and their purpose;

(B) A statement regarding, in an emergency situation, the risks of administering to an individual a short-acting opioid antagonist and the risks of not administering to an individual a short-acting opioid antagonist;

(C) A statement that all schools within the school district have access to short-acting opioid antagonists and the necessary medical supplies to administer the short-acting opioid antagonist on site; and

(D) A statement that a representative of a school may administer to a student a short-acting opioid antagonist in an emergency if the student appears to be unconscious and experiencing an opioid overdose.

(b) A school district board shall ensure that the parent or legal guardian of a minor student enrolled in a school within the school district is immediately notified when a short-acting opioid antagonist is administered to the student if the short-acting opioid antagonist is administered while the student is at school, on school property under the jurisdiction of the school district or at any activity under the jurisdiction of the school district.

SECTION 12. ORS 339.870 is amended to read:

339.870. [*(1)*] **(1)(a)** A school administrator, teacher or other school employee designated by the school administrator is not liable in a criminal action or for civil damages as a result of the administration of nonprescription medication, if the school administrator, teacher or other school employee in good faith administers nonprescription medication to a [*pupil*] **student** pursuant to written permission and instructions of the [*pupil's*] **student's** parents or guardian.

(b) A school administrator, teacher or other school employee may administer a short-acting opioid antagonist to a student who experienced or is experiencing an opioid overdose without written permission and instructions of the student's parents or guardian.

[*(2)*] **(2)(a)** A school administrator, teacher or other school employee designated by the school administrator is not liable in a criminal action or for civil damages as a result of the administration of prescription medication, if the school administrator, teacher or other school employee in compliance with the instructions of a physician, physician assistant, nurse practitioner, naturopathic physician or clinical nurse specialist, in good faith administers prescription medication to a [*pupil*] **student** pursuant to written permission and instructions of the [*pupil's*] **student's** parents or guardian.

(b) A person may not maintain an action for injury, death or loss that results from acts or omissions of a school administrator, teacher or other school employee during the administration of a short-acting opioid antagonist as described in subsection (1)(b) of this section unless it is alleged and proved by the complaining party that the school administrator, teacher or other school employee was grossly negligent in administering the short-acting opioid antagonist.

(c) Unless it is alleged and proved by the complaining party that the school district or member of the school district board was grossly negligent in administering the short-acting opioid antagonist, a person may not maintain an action for damages for injury, death or loss

that results from acts or omissions of a school district or members of the school district board during the administration of a short-acting opioid antagonist:

(A) As described in subsection (1)(b) of this section; or

(B) By any person who administers the short-acting opioid antagonist to a student or other individual who the person believes is experiencing an opioid overdose and the administration occurs on school premises, including at a school, on school property under the jurisdiction of the school district or at any activity under the jurisdiction of the school district.

(3) The civil and criminal immunities imposed by subsections (1) and [*(2)*] **(2)(a)** of this section do not apply to an act or omission amounting to gross negligence or willful and wanton misconduct.

SECTION 13. ORS 339.871 is amended to read:

339.871. (1) A school administrator, school nurse, teacher or other school employee designated by the school administrator is not liable in a criminal action or for civil damages as a result of a student's self-administration of medication, as described in ORS 339.866, if the school administrator, school nurse, teacher or other school employee, in compliance with the instructions of the student's Oregon licensed health care professional, in good faith assists the student's self-administration of the medication, if the medication is available to the student pursuant to written permission and instructions of the student's parent, guardian or Oregon licensed health care professional.

(2) A school administrator, school nurse, teacher or other school employee designated by the school administrator is not liable in a criminal action or for civil damages as a result of the use of medication if the school administrator, school nurse, teacher or other school employee in good faith administers[*:*]

[*(a)*] autoinjectable epinephrine to a student or other individual with a severe allergy who is unable to self-administer the medication, regardless of whether the student or individual has a prescription for epinephrine[*; or*]

[*(b) Naloxone or any similar medication that is in any form available for safe administration and that is designed to rapidly reverse an overdose of an opioid drug to a student or other individual who the school administrator, school nurse, teacher or other school employee believes in good faith is experiencing an overdose of an opioid drug*].

(3) A school district and the members of a school district board are not liable in a criminal action or for civil damages as a result of the use of medication if:

(a) Any person in good faith administers autoinjectable epinephrine to a student or other individual with a severe allergy who is unable to self-administer the medication, regardless of whether the student or individual has a prescription for epinephrine; and

(b) The person administered the autoinjectable epinephrine on school premises, including at a school, on school property under the jurisdiction of the district or at an activity under the jurisdiction of the school district.

[*(4) A school district and the members of a school district board are not liable in a criminal action or for civil damages as a result of the use of medication if:*]

[*(a) Any person in good faith administers naloxone or any similar medication that is in any form available for safe administration and that is designed to rapidly reverse an overdose of an opioid drug to a student or other individual who the person believes in good faith is experiencing an overdose of an opioid drug; and*]

[*(b) The person administered the naloxone or similar medication on school premises, including at a school, on school property under the jurisdiction of the district or at an activity under the jurisdiction of the school district.*]

[*(5)*] **(4)** The civil and criminal immunities imposed by this section do not apply to an act or omission amounting to gross negligence or willful and wanton misconduct.

SECTION 14. (1) The amendments to ORS 339.867, 339.869, 339.870 and 339.871 by sections 10 to 13 of this 2023 Act become operative on January 1, 2024.

(2) The State Board of Education may take any action before the operative date specified in subsection (1) of this section that is necessary to enable the board to exercise, on and after the operative date specified in subsection (1) of this section, all of the duties, functions

and powers conferred on the board by the amendments to ORS 339.867, 339.869, 339.870 and 339.871 by sections 10 to 13 of this 2023 Act.

DRUG PARAPHERNALIA

SECTION 15. Section 16 of this 2023 Act is added to and made a part of ORS 475.525 to 475.565.

SECTION 16. (1) Notwithstanding ORS 475.525 (3), it is unlawful to provide single-use drug test strips or drug testing tools to a minor who is under 15 years of age unless the strips or tools are provided to the minor as part of the minor's substance use disorder treatment provided by a mental health care provider and the strips or tools are provided by the mental health care provider.

(2) As used in this section, "mental health care provider" means a:

(a) Physician licensed under ORS chapter 677;

(b) Physician assistant licensed under ORS 677.505 to 677.525;

(c) Psychologist licensed under ORS 675.010 to 675.150;

(d) Nurse practitioner licensed under ORS 678.375 to 678.390;

(e) Clinical social worker licensed under ORS 675.530;

(f) Licensed professional counselor licensed under ORS 675.715;

(g) Licensed marriage and family therapist licensed under ORS 675.715;

(h) Naturopathic physician licensed under ORS chapter 685;

(i) Chiropractic physician licensed under ORS chapter 684;

(j) Community mental health program established and operated pursuant to ORS 430.620 when approved to do so by the Oregon Health Authority pursuant to rule; or

(k) Organizational provider, as defined in ORS 430.637, that holds a certificate of approval.

SECTION 17. ORS 475.525 is amended to read:

475.525. (1) It is unlawful for any person to sell or deliver, possess with intent to sell or deliver or manufacture with intent to sell or deliver drug paraphernalia, knowing that it will be used to unlawfully plant, propagate, cultivate, grow, harvest, manufacture, compound, convert, produce, process, prepare, test, analyze, pack, repack, store, contain, conceal, inject, ingest, inhale or otherwise introduce into the human body a controlled substance as defined by ORS 475.005.

(2) For the purposes of this section, "drug paraphernalia" means all equipment, products and materials of any kind that are marketed for use or designed for use in planting, propagating, cultivating, growing, harvesting, manufacturing, compounding, converting, producing, processing, preparing, testing, analyzing, packaging, repackaging, storing, containing, concealing, injecting, ingesting, inhaling or otherwise introducing into the human body a controlled substance in violation of ORS 475.752 to 475.980. Drug paraphernalia includes, but is not limited to:

(a) Kits marketed for use or designed for use in unlawfully planting, propagating, cultivating, growing or harvesting of any species of plant that is a controlled substance or from which a controlled substance can be derived;

(b) Kits marketed for use or designed for use in manufacturing, compounding, converting, producing, processing or preparing controlled substances;

(c) Isomerization devices marketed for use or designed for use in increasing the potency of any species of plant that is a controlled substance;

[*(d) Testing equipment marketed for use or designed for use in identifying or in analyzing the strength, effectiveness or purity of controlled substances;*]

[*(e)*] **(d)** Scales and balances marketed for use or designed for use in weighing or measuring controlled substances;

[*(f)*] **(e)** Diluents and adulterants, such as quinine hydrochloride, mannitol, mannite, dextrose and lactose, marketed for use or designed for use in cutting controlled substances;

[*(g)*] **(f)** Lighting equipment specifically designed for growing controlled substances;

[*(h)*] **(g)** Containers and other objects marketed for use or designed for use in storing or concealing controlled substances; and

[*(i)*] **(h)** Objects marketed for use or designed specifically for use in ingesting, inhaling or otherwise introducing a controlled substance into the human body, such as:

[*(A) Metal, wooden, acrylic, glass, stone, plastic or ceramic pipes with or without screens;*]

[*(B) Water pipes;*]

[*(C) Carburetion tubes and devices;*]

[*(D)*] **(A)** Smoking and carburetion masks;

[*(E)*] **(B)** Roach clips, meaning objects used to hold burning material that has become too small or too short to be held in the hand; **or**

[*(F)*] **(C)** Miniature cocaine spoons and cocaine vials[*;*]**.**

[*(G) Chamber pipes;*]

[*(H) Carburetor pipes;*]

[*(I) Electric pipes;*]

[*(J) Air-driven pipes;*]

[*(K) Chillums;*]

[*(L) Bongs; and*]

[*(M) Ice pipes or chillers.*]

(3) For purposes of this section, "drug paraphernalia" does not include hypodermic syringes or needles**, single-use drug test strips, drug testing tools or any other item designed to prevent or reduce the potential harm associated with the use of controlled substances, including but not limited to items that reduce the transmission of infectious disease or prevent injury, infection or overdose**.

(4) The provisions of ORS 475.525 to 475.565 do not apply to persons registered under the provisions of ORS 475.125 or to persons specified as exempt from registration under the provisions of that statute.

(5)(a) The provisions of ORS 475.525 to 475.565 do not apply to a person who sells or delivers marijuana paraphernalia as defined in ORS 475C.373 to a person 21 years of age or older.

(b) In determining whether an object is drug paraphernalia under this section or marijuana paraphernalia under ORS 475C.373, a trier of fact shall consider, in addition to any other relevant factor, the following:

(A) Any oral or written instruction provided with the object related to the object's use;

(B) Any descriptive material packaged with the object that explains or depicts the object's use;

(C) Any national or local advertising related to the object's use;

(D) Any proffered expert testimony related to the object's use;

(E) The manner in which the object is displayed for sale, if applicable; and

(F) Any other proffered evidence substantiating the object's intended use.

(6) A person acting in good faith is immune from civil liability for any act or omission of an acting committed during the course of distributing an item described in subsection (3) of this section.

SECTION 18. ORS 475.744 is amended to read:

475.744. (1) A person may not sell or give a**:**

(a) Hypodermic device to a minor unless the minor demonstrates a lawful need for the hypodermic device by authorization of a physician, naturopathic physician licensed under ORS chapter 685, physician assistant licensed under ORS 677.505 to 677.525, nurse practitioner licensed under ORS 678.375 to 678.390, parent or legal guardian or by other means acceptable to the seller or donor.

(b)(A) Pipe to a minor unless the minor demonstrates a lawful need for the pipe by authorization of a physician, naturopathic physician licensed under ORS chapter 685, physician assistant licensed under ORS 677.505 to 677.525 or nurse practitioner licensed under ORS 678.375 to 678.390, or the minor's parent or legal guardian; and

(B) The minor obtains the consent of the minor's parent or legal guardian to possess the pipe.

(2) As used in this section[,]**:**

(a) "Hypodermic device" means a hypodermic needle or syringe or medication packaged in a hypodermic syringe or any instrument adapted for the subcutaneous injection of a controlled substance as defined in ORS 475.005.

(b) "Pipe" means:

(A) Metal, wooden, acrylic, glass, stone, plastic or ceramic pipes with or without screens;

(B) Water pipes;

(C) Carburetion tubes and devices;

(D) Chamber pipes;

(E) Carburetor pipes;

(F) Electric pipes;

(G) Air-driven pipes; and

(H) Ice pipes or chillers.

SECTION 19. Section 16 of this 2023 Act and the amendments to ORS 475.525 and 475.744 by sections 17 and 18 of this 2023 Act apply to conduct occurring on or after the effective date of this 2023 Act.

OVERDOSE REPORTING

SECTION 20. (1) As used in this section:

(a) "Cause of death" has the meaning given that term in ORS 146.003.

(b) "Local mental health authority" has the meaning given that term in ORS 430.630.

(c) "Manner of death" has the meaning given that term in ORS 146.003.

(d) "Opioid" means a natural, synthetic or semisynthetic chemical that interacts with opioid receptors on nerve cells in the body and brain to reduce the intensity of pain signals and feelings of pain.

(e) "Opioid overdose" means a medical condition that causes depressed consciousness, depressed respiratory function or the impairment of vital bodily functions as a result of ingesting opioids.

(f) "Third-party notification" means notification from a source other than a patient in a program administered by a local mental health authority during the patient's treatment.

(g) "Urban Indian health program" means an urban Indian health program in this state that is operated by an urban Indian organization pursuant to 25 U.S.C. 1651 et seq.

(2)(a) The Oregon Health Authority shall provide guidance for communication among local mental health authorities to improve notifications and information sharing when an individual who is 24 years of age or younger dies and the presumed cause of death is suspected to be the result of an opioid overdose or other overdose. The guidance may address community opioid overdose and other overdose response and efforts to address the potential of future related deaths. The Oregon Health Authority may collaborate with the following entities in providing the guidance described in this subsection:

(A) Local mental health authorities;

(B) The nine federally recognized Indian tribes in this state;

(C) County juvenile departments;

(D) Community-based substance use disorder treatment programs;

(E) Urban Indian health programs;

(F) The Oregon Youth Authority;

(G) The Department of Human Services;

(H) Community developmental disabilities programs; and

(I) Any other organization identified by the Oregon Health Authority or a local mental health authority as necessary to preserve the public health.

(b) The Oregon Health Authority may develop post-intervention guidance to enable local mental health authorities to deploy uniform and effective post-intervention efforts. In developing the guidance, the authority may consult with the entities described in paragraph (a) of this subsection.

(3) No later than 72 hours after receiving a third-party notification, including notice under ORS 146.100, of the death of an individual described in subsection (2)(a) of this section, if the decedent was not domiciled in the county where the death occurred, the local mental health authority shall provide notice of the death to the local mental health authority in the county where the decedent was domiciled.

(4) The local mental health authority in the county where an individual described in subsection (2)(a) of this section was domiciled may notify the local mental health authority in any other county in which the decedent had significant contacts, as described by the Oregon Health Authority by rule.

(5) After receiving notice of the death of an individual described in subsection (2)(a) of this section, each local mental health authority in a county in which the decedent had significant contacts may inform the Oregon Health Authority, in a manner and format determined by the authority, of activities implemented to support individuals and any local entities affected by the death and to prevent the risk of future related deaths. The Oregon Health Authority may serve as a resource to the local mental health authorities as needed by the community.

(6) In compliance with any state or federal laws regulating public disclosure of such information, the notification described in subsections (3) and (4) of this section must contain the following information regarding the decedent to enable the local mental health authorities described in subsections (3) and (4) of this section to deploy effective post-intervention efforts:

(a) The name of the decedent;

(b) The dates of birth and death of the decedent;

(c) The suspected manner of death;

(d) The suspected cause of death; and

(e) Any other information that the local mental health authority determines necessary to preserve the public health.

SECTION 21. ORS 146.100 is amended to read:

146.100. (1) Death investigations shall be under the direction of the district medical examiner and the district attorney for the county where the death occurs.

(2) For purposes of ORS 146.003 to 146.189, if the county where death occurs is unknown, the death shall be deemed to have occurred in the county where the body is found, except that if in an emergency the body is moved by conveyance to another county and is dead on arrival, the death shall be deemed to have occurred in the county from which the body was originally removed.

(3) The district medical examiner or an assistant district medical examiner for the county where death occurs shall be immediately notified of:

(a) All deaths requiring investigation; and

(b) All deaths of persons admitted to a hospital or institution for less than 24 hours, although the medical examiner need not investigate nor certify such deaths.

(4) No person having knowledge of a death requiring investigation shall intentionally or knowingly fail to make notification thereof as required by subsection (3) of this section.

(5) The district medical examiner or medical-legal death investigator shall immediately notify the district attorney for the county where death occurs of all deaths requiring investigation except for those specified by ORS 146.090 (1)(d) to (g).

(6) All peace officers, health care providers as defined in ORS 192.556, supervisors of penal institutions, supervisors of youth correction facilities, juvenile community supervision officers as defined in ORS 420.905, and supervisors of hospitals or institutions caring for the ill or helpless shall cooperate with the medical examiner or medical-legal death investigator by providing a decedent's

medical records and tissue samples and any other material necessary to conduct the death investigation of the decedent and shall make notification of deaths as required by subsection (3) of this section. A person who cooperates with the medical examiner or medical-legal death investigator in accordance with this subsection does not:

(a) Waive any claim of privilege applicable to, or the confidentiality of, the materials and records provided.

(b) Waive any claim that the materials and records are subject to an exemption from disclosure under ORS 192.311 to 192.478.

(c) Violate the restrictions on disclosing or providing copies of reports and other materials in ORS 419A.257.

(7) Records or materials described in subsection (6) of this section may be released by the medical examiner or medical-legal death investigator only pursuant to a valid court order.

(8)(a) If a death is suspected to be suicide and the decedent was 24 years of age or younger, the district medical examiner or medical-legal death investigator shall notify the local mental health authority in the county where the death occurred and, if the decedent was a member of a federally recognized [*Oregon tribe*] **Indian tribe in Oregon**, shall also notify the tribe's mental health authority.

(b) For the purposes of this subsection, the manner of death is suspected to be suicide if the district medical examiner, the assistant district medical examiner, a pathologist authorized under ORS 146.045 (2)(b) or a designee of the district medical examiner, including a medical-legal death investigator, confirms orally or in writing that the district medical examiner, assistant district medical examiner, pathologist or designee of the district medical examiner reasonably believes that the manner of death was suicide.

(c) The notification under this subsection must include the decedent's name, date of birth, date of death, suspected manner of death and cause of death.

(d) The notification under this subsection may include any other information that the district medical examiner or medical-legal death investigator determines is necessary to preserve the public health and that is not otherwise protected from public disclosure by state or federal law, including information regarding the decedent's school attended and extracurricular activities.

(e) The district medical examiner or medical-legal death investigator must provide the notification under this subsection no later than:

(A) 48 hours after receiving notification of the death if the county where the death occurred has a population of 400,000 or more; or

(B) 72 hours after receiving notification of the death if the county where the death occurred has a population of fewer than 400,000.

(9)(a) If a death is suspected to be the result of an opioid overdose or other overdose and the decedent was 24 years of age or younger, the district medical examiner or medical-legal death investigator shall notify the local mental health authority in the county where the death occurred and, if the decedent was a member of a federally recognized Indian tribe in Oregon, shall also notify the tribe's mental health authority.

(b) For purposes of this subsection, the cause of death is suspected to be the result of an opioid overdose or other overdose if the district medical examiner, the assistant district medical examiner, a pathologist authorized under ORS 146.045 (2)(b) or a designee of the district medical examiner, including a medical-legal death investigator, confirms orally or in writing that the district medical examiner, assistant district medical examiner, pathologist or designee of the district medical examiner reasonably believes that the cause of death was the result of an opioid overdose or other overdose.

(c) The notification under this subsection must include the decedent's name, date of birth, date of death, suspected manner of death and cause of death. The notification may include the information described in subsection (8)(d) of this section and be provided as required under subsection (8)(e) of this section.

[*(f)*] **(10)** As used in this [*subsection,*] **section:**

(a) "Local mental health authority" has the meaning given that term in ORS 430.630.

(b) "Opioid" means a natural, synthetic or semisynthetic chemical that interacts with opioid receptors on nerve cells in the body and brain to reduce the intensity of pain signals and feelings of pain.

(c) "Opioid overdose" means a medical condition that causes depressed consciousness, depressed respiratory function or the impairment of vital bodily functions as a result of ingesting opioids.

SECTION 22. Section 20 of this 2023 Act and the amendments to ORS 146.100 by section 21 of this 2023 Act apply to deaths occurring on and after the operative date specified in section 23 of this 2023 Act.

SECTION 23. (1) Section 20 of this 2023 Act and the amendments to ORS 146.100 by section 21 of this 2023 Act become operative on January 1, 2024.

(2) The Oregon Health Authority may take any action before the operative date specified in subsection (1) of this section that is necessary to enable the authority to exercise, on and after the operative date specified in subsection (1) of this section, all of the duties, functions and powers conferred on the authority by section 20 of this 2023 Act and the amendments to ORS 146.100 by section 21 of this 2023 Act.

CONFORMING AMENDMENTS

SECTION 24. ORS 430.389 is amended to read:

430.389. (1) The Oversight and Accountability Council shall oversee and approve grants and funding to implement Behavioral Health Resource Networks and increase access to community care, as set forth below. A Behavioral Health Resource Network is an entity or collection of entities that individually or jointly provide some or all of the services described in subsection (2)(d) of this section.

(2)(a) The Oversight and Accountability Council, in consultation with the Oregon Health Authority, shall provide grants and funding to agencies or organizations, whether government or community based, to establish Behavioral Health Resource Networks for the purposes of immediately screening the acute needs of people who use drugs and assessing and addressing any ongoing needs through ongoing case management, harm reduction, treatment, housing and linkage to other care and services. Recipients of grants or funding to provide substance use disorder treatment or services must be licensed, certified or credentialed by the state, including certification under ORS 743A.168 (8), or meet criteria prescribed by rule by the Oversight and Accountability Council under ORS 430.390. A recipient of a grant or funding under this subsection may not use the grant or funding to supplant the recipient's existing funding.

(b) The council and the authority shall ensure that residents of each county have access to all of the services described in paragraph (d) of this subsection.

(c) Applicants for grants and funding may apply individually or jointly with other network participants to provide services in one or more counties.

(d) A network must have the capacity to provide the following services and any other services specified by the council by rule:

(A) Screening by certified addiction peer support or wellness specialists or other qualified persons designated by the council to determine a client's need for immediate medical or other treatment to determine what acute care is needed and where it can be best provided, identify other needs and link the client to other appropriate local or statewide services, including treatment for substance [*abuse*] **use** and coexisting health problems, housing, employment, training and child care. Networks shall provide this service 24 hours a day, seven days a week, every calendar day of the year. Notwithstanding paragraph (b) of this subsection, only one grantee in each network within each county is required to provide the screenings described in this subparagraph.

(B) Comprehensive behavioral health needs assessment, including a substance use disorder screening by a certified alcohol and drug counselor or other credentialed addiction treatment professional. The assessment shall prioritize the self-identified needs of a client.

(C) Individual intervention planning, case management and connection to services. If, after the completion of a screening, a client indicates a desire to address some or all of the identified needs, a case manager shall work with the client to design an individual intervention plan. The plan must address the client's need for substance use disorder treatment, coexisting health problems, housing, employment and training, child care and other services.

(D) Ongoing peer counseling and support from screening and assessment through implementation of individual intervention plans as well as peer outreach workers to engage directly with marginalized community members who could potentially benefit from the network's services.

(E) Assessment of the need for, and provision of, mobile or virtual outreach services to:

(i) Reach clients who are unable to access the network; and

(ii) Increase public awareness of network services.

(F) Harm reduction services and information and education about harm reduction services.

(G) Low-barrier substance use disorder treatment.

(H) Transitional and supportive housing for individuals with substance use disorders.

(e) If an applicant for a grant or funding under this subsection is unable to provide all of the services described in paragraph (d) of this subsection, the applicant may identify how the applicant intends to partner with other entities to provide the services, and the Oregon Health Authority and the council may facilitate collaboration among applicants.

(f) All services provided through the networks must be evidence-informed, trauma-informed, culturally specific, linguistically responsive, person-centered and nonjudgmental. The goal shall be to address effectively the client's substance use and any other social determinants of health.

(g) The networks must be adequately staffed to address the needs of people with substance use disorders within their regions as prescribed by the council by rule, including, at a minimum, at least one person qualified by the Oregon Health Authority in each of the following categories:

(A) Certified alcohol and drug counselor or other credentialed addiction treatment professional;

(B) Case manager; and

(C) Certified addiction peer support or wellness specialist.

(h) Verification of a screening by a certified addiction peer support specialist, wellness specialist or other person in accordance with subsection (2)(d)(A) of this section shall promptly be provided to the client by the entity conducting the screening. If the client executes a valid release of information, the entity shall provide verification of the screening to the Oregon Health Authority or a contractor of the authority and the authority or the authority's contractor shall forward the verification to the court, in the manner prescribed by the Chief Justice of the Supreme Court, to satisfy the conditions for dismissal under ORS 153.062 or 475.237.

(3)(a) If moneys remain in the Drug Treatment and Recovery Services Fund after the council has committed grants and funding to establish behavioral health resource networks serving every county in this state, the council shall provide grants and funding to other agencies or organizations, whether government or community based, and to the nine federally recognized tribes in this state and service providers that are affiliated with the nine federally recognized tribes in this state to increase access to one or more of the following:

(A) Low-barrier substance use disorder treatment that is evidence-informed, trauma-informed, culturally specific, linguistically responsive, person-centered and nonjudgmental;

(B) Peer support and recovery services;

(C) Transitional, supportive and permanent housing for persons with substance use disorder;

(D) Harm reduction interventions including, but not limited to, overdose prevention education, access to [*naloxone hydrochloride*] **short-acting opioid antagonists, as defined in ORS 689.681,** and sterile syringes and stimulant-specific drug education and outreach; or

(E) Incentives and supports to expand the behavioral health workforce to support the services delivered by behavioral health resource networks and entities receiving grants or funding under this subsection.

(b) A recipient of a grant or funding under this subsection may not use the grant or funding to supplant the recipient's existing funding.

(4) In awarding grants and funding under subsections (2) and (3) of this section, the council shall:

(a) Distribute grants and funding to ensure access to:

(A) Historically underserved populations; and

(B) Culturally specific and linguistically responsive services.

(b) Consider any inventories or surveys of currently available behavioral health services.

(c) Consider available regional data related to the substance use disorder treatment needs and the access to culturally specific and linguistically responsive services in communities in this state.

(d) Consider the needs of residents of this state for services, supports and treatment at all ages.

(5) The council shall require any government entity that applies for a grant to specify in the application details regarding subgrantees and how the government entity will fund culturally specific organizations and culturally specific services. A government entity receiving a grant must make an explicit commitment not to supplant or decrease any existing funding used to provide services funded by the grant.

(6) In determining grants and funding to be awarded, the council may consult the comprehensive addiction, prevention, treatment and recovery plan established by the Alcohol and Drug Policy Commission under ORS 430.223 and the advice of any other group, agency, organization or individual that desires to provide advice to the council that is consistent with the terms of this section.

(7) Services provided by grantees, including services provided by a Behavioral Health Resource Network, shall be free of charge to the clients receiving the services. Grantees in each network shall seek reimbursement from insurance issuers, the medical assistance program or any other third party responsible for the cost of services provided to a client and grants and funding provided by the council or the authority under subsection (2) of this section may be used for copayments, deductibles or other out-of-pocket costs incurred by the client for the services.

(8) Subsection (7) of this section does not require the medical assistance program to reimburse the cost of services for which another third party is responsible in violation of 42 U.S.C. 1396a(25).

SECTION 25. ORS 431A.855 is amended to read:

431A.855. (1)(a) The Oregon Health Authority, in consultation with the Prescription Monitoring Program Advisory Commission, shall establish and maintain a prescription monitoring program for monitoring and reporting:

(A) Prescription drugs dispensed by pharmacies licensed by the State Board of Pharmacy that are classified in schedules II through IV under the federal Controlled Substances Act, 21 U.S.C. 811 and 812, as modified by the board by rule under ORS 475.035;

(B) Prescribed gabapentin and [*naloxone*] **short-acting opioid antagonists, as defined in ORS 689.681,** dispensed by pharmacies; and

(C) Other drugs identified by rules adopted by the authority.

(b)(A) To fulfill the requirements of this subsection, the authority shall establish, maintain and operate an electronic system to monitor and report drugs described in paragraph (a) of this subsection that are dispensed by prescription.

(B) The electronic system must:

(i) Operate and be accessible by practitioners and pharmacies 24 hours a day, seven days a week; and

(ii) Allow practitioners to register as required under ORS 431A.877 and to apply for access to the electronic system in accordance with rules adopted by the authority under subsection (2) of this section.

(C) The authority may contract with a state agency or private entity to ensure the effective operation of the electronic system.

(2) In consultation with the commission, the authority shall adopt rules for the operation of the electronic prescription monitoring program established under subsection (1) of this section, including standards for:

(a) Reporting data;

(b) Providing maintenance, security and disclosure of data;

(c) Ensuring accuracy and completeness of data;

(d) Complying with the federal Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) and regulations adopted under that law, including 45 C.F.R. parts 160 and 164, federal alcohol and drug treatment confidentiality laws and regulations adopted under those laws, including 42 C.F.R. part 2, and state health and mental health confidentiality laws, including ORS 179.505, 192.517 and 192.553 to 192.581;

(e) Ensuring accurate identification of persons or entities requesting information from the database;

(f) Accepting printed or nonelectronic reports from pharmacies that do not have the capability to provide electronic reports;

(g) Notifying a patient, before or when a drug classified in schedules II through IV is dispensed to the patient, about the prescription monitoring program and the entry of the prescription in the electronic system; and

(h) Registering practitioners with the electronic system.

(3) The authority shall submit an annual report to the commission regarding the prescription monitoring program established under this section.

SECTION 26. ORS 431A.865 is amended to read:

431A.865. (1)(a) Except as provided under subsections (2) and (3) of this section, prescription monitoring information submitted under ORS 431A.860 to the prescription monitoring program established in ORS 431A.855:

(A) Is protected health information under ORS 192.553 to 192.581.

(B) Is confidential and not subject to disclosure under ORS 192.311 to 192.478.

(b) Except as provided under subsection (3)(a)(H) of this section, prescription monitoring information submitted under ORS 431A.860 to the prescription monitoring program may not be used to evaluate a practitioner's professional practice.

(2) The Oregon Health Authority may review the prescription monitoring information of an individual who dies from a drug overdose.

(3)(a) Except as provided in paragraph (c) of this subsection, the Oregon Health Authority shall disclose prescription monitoring information reported to the authority under ORS 431A.860:

(A) To a practitioner or pharmacist, or, if a practitioner or pharmacist authorizes the authority to disclose the information to a member of the practitioner's or pharmacist's staff, to a member of the practitioner's or pharmacist's staff. If a practitioner or pharmacist authorizes disclosing the information to a member of the practitioner's or pharmacist's staff under this subparagraph, the practitioner or pharmacist remains responsible for the use or misuse of the information by the staff member. To receive information under this subparagraph, or to authorize the receipt of information by a staff member under this subparagraph, a practitioner or pharmacist must certify that the requested information is for the purpose of evaluating the need for or providing medical or pharmaceutical treatment for a patient to whom the practitioner or pharmacist anticipates providing, is providing or has provided care.

(B) To a dental director, medical director or pharmacy director, or, if a dental director, medical director or pharmacy director authorizes the authority to disclose the information to a member of the dental director's, medical director's or pharmacy director's staff, to a member of the dental director's, medical director's or pharmacy director's staff. If a dental director, medical director or pharmacy director authorizes disclosing the information to a member of the dental director's, medical director's or pharmacy director's staff under this subparagraph, the dental director, medical director or pharmacy director remains responsible for the use or misuse of the information by the

staff member. To receive information under this subparagraph, or to authorize the receipt of information by a staff member under this subparagraph:

(i) A dental director must certify that the requested information is for the purposes of overseeing the operations of a coordinated care organization, dental clinic or office, or a system of dental clinics or offices, and ensuring the delivery of quality dental care within the coordinated care organization, clinic, office or system.

(ii) A medical director must certify that the requested information is for the purposes of overseeing the operations of a coordinated care organization, hospital, health care clinic or system of hospitals or health care clinics and ensuring the delivery of quality health care within the coordinated care organization, hospital, clinic or system.

(iii) A pharmacy director must certify that the requested information is for the purposes of overseeing the operations of a coordinated care organization, pharmacy or system of pharmacies and ensuring the delivery of quality pharmaceutical care within the coordinated care organization, pharmacy or system.

(C) In accordance with subparagraphs (A) and (B) of this paragraph, to an individual described in subparagraphs (A) and (B) of this paragraph through a health information technology system that is used by the individual to access information about patients if:

(i) The individual is authorized to access the information in the health information technology system;

(ii) The information is not permanently retained in the health information technology system, except for purposes of conducting audits and maintaining patient records; and

(iii) The health information technology system meets any privacy and security requirements and other criteria, including criteria required by the federal Health Insurance Portability and Accountability Act, established by the authority by rule.

(D) To a practitioner in a form that catalogs all prescription drugs prescribed by the practitioner according to the number assigned to the practitioner by the Drug Enforcement Administration of the United States Department of Justice.

(E) To the Chief Medical Examiner or designee of the Chief Medical Examiner, for the purpose of conducting a medicolegal investigation or autopsy.

(F) To designated representatives of the authority or any vendor or contractor with whom the authority has contracted to establish or maintain the electronic system established under ORS 431A.855.

(G) Pursuant to a valid court order based on probable cause and issued at the request of a federal, state or local law enforcement agency engaged in an authorized drug-related investigation involving a person to whom the requested information pertains.

(H) To a health professional regulatory board that certifies in writing that the requested information is necessary for an investigation related to licensure, license renewal or disciplinary action involving the applicant, licensee or registrant to whom the requested information pertains.

(I) Pursuant to an agreement entered into under ORS 431A.869.

(b) The authority may disclose information from the prescription monitoring program that does not identify a patient, practitioner or drug outlet:

(A) For educational, research or public health purposes;

(B) For the purpose of educating practitioners about the prescribing of opioids and other controlled substances;

(C) To a health professional regulatory board;

(D) To a local public health authority, as defined in ORS 431.003; or

(E) To officials of the authority who are conducting special epidemiologic morbidity and mortality studies in accordance with ORS 413.196 and rules adopted under ORS 431.001 to 431.550 and 431.990.

(c) The authority may not disclose, except as provided in paragraph (b) of this subsection:

(A) Prescription drug monitoring information to the extent that the disclosure fails to comply with applicable provisions of the federal Health Insurance Portability and Accountability Act of

1996 (P.L. 104-191) and regulations adopted under that law, including 45 C.F.R. parts 160 and 164, federal alcohol and drug treatment confidentiality laws and regulations, including 42 C.F.R. part 2, and state health and mental health confidentiality laws, including ORS 179.505, 192.517 and 192.553 to 192.581.

(B) The sex of a patient for whom a drug was prescribed.

(C) The identity of a patient for whom [*naloxone*] **a short-acting opioid antagonist, as defined in ORS 689.681,** was prescribed.

(d) The authority shall disclose information relating to a patient maintained in the electronic system established under ORS 431A.855 to that patient at no cost to the patient within 10 business days after the authority receives a request from the patient for the information.

(e)(A) A patient may request the authority to correct any information related to the patient that is maintained in the electronic system established under ORS 431A.855 that is erroneous. The authority shall grant or deny a request to correct information within 10 business days after the authority receives the request. If a request to correct information cannot be granted because the error occurred at the pharmacy where the information was inputted, the authority shall inform the patient that the information cannot be corrected because the error occurred at the pharmacy.

(B) If the authority denies a patient's request to correct information under this paragraph, or fails to grant a patient's request to correct information under this paragraph within 10 business days after the authority receives the request, the patient may appeal the denial or failure to grant the request. Upon receiving notice of an appeal under this subparagraph, the authority shall conduct a contested case hearing as provided in ORS chapter 183. Notwithstanding ORS 183.450, the authority has the burden in the contested case hearing of establishing that the information is correct.

(f) The information in the prescription monitoring program may not be used for any commercial purpose.

(g) In accordance with ORS 192.553 to 192.581 and federal laws and regulations related to privacy, any person authorized to prescribe or dispense a prescription drug who is entitled to access a patient's prescription monitoring information may discuss the information with or release the information to other health care providers involved with the patient's care for the purpose of providing safe and appropriate care coordination.

(4)(a) The authority shall maintain records of the information disclosed through the prescription monitoring program including:

(A) The identity of each person who requests or receives information from the program and any organization the person represents;

(B) The information released to each person or organization; and

(C) The date and time the information was requested and the date and time the information was provided.

(b) Records maintained as required by this subsection may be reviewed by the Prescription Monitoring Program Advisory Commission.

(5) Information in the prescription monitoring program that identifies an individual patient must be removed no later than three years from the date the information is entered into the program.

(6) The authority shall notify the Attorney General and each individual affected by an improper disclosure of information from the prescription monitoring program of the disclosure.

(7)(a) If the authority or a person or entity required to report or authorized to receive or release prescription information under this section violates this section or ORS 431A.860 or 431A.870, a person injured by the violation may bring a civil action against the authority, person or entity and may recover damages in the amount of $1,000 or actual damages, whichever is greater.

(b) Notwithstanding paragraph (a) of this subsection, the authority and a person or entity required to report or authorized to receive or release prescription information under this section are immune from civil liability for violations of this section or ORS 431A.860 or 431A.870 unless the authority, person or entity acts with malice, criminal intent, gross negligence, recklessness or willful intent.

(8) Nothing in ORS 431A.855 to 431A.900 requires a practitioner or pharmacist who prescribes or dispenses a prescription drug to obtain information about a patient from the prescription monitoring program. A practitioner or pharmacist who prescribes or dispenses a prescription drug may not be held liable for damages in any civil action on the basis that the practitioner or pharmacist did or did not request or obtain information from the prescription monitoring program.

(9) The authority shall, at regular intervals, ensure compliance of a health information technology system described in subsection (3) of this section with the privacy and security requirements and other criteria established by the authority under subsection (3) of this section.

SECTION 27. If House Bill 2421 becomes law, section 7a, chapter ___, Oregon Laws 2023 (Enrolled House Bill 2421) (amending ORS 109.675), is repealed.

CAPTIONS

SECTION 28. The unit captions used in this 2023 Act are provided only for the convenience of the reader and do not become part of the statutory law of this state or express any legislative intent in the enactment of this 2023 Act.

EFFECTIVE DATE

SECTION 29. This 2023 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2023 Act takes effect on its passage.

Passed by House March 6, 2023

Repassed by House June 24, 2023

.....
Timothy G. Sekerak, Chief Clerk of House

.....
Dan Rayfield, Speaker of House

Passed by Senate June 24, 2023

.....
Rob Wagner, President of Senate

Received by Governor:

.....M.,....., 2023

Approved:

.....M.,....., 2023

.....
Tina Kotek, Governor

Filed in Office of Secretary of State:

.....M.,....., 2023

.....
Secretary of State

Enrolled
House Bill 2490

Sponsored by Representatives NATHANSON, NERON (Presession filed.)

CHAPTER .....

AN ACT

Relating to cybersecurity; amending ORS 192.355.

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

SECTION 1. ORS 192.355, as amended by section 5, chapter 60, Oregon Laws 2022, is amended to read:

192.355. The following public records are exempt from disclosure under ORS 192.311 to 192.478:

(1) Communications within a public body or between public bodies of an advisory nature to the extent that they cover other than purely factual materials and are preliminary to any final agency determination of policy or action. This exemption shall not apply unless the public body shows that in the particular instance the public interest in encouraging frank communication between officials and employees of public bodies clearly outweighs the public interest in disclosure.

(2)(a) Information of a personal nature such as but not limited to that kept in a personal, medical or similar file, if public disclosure would constitute an unreasonable invasion of privacy, unless the public interest by clear and convincing evidence requires disclosure in the particular instance. The party seeking disclosure shall have the burden of showing that public disclosure would not constitute an unreasonable invasion of privacy.

(b) Images of a dead body, or parts of a dead body, that are part of a law enforcement agency investigation, if public disclosure would create an unreasonable invasion of privacy of the family of the deceased person, unless the public interest by clear and convincing evidence requires disclosure in the particular instance. The party seeking disclosure shall have the burden of showing that public disclosure would not constitute an unreasonable invasion of privacy.

(3) Upon compliance with ORS 192.363, public body employee or volunteer residential addresses, residential telephone numbers, personal cellular telephone numbers, personal electronic mail addresses, driver license numbers, employer-issued identification card numbers, emergency contact information, Social Security numbers, dates of birth and other telephone numbers contained in personnel records maintained by the public body that is the employer or the recipient of volunteer services. This exemption:

(a) Does not apply to the addresses, dates of birth and telephone numbers of employees or volunteers who are elected officials, except that a judge or district attorney subject to election may seek to exempt the judge's or district attorney's address or telephone number, or both, under the terms of ORS 192.368;

(b) Does not apply to employees or volunteers to the extent that the party seeking disclosure shows by clear and convincing evidence that the public interest requires disclosure in a particular instance pursuant to ORS 192.363;

(c) Does not apply to a substitute teacher as defined in ORS 342.815 when requested by a professional education association of which the substitute teacher may be a member; and

(d) Does not relieve a public employer of any duty under ORS 243.650 to 243.809.

(4) Information submitted to a public body in confidence and not otherwise required by law to be submitted, where such information should reasonably be considered confidential, the public body has obliged itself in good faith not to disclose the information, and when the public interest would suffer by the disclosure.

(5) Information or records of the Department of Corrections, including the State Board of Parole and Post-Prison Supervision, to the extent that disclosure would interfere with the rehabilitation of a person in custody of the department or substantially prejudice or prevent the carrying out of the functions of the department, if the public interest in confidentiality clearly outweighs the public interest in disclosure.

(6) Records, reports and other information received or compiled by the Director of the Department of Consumer and Business Services in the administration of ORS chapters 723 and 725 not otherwise required by law to be made public, to the extent that the interests of lending institutions, their officers, employees and customers in preserving the confidentiality of such information outweighs the public interest in disclosure.

(7) Reports made to or filed with the court under ORS 137.077 or 137.530.

(8) Any public records or information the disclosure of which is prohibited by federal law or regulations.

(9)(a) Public records or information the disclosure of which is prohibited or restricted or otherwise made confidential or privileged under Oregon law.

(b) Subject to ORS 192.360, paragraph (a) of this subsection does not apply to factual information compiled in a public record when:

(A) The basis for the claim of exemption is ORS 40.225;

(B) The factual information is not prohibited from disclosure under any applicable state or federal law, regulation or court order and is not otherwise exempt from disclosure under ORS 192.311 to 192.478;

(C) The factual information was compiled by or at the direction of an attorney as part of an investigation on behalf of the public body in response to information of possible wrongdoing by the public body;

(D) The factual information was not compiled in preparation for litigation, arbitration or an administrative proceeding that was reasonably likely to be initiated or that has been initiated by or against the public body; and

(E) The holder of the privilege under ORS 40.225 has made or authorized a public statement characterizing or partially disclosing the factual information compiled by or at the attorney's direction.

(10) Public records or information described in this section, furnished by the public body originally compiling, preparing or receiving them to any other public officer or public body in connection with performance of the duties of the recipient, if the considerations originally giving rise to the confidential or exempt nature of the public records or information remain applicable.

(11) Records of the Energy Facility Siting Council concerning the review or approval of security programs pursuant to ORS 469.530.

(12) Employee and retiree address, telephone number and other nonfinancial membership records and employee financial records maintained by the Public Employees Retirement System pursuant to ORS chapters 238 and 238A.

(13) Records of or submitted to the State Treasurer, the Oregon Investment Council or the agents of the treasurer or the council relating to active or proposed publicly traded investments under ORS chapter 293, including but not limited to records regarding the acquisition, exchange or liquidation of the investments. For the purposes of this subsection:

(a) The exemption does not apply to:

(A) Information in investment records solely related to the amount paid directly into an investment by, or returned from the investment directly to, the treasurer or council; or

(B) The identity of the entity to which the amount was paid directly or from which the amount was received directly.

(b) An investment in a publicly traded investment is no longer active when acquisition, exchange or liquidation of the investment has been concluded.

(14)(a) Records of or submitted to the State Treasurer, the Oregon Investment Council, the Oregon Growth Board or the agents of the treasurer, council or board relating to actual or proposed investments under ORS chapter 293 or 348 in a privately placed investment fund or a private asset including but not limited to records regarding the solicitation, acquisition, deployment, exchange or liquidation of the investments including but not limited to:

(A) Due diligence materials that are proprietary to an investment fund, to an asset ownership or to their respective investment vehicles.

(B) Financial statements of an investment fund, an asset ownership or their respective investment vehicles.

(C) Meeting materials of an investment fund, an asset ownership or their respective investment vehicles.

(D) Records containing information regarding the portfolio positions in which an investment fund, an asset ownership or their respective investment vehicles invest.

(E) Capital call and distribution notices of an investment fund, an asset ownership or their respective investment vehicles.

(F) Investment agreements and related documents.

(b) The exemption under this subsection does not apply to:

(A) The name, address and vintage year of each privately placed investment fund.

(B) The dollar amount of the commitment made to each privately placed investment fund since inception of the fund.

(C) The dollar amount of cash contributions made to each privately placed investment fund since inception of the fund.

(D) The dollar amount, on a fiscal year-end basis, of cash distributions received by the State Treasurer, the Oregon Investment Council, the Oregon Growth Board or the agents of the treasurer, council or board from each privately placed investment fund.

(E) The dollar amount, on a fiscal year-end basis, of the remaining value of assets in a privately placed investment fund attributable to an investment by the State Treasurer, the Oregon Investment Council, the Oregon Growth Board or the agents of the treasurer, council or board.

(F) The net internal rate of return of each privately placed investment fund since inception of the fund.

(G) The investment multiple of each privately placed investment fund since inception of the fund.

(H) The dollar amount of the total management fees and costs paid on an annual fiscal year-end basis to each privately placed investment fund.

(I) The dollar amount of cash profit received from each privately placed investment fund on a fiscal year-end basis.

(15) The monthly reports prepared and submitted under ORS 293.761 and 293.766 concerning the Public Employees Retirement Fund and the Industrial Accident Fund may be uniformly treated as exempt from disclosure for a period of up to 90 days after the end of the calendar quarter.

(16) Reports of unclaimed property filed by the holders of such property to the extent permitted by ORS 98.352.

(17)(a) The following records, communications and information submitted to the Oregon Business Development Commission, the Oregon Business Development Department, the State Department of Agriculture, the Oregon Growth Board, the Port of Portland or other ports as defined in ORS 777.005, or a county or city governing body and any board, department, commission, council or agency thereof, by applicants for investment funds, grants, loans, services or economic development moneys, support or assistance including, but not limited to, those described in ORS 285A.224:

(A) Personal financial statements.

(B) Financial statements of applicants.

(C) Customer lists.

(D) Information of an applicant pertaining to litigation to which the applicant is a party if the complaint has been filed, or if the complaint has not been filed, if the applicant shows that such litigation is reasonably likely to occur; this exemption does not apply to litigation which has been concluded, and nothing in this subparagraph shall limit any right or opportunity granted by discovery or deposition statutes to a party to litigation or potential litigation.

(E) Production, sales and cost data.

(F) Marketing strategy information that relates to applicant's plan to address specific markets and applicant's strategy regarding specific competitors.

(b) The following records, communications and information submitted to the State Department of Energy by applicants for tax credits or for grants awarded under ORS 469B.256:

(A) Personal financial statements.

(B) Financial statements of applicants.

(C) Customer lists.

(D) Information of an applicant pertaining to litigation to which the applicant is a party if the complaint has been filed, or if the complaint has not been filed, if the applicant shows that such litigation is reasonably likely to occur; this exemption does not apply to litigation which has been concluded, and nothing in this subparagraph shall limit any right or opportunity granted by discovery or deposition statutes to a party to litigation or potential litigation.

(E) Production, sales and cost data.

(F) Marketing strategy information that relates to applicant's plan to address specific markets and applicant's strategy regarding specific competitors.

(18) Records, reports or returns submitted by private concerns or enterprises required by law to be submitted to or inspected by a governmental body to allow it to determine the amount of any transient lodging tax payable and the amounts of such tax payable or paid, to the extent that such information is in a form which would permit identification of the individual concern or enterprise. Nothing in this subsection shall limit the use which can be made of such information for regulatory purposes or its admissibility in any enforcement proceedings. The public body shall notify the taxpayer of the delinquency immediately by certified mail. However, in the event that the payment or delivery of transient lodging taxes otherwise due to a public body is delinquent by over 60 days, the public body shall disclose, upon the request of any person, the following information:

(a) The identity of the individual concern or enterprise that is delinquent over 60 days in the payment or delivery of the taxes.

(b) The period for which the taxes are delinquent.

(c) The actual, or estimated, amount of the delinquency.

(19) All information supplied by a person under ORS 151.485 for the purpose of requesting appointed counsel, and all information supplied to the court from whatever source for the purpose of verifying the financial eligibility of a person pursuant to ORS 151.485.

(20) Workers' compensation claim records of the Department of Consumer and Business Services, except in accordance with rules adopted by the Director of the Department of Consumer and Business Services, in any of the following circumstances:

(a) When necessary for insurers, self-insured employers and third party claim administrators to process workers' compensation claims.

(b) When necessary for the director, other governmental agencies of this state or the United States to carry out their duties, functions or powers.

(c) When the disclosure is made in such a manner that the disclosed information cannot be used to identify any worker who is the subject of a claim.

(d) When a worker or the worker's representative requests review of the worker's claim record.

(21) Sensitive business records or financial or commercial information of the Oregon Health and Science University that is not customarily provided to business competitors.

(22) Records of Oregon Health and Science University regarding candidates for the position of president of the university.

(23) The records of a library, including:

(a) Circulation records, showing use of specific library material by a named person;

(b) The name of a library patron together with the address or telephone number of the patron; and

(c) The electronic mail address of a patron.

(24) The following records, communications and information obtained by the Housing and Community Services Department in connection with the department's monitoring or administration of financial assistance or of housing or other developments:

(a) Personal and corporate financial statements and information, including tax returns.

(b) Credit reports.

(c) Project appraisals, excluding appraisals obtained in the course of transactions involving an interest in real estate that is acquired, leased, rented, exchanged, transferred or otherwise disposed of as part of the project, but only after the transactions have closed and are concluded.

(d) Market studies and analyses.

(e) Articles of incorporation, partnership agreements and operating agreements.

(f) Commitment letters.

(g) Project pro forma statements.

(h) Project cost certifications and cost data.

(i) Audits.

(j) Project tenant correspondence.

(k) Personal information about a tenant.

(L) Housing assistance payments.

(25) Raster geographic information system (GIS) digital databases, provided by private forestland owners or their representatives, voluntarily and in confidence to the State Forestry Department, that is not otherwise required by law to be submitted.

(26) Sensitive business, commercial or financial information furnished to or developed by a public body engaged in the business of providing electricity or electricity services, if the information is directly related to a transaction described in ORS 261.348, or if the information is directly related to a bid, proposal or negotiations for the sale or purchase of electricity or electricity services, and disclosure of the information would cause a competitive disadvantage for the public body or its retail electricity customers. This subsection does not apply to cost-of-service studies used in the development or review of generally applicable rate schedules.

(27) Sensitive business, commercial or financial information furnished to or developed by the City of Klamath Falls, acting solely in connection with the ownership and operation of the Klamath Cogeneration Project, if the information is directly related to a transaction described in ORS 225.085 and disclosure of the information would cause a competitive disadvantage for the Klamath Cogeneration Project. This subsection does not apply to cost-of-service studies used in the development or review of generally applicable rate schedules.

(28) Personally identifiable information about customers of a municipal electric utility or a people's utility district or the names, dates of birth, driver license numbers, telephone numbers, electronic mail addresses or Social Security numbers of customers who receive water, sewer or storm drain services from a public body as defined in ORS 174.109. The utility or district may release personally identifiable information about a customer, and a public body providing water, sewer or storm drain services may release the name, date of birth, driver license number, telephone number, electronic mail address or Social Security number of a customer, if the customer consents in writing or electronically, if the disclosure is necessary for the utility, district or other public body to render services to the customer, if the disclosure is required pursuant to a court order or if the disclosure is otherwise required by federal or state law. The utility, district or other public body may charge as appropriate for the costs of providing such information. The utility, district or other public body may make customer records available to third party credit agencies on a regular basis

in connection with the establishment and management of customer accounts or in the event such accounts are delinquent.

(29) A record of the street and number of an employee's address submitted to a special district to obtain assistance in promoting an alternative to single occupant motor vehicle transportation.

(30) Sensitive business records, capital development plans or financial or commercial information of Oregon Corrections Enterprises that is not customarily provided to business competitors.

(31) Documents, materials or other information submitted to the Director of the Department of Consumer and Business Services in confidence by a state, federal, foreign or international regulatory or law enforcement agency or by the National Association of Insurance Commissioners, its affiliates or subsidiaries under ORS 86A.095 to 86A.198, 697.005 to 697.095, 697.602 to 697.842, 705.137, 717.200 to 717.320, 717.900 or 717.905, ORS chapter 59, 723, 725 or 726, the Bank Act or the Insurance Code when:

(a) The document, material or other information is received upon notice or with an understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or other information; and

(b) The director has obligated the Department of Consumer and Business Services not to disclose the document, material or other information.

(32) A county elections security plan developed and filed under ORS 254.074.

(33) Information about review or approval of programs relating to the security of:

(a) Generation, storage or conveyance of:

(A) Electricity;

(B) Gas in liquefied or gaseous form;

(C) Hazardous substances as defined in ORS 453.005 (7)(a), (b) and (d);

(D) Petroleum products;

(E) Sewage; or

(F) Water.

(b) Telecommunication systems, including cellular, wireless or radio systems.

(c) Data transmissions by whatever means provided.

(34) The information specified in ORS 25.020 (8) if the Chief Justice of the Supreme Court designates the information as confidential by rule under ORS 1.002.

(35)(a) Employer account records of the State Accident Insurance Fund Corporation.

(b) As used in this subsection, "employer account records" means all records maintained in any form that are specifically related to the account of any employer insured, previously insured or under consideration to be insured by the State Accident Insurance Fund Corporation and any information obtained or developed by the corporation in connection with providing, offering to provide or declining to provide insurance to a specific employer. "Employer account records" includes, but is not limited to, an employer's payroll records, premium payment history, payroll classifications, employee names and identification information, experience modification factors, loss experience and dividend payment history.

(c) The exemption provided by this subsection may not serve as the basis for opposition to the discovery documents in litigation pursuant to applicable rules of civil procedure.

(36)(a) Claimant files of the State Accident Insurance Fund Corporation.

(b) As used in this subsection, "claimant files" includes, but is not limited to, all records held by the corporation pertaining to a person who has made a claim, as defined in ORS 656.005, and all records pertaining to such a claim.

(c) The exemption provided by this subsection may not serve as the basis for opposition to the discovery documents in litigation pursuant to applicable rules of civil procedure.

(37) Except as authorized by ORS 408.425, records that certify or verify an individual's discharge or other separation from military service.

(38) Records of or submitted to a domestic violence service or resource center that relate to the name or personal information of an individual who visits a center for service, including the date of service, the type of service received, referrals or contact information or personal information of a

family member of the individual. As used in this subsection, "domestic violence service or resource center" means an entity, the primary purpose of which is to assist persons affected by domestic or sexual violence by providing referrals, resource information or other assistance specifically of benefit to domestic or sexual violence victims.

(39) Information reported to the Oregon Health Authority under ORS 431A.860, except as provided in ORS 431A.865 (3)(b), information disclosed by the authority under ORS 431A.865 and any information related to disclosures made by the authority under ORS 431A.865, including information identifying the recipient of the information.

(40)(a) Electronic mail addresses in the possession or custody of an agency or subdivision of the executive department, as defined in ORS 174.112, the legislative department, as defined in ORS 174.114, a local government or local service district, as defined in ORS 174.116, or a special government body, as defined in ORS 174.117.

(b) This subsection does not apply to electronic mail addresses assigned by a public body to public employees for use by the employees in the ordinary course of their employment.

(c) This subsection and ORS 244.040 do not prohibit the campaign office of the current officeholder or current candidates who have filed to run for that elective office from receiving upon request the electronic mail addresses used by the current officeholder's legislative office for newsletter distribution, except that a campaign office that receives electronic mail addresses under this paragraph may not make a further disclosure of those electronic mail addresses to any other person.

(41) Residential addresses, residential telephone numbers, personal cellular telephone numbers, personal electronic mail addresses, driver license numbers, emergency contact information, Social Security numbers, dates of birth and other telephone numbers of individuals currently or previously certified or licensed by the Department of Public Safety Standards and Training contained in the records maintained by the department.

(42) Personally identifiable information and contact information of veterans as defined in ORS 408.225 and of persons serving on active duty or as reserve members with the Armed Forces of the United States, National Guard or other reserve component that was obtained by the Department of Veterans' Affairs in the course of performing its duties and functions, including but not limited to names, residential and employment addresses, dates of birth, driver license numbers, telephone numbers, electronic mail addresses, Social Security numbers, marital status, dependents, the character of discharge from military service, military rating or rank, that the person is a veteran or has provided military service, information relating to an application for or receipt of federal or state benefits, information relating to the basis for receipt or denial of federal or state benefits and information relating to a home loan or grant application, including but not limited to financial information provided in connection with the application.

(43) Business, commercial, financial, operational and research data and information, including but not limited to pricing, intellectual property and customer records, furnished to, developed by or generated in connection with the ownership and operation of an unmanned aerial system test range, if disclosure of the information would cause a competitive disadvantage to the test range or its users.

(44) Personally identifiable information about a child under the age of 16 years that is submitted to the State Fish and Wildlife Commission or an agent of the commission to obtain a license, tag or permit under the wildlife laws.

(45) Proprietary information subject to a nondisclosure agreement that is provided to the Oregon Broadband Office pursuant to section 4, chapter 60, Oregon Laws 2022.

(46) Any document, record or plan for protection relating to the existence, nature, location or function of cybersecurity devices, programs or systems designed to protect computer, information technology or communications systems against threat or attack, including but not limited to:

(a) Records pertaining to devices, programs or systems that depend for their effectiveness in whole or part upon a lack of public knowledge; and

(b) Contractual records or insurance records that set forth cybersecurity specifications, insurance application and coverage details.

Passed by House March 23, 2023

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Timothy G. Sekerak, Chief Clerk of House

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Dan Rayfield, Speaker of House

Passed by Senate June 21, 2023

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Rob Wagner, President of Senate

Received by Governor:

.....M.,....., 2023

Approved:

.....M.,....., 2023

.....
Tina Kotek, Governor

Filed in Office of Secretary of State:

.....M.,....., 2023

.....
Secretary of State

Enrolled
House Bill 2696

Sponsored by Representative RAYFIELD, Senator ANDERSON; Representative HOLVEY, Senator SOLLMAN (Presession filed.)

CHAPTER .....

AN ACT

Relating to sign language interpreters; creating new provisions; amending ORS 676.565, 676.579, 676.590, 676.612, 676.613, 676.622 and 676.992; and declaring an emergency.

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

SECTION 1. As used in sections 1 to 14 of this 2023 Act:

(1) "Licensee" means an individual who holds a license issued under sections 1 to 14 of this 2023 Act.

(2) "Signed language interpretation services" means the interpretation of conversations and other communications by use of a visual signed language.

(3) "Sign language interpreter" means an individual who provides signed language interpretation services.

SECTION 2. (1) The Health Licensing Office may issue a supervisory sign language interpreter license to an applicant who:

(a) Is at least 18 years of age;

(b) Demonstrates compliance with the code of professional conduct authored by the Registry of Interpreters for the Deaf, or its successor organization, and the National Association of the Deaf, or its successor organization, and approved by the State Board of Sign Language Interpreters;

(c) Has at least three years of qualifying experience, as determined by the board;

(d) Meets the requirements established by the board relating to minimum qualifications, education or training or any combination thereof;

(e) Meets any other requirements established by the board; and

(f) Pays a fee established by the office.

(2) A licensed supervisory sign language interpreter:

(a) May not provide signed language interpretation services in a legal or medical setting without a license issued under section 6 or 7 of this 2023 Act.

(b) May supervise licensed provisional sign language interpreters.

SECTION 3. (1) The Health Licensing Office may issue a sign language interpreter license to an applicant who:

(a) Is at least 18 years of age;

(b) Demonstrates compliance with the code of professional conduct authored by the Registry of Interpreters for the Deaf, or its successor organization, and the National Association of the Deaf, or its successor organization, and approved by the State Board of Sign Language Interpreters;

(c) Meets the requirements established by the board relating to minimum qualifications, education or training or any combination thereof;

(d) Meets any other requirements established by the board; and

(e) Pays a fee established by the office.

(2) A license issued under this section may be renewed twice.

(3) A licensed sign language interpreter may not provide signed language interpretation services in a legal or medical setting without a license issued under section 6 or 7 of this 2023 Act.

SECTION 4. (1) The Health Licensing Office may issue a provisional sign language interpreter license to an applicant who:

(a) Is at least 18 years of age;

(b) Demonstrates compliance with the code of professional conduct authored by the Registry of Interpreters for the Deaf, or its successor organization, and the National Association of the Deaf, or its successor organization, and approved by the State Board of Sign Language Interpreters;

(c) Meets the requirements established by the board relating to minimum qualifications, education or training or any combination thereof;

(d) Meets any other requirements established by the board; and

(e) Pays a fee established by the office.

(2) A license issued under this section may be renewed up to five times.

(3) A licensed provisional sign language interpreter:

(a) May provide signed language interpretation services only under the supervision of a licensed supervisory sign language interpreter.

(b) May not provide signed language interpretation services in an educational, legal or medical setting without a license issued under section 5, 6 or 7 of this 2023 Act.

SECTION 5. (1) The Health Licensing Office may issue an educational sign language interpreter license to an applicant who:

(a) Is at least 18 years of age;

(b) Demonstrates compliance with the code of professional conduct authored by the Registry of Interpreters for the Deaf, or its successor organization, and the National Association of the Deaf, or its successor organization, and approved by the State Board of Sign Language Interpreters;

(c) Meets the requirements established by the Department of Education by rule relating to sign language interpreters serving in schools;

(d) Meets any other requirements established by the board; and

(e) Pays a fee established by the office.

(2) A license issued under this section may be renewed up to five times.

(3) Only a licensed sign language interpreter, licensed supervisory sign language interpreter or licensed educational sign language interpreter may provide signed language interpretation services in an educational setting as defined by the board.

SECTION 6. (1) The Health Licensing Office may issue a medical sign language interpreter license to an applicant who:

(a) Is a licensed supervisory sign language interpreter or a licensed sign language interpreter;

(b) Meets any requirements established by the State Board of Sign Language Interpreters; and

(c) Pays a fee established by the office.

(2) Only a licensed medical sign language interpreter may provide signed language interpretation services in a medical setting as defined by the board.

SECTION 7. (1) The Health Licensing Office may issue a legal sign language interpreter license to an applicant who:

(a) Is a licensed supervisory sign language interpreter or a licensed sign language interpreter;

(b) Meets any requirements established by the State Board of Sign Language Interpreters; and

(c) Pays a fee established by the office.

(2) Only a licensed legal sign language interpreter may provide signed language interpretation services in a legal setting as defined by the board.

SECTION 8. (1)(a) Except as provided in paragraph (b) of this subsection, a person who is not licensed under sections 1 to 14 of this 2023 Act may not provide signed language interpretation services.

(b) A person who is not licensed under sections 1 to 14 of this 2023 Act may provide signed language interpretation services:

(A) In circumstances in which a license issued under sections 1 to 14 of this 2023 Act is not required.

(B) In emergency situations involving imminent or immediate harm and during which a licensee is not available.

(C) In other extenuating circumstances, as determined by the State Board of Sign Language Interpreters.

(D) If the person is a qualified interpreter under ORS 45.288 or a court interpreter certified under ORS 45.291 providing signed language interpretation services for the purpose of a proceeding in the Supreme Court, Court of Appeals, Oregon Tax Court or a circuit court or at the direction or with the approval of the Chief Justice of the Supreme Court or the presiding judge of the court in which the proceeding occurs.

(2) A person who is not licensed under sections 1 to 14 of this 2023 Act may not assume or use any title, words, abbreviations, signs or insignias, including but not limited to the titles "licensed supervisory sign language interpreter," "licensed sign language interpreter," "licensed provisional sign language interpreter," "licensed educational sign language interpreter," "licensed legal sign language interpreter" or "licensed medical sign language interpreter," that indicate that the person is licensed to provide signed language interpretation services under sections 1 to 14 of this 2023 Act.

(3) For the purpose of providing signed language interpretation services, a person may not employ or contract with an individual who is not licensed to provide signed language interpretation services under sections 1 to 14 of this 2023 Act.

SECTION 9. A licensee who acquires any information protected by confidentiality, privilege or privacy laws while providing signed language interpretation services may not be required to disclose the information in an investigation, trial or other legal proceeding without the consent of the individuals for whom the signed language interpretation services were provided.

SECTION 10. In the manner prescribed in ORS chapter 183 for contested cases, and at the direction of the State Board of Sign Language Interpreters, the Health Licensing Office may impose a form of discipline listed in ORS 676.612 for a violation of sections 1 to 14 of this 2023 Act or rules adopted under sections 1 to 14 of this 2023 Act.

SECTION 11. (1) There is established within the Health Licensing Office the State Board of Sign Language Interpreters consisting of seven members appointed by the Governor as follows:

(a)(A) Two members who are deaf, deafblind or hard of hearing and who represent an association in this state that promotes and protects the rights of persons who are deaf and hard of hearing;

(B) One member who represents a professional organization in this state for sign language interpreters and who holds a license issued under sections 1 to 14 of this 2023 Act;

(C) One member who represents a sign language interpreter education program at a post-secondary institution in this state and who holds a license issued under sections 1 to 14 of this 2023 Act;

(D) Two members who are hearing interpreters certified by or registered with a national organization for sign language interpreters and who hold licenses issued under sections 1 to 14 of this 2023 Act; and

(E) One member who is a deaf interpreter certified by or registered with a national organization for sign language interpreters and who holds a license issued under sections 1 to 14 of this 2023 Act.

(b) All members must be residents of this state and proficient in American Sign Language. To the extent practicable, the members must reflect the geographic and racial diversity of this state.

(2) The term of office of each member of the board is three years, but a member serves at the pleasure of the Governor. Before the expiration of a term of a member, the Governor shall appoint a successor whose term begins on January 1 next following. A member is eligible for reappointment. If there is a vacancy for any cause, the Governor shall make an appointment to become immediately effective for the unexpired term.

(3) A member of the board is entitled to compensation and expenses as provided in ORS 292.495.

(4) The board shall select one of its members as chairperson and another as vice chairperson, for such terms and with duties and powers necessary for the performance of the functions of the office of chairperson and vice chairperson as the board determines.

(5) A majority of the members constitutes a quorum for the transaction of business.

(6) The board shall meet at least once each quarter as determined by the office. The board may also meet at other times and places specified by the call of the chairperson or of a majority of the members of the board.

SECTION 12. The State Board of Sign Language Interpreters:

(1) Shall advise the Health Licensing Office in the establishment of:

(a) A publicly available registry of licensees that includes at least the names and specific license of each licensee.

(b) A process to receive and address grievances regarding licensees and signed language interpretation services.

(2) Shall adopt rules to carry out sections 1 to 14 of this 2023 Act, including rules to:

(a) Establish standards relating to minimum qualifications, education or training or any combination thereof for issuance of licenses under sections 1 to 14 of this 2023 Act;

(b) Determine qualifications for renewal of licenses issued under sections 1 to 14 of this 2023 Act;

(c) Establish supervision requirements; and

(d) Establish a code of professional conduct for sign language interpreters licensed under sections 1 to 14 of this 2023 Act.

(3) May establish additional specialty licenses for sign language interpreters that the board determines necessary.

SECTION 13. The Health Licensing Office and Department of Education may adopt rules with the advice of the State Board of Sign Language Interpreters to carry out the office's and the department's duties under sections 1 to 14 of this 2023 Act.

SECTION 14. Violation of any provision of sections 1 to 14 of this 2023 Act is a Class C misdemeanor.

SECTION 15. ORS 676.565 is amended to read:

676.565. Pursuant to ORS 676.568, the Health Licensing Office shall provide administrative and regulatory oversight and centralized service for the following boards, councils and programs:

(1) Board of Athletic Trainers, as provided in ORS 688.701 to 688.734;

(2) Board of Cosmetology, as provided in ORS 690.005 to 690.225;

(3) State Board of Denture Technology, as provided in ORS 680.500 to 680.565;

(4) State Board of Direct Entry Midwifery, as provided in ORS 687.405 to 687.495;

(5) Respiratory Therapist and Polysomnographic Technologist Licensing Board, as provided in ORS 688.800 to 688.840;

(6) Environmental Health Registration Board, as provided in ORS chapter 700;

(7) Board of Electrologists and Body Art Practitioners, as provided in ORS 690.350 to 690.410;

(8) Advisory Council on Hearing Aids, as provided in ORS 694.015 to 694.170;

(9) Sexual Offense Treatment Board, as provided in ORS 675.365 to 675.410;

(10) Long Term Care Administrators Board, as provided in ORS 678.710 to 678.820;

(11) Board of Licensed Dietitians, as provided in ORS 691.405 to 691.485;

(12) Behavior Analysis Regulatory Board, as provided in ORS 676.806;

(13) Board of Certified Advanced Estheticians, as provided in ORS 676.630 to 676.660;

(14) Art therapy, as provided in ORS 681.740 to 681.758;

(15) Lactation consultation, as provided in ORS 676.665 to 676.689;

(16) Music therapy, as provided in ORS 681.700 to 681.730; [*and*]

(17) Genetic counseling, as provided in ORS 676.730 to 676.748[.]**; and**

(18) State Board of Sign Language Interpreters, as provided in sections 1 to 14 of this 2023 Act.

SECTION 16. ORS 676.565, as amended by section 9, chapter 92, Oregon Laws 2022, is amended to read:

676.565. Pursuant to ORS 676.568, the Health Licensing Office shall provide administrative and regulatory oversight and centralized service for the following boards, councils and programs:

(1) Board of Athletic Trainers, as provided in ORS 688.701 to 688.734;

(2) Board of Cosmetology, as provided in ORS 690.005 to 690.225;

(3) State Board of Denture Technology, as provided in ORS 680.500 to 680.565;

(4) State Board of Direct Entry Midwifery, as provided in ORS 687.405 to 687.495;

(5) Respiratory Therapist and Polysomnographic Technologist Licensing Board, as provided in ORS 688.800 to 688.840;

(6) Environmental Health Registration Board, as provided in ORS chapter 700;

(7) Board of Electrologists and Body Art Practitioners, as provided in ORS 690.350 to 690.410;

(8) Advisory Council on Hearing Aids, as provided in ORS 694.015 to 694.170;

(9) Sexual Offense Treatment Board, as provided in ORS 675.365 to 675.410;

(10) Long Term Care Administrators Board, as provided in ORS 678.710 to 678.820;

(11) Board of Licensed Dietitians, as provided in ORS 691.405 to 691.485;

(12) Behavior Analysis Regulatory Board, as provided in ORS 676.806;

(13) Board of Certified Advanced Estheticians, as provided in ORS 676.630 to 676.660;

(14) Art therapy, as provided in ORS 681.740 to 681.758;

(15) Lactation consultation, as provided in ORS 676.665 to 676.689;

(16) Music therapy, as provided in ORS 681.700 to 681.730;

(17) Genetic counseling, as provided in ORS 676.730 to 676.748; [*and*]

(18) State Board of Sign Language Interpreters, as provided in sections 1 to 14 of this 2023 Act; and

[*(18)*] **(19)** Temporary staffing agencies, as provided in sections 1 to 7, chapter 92, Oregon Laws 2022.

SECTION 17. ORS 676.579 is amended to read:

676.579. (1)(a) The Health Licensing Office is under the supervision and control of a director, who is responsible for the performance of the duties, functions and powers and for the organization of the office.

(b) The Director of the Oregon Health Authority shall establish the qualifications for and appoint the Director of the Health Licensing Office, who holds office at the pleasure of the Director of the Oregon Health Authority.

(c) The Director of the Health Licensing Office shall receive a salary as provided by law or, if not so provided, as prescribed by the Director of the Oregon Health Authority.

(d) The Director of the Health Licensing Office is in the unclassified service.

(2) The Director of the Health Licensing Office shall provide the boards, councils and programs administered by the office with any services and employees as the office requires to carry out the office's duties. Subject to any applicable provisions of the State Personnel Relations Law, the Director of the Health Licensing Office shall appoint all subordinate officers and employees of the office, prescribe their duties and fix their compensation.

(3) The Director of the Health Licensing Office is responsible for carrying out the duties, functions and powers under ORS 675.365 to 675.410, 676.560 to 676.625, 676.630 to 676.660, 676.665 to 676.689, 676.730 to 676.748, 676.810, 676.815, 676.825, 676.992, 678.710 to 678.820, 680.500 to 680.565, 681.700 to 681.730, 681.740 to 681.758, 687.405 to 687.495, 687.895, 688.701 to 688.734, 688.800 to 688.840, 690.005 to 690.225, 690.350 to 690.410, 691.405 to 691.485 and 694.015 to 694.170 and ORS chapter 700 **and sections 1 to 14 of this 2023 Act**.

(4) The enumeration of duties, functions and powers in subsection (3) of this section is not intended to be exclusive or to limit the duties, functions and powers imposed on or vested in the office by other statutes.

SECTION 18. ORS 676.579, as amended by section 10, chapter 92, Oregon Laws 2022, is amended to read:

676.579. (1)(a) The Health Licensing Office is under the supervision and control of a director, who is responsible for the performance of the duties, functions and powers and for the organization of the office.

(b) The Director of the Oregon Health Authority shall establish the qualifications for and appoint the Director of the Health Licensing Office, who holds office at the pleasure of the Director of the Oregon Health Authority.

(c) The Director of the Health Licensing Office shall receive a salary as provided by law or, if not so provided, as prescribed by the Director of the Oregon Health Authority.

(d) The Director of the Health Licensing Office is in the unclassified service.

(2) The Director of the Health Licensing Office shall provide the boards, councils and programs administered by the office with any services and employees as the office requires to carry out the office's duties. Subject to any applicable provisions of the State Personnel Relations Law, the Director of the Health Licensing Office shall appoint all subordinate officers and employees of the office, prescribe their duties and fix their compensation.

(3) The Director of the Health Licensing Office is responsible for carrying out the duties, functions and powers under ORS 675.365 to 675.410, 676.560 to 676.625, 676.630 to 676.660, 676.665 to 676.689, 676.730 to 676.748, 676.810, 676.815, 676.825, 676.992, 678.710 to 678.820, 680.500 to 680.565, 681.700 to 681.730, 681.740 to 681.758, 687.405 to 687.495, 687.895, 688.701 to 688.734, 688.800 to 688.840, 690.005 to 690.225, 690.350 to 690.410, 691.405 to 691.485 and 694.015 to 694.170 and ORS chapter 700 and sections 1 to 7, chapter 92, Oregon Laws 2022**, and sections 1 to 14 of this 2023 Act**.

(4) The enumeration of duties, functions and powers in subsection (3) of this section is not intended to be exclusive or to limit the duties, functions and powers imposed on or vested in the office by other statutes.

SECTION 19. ORS 676.590 is amended to read:

676.590. (1) Information obtained by the Health Licensing Office as part of an investigation conducted under the following laws and any reports issued by an investigator are exempt from public disclosure:

(a) ORS 676.630 to 676.660, 676.665 to 676.689, 676.730 to 676.748, 681.700 to 681.730, 681.740 to 681.758, 690.005 to 690.225, 690.350 to 690.410 or 694.015 to 694.170 **or sections 1 to 14 of this 2023 Act**.

(b) ORS 676.560 to 676.625 if the investigation is related to the regulation of:

(A) Advanced nonablative esthetics under ORS 676.630 to 676.660;

(B) Lactation consultation under ORS 676.665 to 676.689;

(C) Music therapy under ORS 681.700 to 681.730;

(D) Art therapy under ORS 681.740 to 681.758;

(E) Barbering, hair design, esthetics, nail technology or natural hair care under ORS 690.005 to 690.225;

(F) Electrologists and body art practitioners under ORS 690.350 to 690.410;

(G) Dealing in hearing aids under ORS 694.015 to 694.170; [*or*]

(H) Genetic counseling under ORS 676.730 to 676.748[*.*]**; or**

(I) Signed language interpretation under sections 1 to 14 of this 2023 Act.

(2) The office shall disclose information obtained as part of an investigation described in subsection (1) of this section to a person who demonstrates by clear and convincing evidence that the public interest in disclosure outweighs other interests in nondisclosure, including the public interest in nondisclosure.

(3) A complaint that forms the basis for an investigation described in subsection (1) of this section shall not be considered information obtained as part of an investigation and is not exempt from public disclosure.

(4) Upon request, the office shall disclose to a person against whom disciplinary action is sought any information obtained as part of an investigation described in subsection (1) of this section, if the information is not otherwise privileged or confidential under state or federal law.

SECTION 20. ORS 676.590, as amended by section 11, chapter 92, Oregon Laws 2022, is amended to read:

676.590. (1) Information obtained by the Health Licensing Office as part of an investigation conducted under the following laws and any reports issued by an investigator are exempt from public disclosure:

(a) ORS 676.630 to 676.660, 676.665 to 676.689, 676.730 to 676.748, 681.700 to 681.730, 681.740 to 681.758, 690.005 to 690.225, 690.350 to 690.410 or 694.015 to 694.170 [*and*] **or** sections 1 to 7, chapter 92, Oregon Laws 2022**, or sections 1 to 14 of this 2023 Act**.

(b) ORS 676.560 to 676.625 if the investigation is related to the regulation of:

(A) Advanced nonablative esthetics under ORS 676.630 to 676.660;

(B) Lactation consultation under ORS 676.665 to 676.689;

(C) Music therapy under ORS 681.700 to 681.730;

(D) Art therapy under ORS 681.740 to 681.758;

(E) Barbering, hair design, esthetics, nail technology or natural hair care under ORS 690.005 to 690.225;

(F) Electrologists and body art practitioners under ORS 690.350 to 690.410;

(G) Dealing in hearing aids under ORS 694.015 to 694.170;

(H) Genetic counseling under ORS 676.730 to 676.748; [*or*]

(I) Signed language interpretation under sections 1 to 14 of this 2023 Act; or

[*(I)*] **(J)** Temporary staffing agencies under sections 1 to 7, chapter 92, Oregon Laws 2022.

(2) The office shall disclose information obtained as part of an investigation described in subsection (1) of this section to a person who demonstrates by clear and convincing evidence that the public interest in disclosure outweighs other interests in nondisclosure, including the public interest in nondisclosure.

(3) A complaint that forms the basis for an investigation described in subsection (1) of this section shall not be considered information obtained as part of an investigation and is not exempt from public disclosure.

(4) Upon request, the office shall disclose to a person against whom disciplinary action is sought any information obtained as part of an investigation described in subsection (1) of this section, if the information is not otherwise privileged or confidential under state or federal law.

SECTION 21. ORS 676.612 is amended to read:

676.612. (1) Subject to ORS 676.616 and 687.445, and in the manner prescribed in ORS chapter 183 for contested cases and as specified in ORS 675.385, 676.660, 676.685, 676.745, 676.825, 678.780,

680.535, 681.733, 681.755, 687.445, 688.734, 688.836, 690.167, 690.407, 691.477, 694.147 and 700.111 **and section 10 of this 2023 Act**, the Health Licensing Office may refuse to issue or renew, may suspend or revoke or may otherwise condition or limit an authorization or may discipline or place on probation an authorization holder for commission of the prohibited acts listed in subsection (2) of this section.

(2) A person subject to the authority of a board, council or program listed in ORS 676.565 commits a prohibited act if the person engages in:

(a) Fraud, misrepresentation, concealment of material facts or deception in applying for or obtaining an authorization to practice in this state, or in any written or oral communication to the office concerning the issuance or retention of the authorization.

(b) Using, causing or promoting the use of any advertising matter, promotional literature, testimonial, guarantee, warranty, label, insignia or any other representation, however disseminated or published, that is false, misleading or deceptive.

(c) Making a representation that the authorization holder knew or should have known is false or misleading regarding skill or the efficacy or value of treatment or remedy administered by the authorization holder.

(d) Practicing under a false, misleading or deceptive name, or impersonating another authorization holder.

(e) Permitting a person other than the authorization holder to use the authorization.

(f) Practicing with a physical or mental condition that presents an unreasonable risk of harm to the authorization holder or to the person or property of others in the course of performing the authorization holder's duties.

(g) Practicing while under the influence of alcohol, cannabis, controlled substances or other skill-impairing substances, or engaging in the illegal use of controlled substances or other skill-impairing substances so as to create a risk of harm to the person or property of others in the course of performing the duties of an authorization holder.

(h) Failing to properly and reasonably accept responsibility for the actions of employees.

(i) Employing, directly or indirectly, any suspended, uncertified, unlicensed or unregistered person to practice a regulated occupation or profession subject to the authority of the boards, councils and programs listed in ORS 676.565.

(j) Unprofessional conduct, negligence, incompetence, repeated violations or any departure from or failure to conform to standards of practice in performing services or practicing in a regulated occupation or profession subject to the authority of the boards, councils and programs listed under ORS 676.565.

(k) Conviction of any criminal offense, subject to ORS 670.280. A copy of the record of conviction, certified by the clerk of the court entering the conviction, is conclusive evidence of the conviction. A plea of no contest or an admission of guilt is a conviction for purposes of this paragraph.

(L) Failing to report any adverse action, as required by statute or rule, taken against the authorization holder by another regulatory jurisdiction or any peer review body, health care institution, professional association, governmental agency, law enforcement agency or court for acts or conduct similar to acts or conduct that would constitute grounds for disciplinary action as described in this section.

(m) Violation of a statute regulating an occupation or profession subject to the authority of the boards, councils and programs listed in ORS 676.565.

(n) Violation of any rule regulating an occupation or profession subject to the authority of the boards, councils and programs listed in ORS 676.565.

(o) Failing to cooperate with the office in any investigation, inspection or request for information.

(p) Selling or fraudulently obtaining or furnishing an authorization to practice in a regulated occupation or profession subject to the authority of the boards, councils and programs listed in ORS 676.565, or aiding or abetting such an act.

(q) Selling or fraudulently obtaining or furnishing any record related to practice in a regulated occupation or profession subject to the authority of the boards, councils and programs listed in ORS 676.565, or aiding or abetting such an act.

(r) Failing to pay an outstanding civil penalty or fee that is due or failing to meet the terms of any order issued by the office that has become final.

(3) For the purpose of requesting a state or nationwide criminal records check under ORS 181A.195, the office may require the fingerprints of a person who is:

(a) Applying for an authorization;

(b) Applying for renewal of an authorization; or

(c) Under investigation by the office.

(4) If the office places an authorization holder on probation under subsection (1) of this section, the office, in consultation with the appropriate board, council or program, may determine and at any time modify the conditions of the probation.

(5) If an authorization is suspended, the authorization holder may not practice during the term of suspension. Upon the expiration of the term of suspension, the authorization may be reinstated by the office if the conditions of suspension no longer exist and the authorization holder has satisfied all requirements in the relevant statutes or administrative rules for issuance, renewal or reinstatement.

SECTION 22. ORS 676.613 is amended to read:

676.613. (1) In addition to all other remedies, when it appears to the Health Licensing Office that a person is engaged in, has engaged in or is about to engage in any act, practice or transaction that violates any provision of ORS 675.365 to 675.410, 676.630 to 676.660, 676.665 to 676.689, 676.730 to 676.748, 676.810, 676.815, 678.710 to 678.820, 680.500 to 680.565, 681.700 to 681.730, 681.740 to 681.758, 687.405 to 687.495, 688.701 to 688.734, 688.800 to 688.840, 690.005 to 690.225, 690.350 to 690.410, 691.405 to 691.485 or 694.015 to 694.170 or ORS chapter 700 **or sections 1 to 14 of this 2023 Act**, the office may, through the Attorney General or the district attorney of the county in which the act, practice or transaction occurs or will occur, apply to the court for an injunction restraining the person from the act, practice or transaction.

(2) A court may issue an injunction under this section without proof of actual damages. An injunction issued under this section does not relieve a person from any other prosecution or enforcement action taken for violation of statutes listed in subsection (1) of this section.

SECTION 23. ORS 676.613, as amended by section 12, chapter 92, Oregon Laws 2022, is amended to read:

676.613. (1) In addition to all other remedies, when it appears to the Health Licensing Office that a person is engaged in, has engaged in or is about to engage in any act, practice or transaction that violates any provision of ORS 675.365 to 675.410, 676.630 to 676.660, 676.665 to 676.689, 676.730 to 676.748, 676.810, 676.815, 678.710 to 678.820, 680.500 to 680.565, 681.700 to 681.730, 681.740 to 681.758, 687.405 to 687.495, 688.701 to 688.734, 688.800 to 688.840, 690.005 to 690.225, 690.350 to 690.410, 691.405 to 691.485 or 694.015 to 694.170 or ORS chapter 700 or sections 1 to 7, chapter 92, Oregon Laws 2022, **or sections 1 to 14 of this 2023 Act,** the office may, through the Attorney General or the district attorney of the county in which the act, practice or transaction occurs or will occur, apply to the court for an injunction restraining the person from the act, practice or transaction.

(2) A court may issue an injunction under this section without proof of actual damages. An injunction issued under this section does not relieve a person from any other prosecution or enforcement action taken for violation of statutes listed in subsection (1) of this section.

SECTION 24. ORS 676.622 is amended to read:

676.622. (1) A transaction conducted through a state or local system or network that provides electronic access to the Health Licensing Office information and services is exempt from any requirement under ORS 675.365 to 675.410, 676.560 to 676.625, 676.630 to 676.660, 676.665 to 676.689, 676.730 to 676.748, 676.810, 676.815, 676.992, 680.500 to 680.565, 681.700 to 681.730, 681.740 to 681.758, 687.405 to 687.495, 688.701 to 688.734, 688.800 to 688.840, 690.005 to 690.225, 690.350 to 690.410, 691.405 to 691.485 and 694.015 to 694.170 and ORS chapter 700 **and sections 1 to 14 of this 2023**

Act, and rules adopted thereunder, requiring an original signature or the submission of handwritten materials.

(2) Electronic signatures subject to ORS 84.001 to 84.061 and facsimile signatures are acceptable and have the same force as original signatures.

SECTION 25. ORS 676.622, as amended by section 13, chapter 92, Oregon Laws 2022, is amended to read:

676.622. (1) A transaction conducted through a state or local system or network that provides electronic access to the Health Licensing Office information and services is exempt from any requirement under ORS 675.365 to 675.410, 676.560 to 676.625, 676.630 to 676.660, 676.665 to 676.689, 676.730 to 676.748, 676.810, 676.815, 676.992, 680.500 to 680.565, 681.700 to 681.730, 681.740 to 681.758, 687.405 to 687.495, 688.701 to 688.734, 688.800 to 688.840, 690.005 to 690.225, 690.350 to 690.410, 691.405 to 691.485 and 694.015 to 694.170 and ORS chapter 700 and sections 1 to 7, chapter 92, Oregon Laws 2022, **and sections 1 to 14 of this 2023 Act,** and rules adopted thereunder, requiring an original signature or the submission of handwritten materials.

(2) Electronic signatures subject to ORS 84.001 to 84.061 and facsimile signatures are acceptable and have the same force as original signatures.

SECTION 26. ORS 676.992 is amended to read:

676.992. (1) Except as provided in subsection (3) of this section, and in addition to any other penalty or remedy provided by law, the Health Licensing Office may impose a civil penalty not to exceed $5,000 for each violation of the following statutes and any rule adopted under the following statutes:

(a) ORS 688.701 to 688.734 (athletic training);

(b) ORS 690.005 to 690.225 (cosmetology);

(c) ORS 680.500 to 680.565 (denture technology);

(d) Subject to ORS 676.616 and 687.445, ORS 687.405 to 687.495 (direct entry midwifery);

(e) ORS 690.350 to 690.410 (tattooing, electrolysis, body piercing, earlobe piercing, dermal implanting and scarification);

(f) ORS 694.015 to 694.170 (dealing in hearing aids);

(g) ORS 688.800 to 688.840 (respiratory therapy and polysomnography);

(h) ORS chapter 700 (environmental sanitation);

(i) ORS 675.365 to 675.410 (sexual abuse specific treatment);

(j) ORS 678.710 to 678.820 (nursing home administrators and residential care facility administrators);

(k) ORS 691.405 to 691.485 (dietitians);

(L) ORS 676.612 (prohibited acts);

(m) ORS 676.810 and 676.815 (applied behavior analysis);

(n) ORS 681.700 to 681.730 (music therapy);

(o) ORS 676.630 to 676.660 (advanced nonablative esthetics procedure);

(p) ORS 681.740 to 681.758 (art therapy);

(q) ORS 676.665 to 676.689 (lactation consultation); [*and*]

(r) ORS 676.730 to 676.748 (genetic counseling)**; and**

(s) Sections 1 to 14 of this 2023 Act (signed language interpretation).

(2) The office may take any other disciplinary action that it finds proper, including but not limited to assessment of costs of disciplinary proceedings, not to exceed $5,000, for violation of any statute listed in subsection (1) of this section or any rule adopted under any statute listed in subsection (1) of this section.

(3) Subsection (1) of this section does not limit the amount of the civil penalty resulting from a violation of ORS 694.042.

(4) In imposing a civil penalty under this section, the office shall consider the following factors:

(a) The immediacy and extent to which the violation threatens the public health or safety;

(b) Any prior violations of statutes, rules or orders;

(c) The history of the person incurring a penalty in taking all feasible steps to correct any violation; and

(d) Any other aggravating or mitigating factors.

(5) Civil penalties under this section shall be imposed as provided in ORS 183.745.

(6) The moneys received by the office from civil penalties under this section shall be deposited in the Health Licensing Office Account and are continuously appropriated to the office for the administration and enforcement of the laws the office is charged with administering and enforcing that govern the person against whom the penalty was imposed.

SECTION 27. (1) Notwithstanding the term of office specified by section 11 of this 2023 Act, of the members first appointed to the State Board of Sign Language Interpreters:

(a) Two shall serve for a term ending December 31, 2024.

(b) Two shall serve for a term ending December 31, 2025.

(c) Three shall serve for a term ending December 31, 2026.

(2) The members who are required to hold a license under sections 1 to 14 of this 2023 Act shall obtain a license not later than January 31, 2024.

SECTION 28. Notwithstanding sections 3 and 4 of this 2023 Act, a licensed sign language interpreter may supervise a licensed provisional sign language interpreter.

SECTION 29. Section 28 of this 2023 Act is repealed on July 1, 2030.

SECTION 30. Notwithstanding any other law limiting expenditures, the amount of $100,100 is established for the biennium beginning July 1, 2023, as the maximum limit for payment of expenses from fees, moneys or other revenues, including Miscellaneous Receipts, but excluding lottery funds and federal funds, collected or received by the Oregon Health Authority, for the Health Licensing Office, to establish, compensate and support the State Board of Sign Language Interpreters.

SECTION 31. (1) Sections 1 to 14 of this 2023 Act and the amendments to ORS 676.565, 676.579, 676.590, 676.612, 676.613, 676.622 and 676.992 by sections 15 to 26 of this 2023 Act become operative on January 1, 2024.

(2) The Governor, the Health Licensing Office and the Department of Education may take any action before the operative date specified in subsection (1) of this section that is necessary to enable the Governor, the office and the department to exercise, on and after the operative date specified in subsection (1) of this section, all of the duties, functions and powers conferred on the Governor, the office and the department by sections 1 to 14 of this 2023 Act and the amendments to ORS 676.565, 676.579, 676.590, 676.612, 676.613, 676.622 and 676.992 by sections 15 to 26 of this 2023 Act.

SECTION 32. This 2023 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2023 Act takes effect on its passage.

Passed by House June 8, 2023

.....
Timothy G. Sekerak, Chief Clerk of House

.....
Dan Rayfield, Speaker of House

Passed by Senate June 22, 2023

.....
Rob Wagner, President of Senate

Received by Governor:

.....M.,....., 2023

Approved:

.....M.,....., 2023

.....
Tina Kotek, Governor

Filed in Office of Secretary of State:

.....M.,....., 2023

.....
Secretary of State

Enrolled
House Bill 2805

Sponsored by Representatives SOSA, NERON, MORGAN (Presession filed.)

CHAPTER .....

AN ACT

Relating to public meetings; creating new provisions; amending ORS 192.610, 192.680, 192.685, 192.690, 244.255, 244.260, 244.270, 244.290 and 244.350; repealing section 1, chapter 68, Oregon Laws 2023 (Enrolled Senate Bill 207); and prescribing an effective date.

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

PUBLIC MEETINGS
(Scope of public meetings law)

SECTION 1. ORS 192.610 is amended to read:

192.610. As used in ORS 192.610 to 192.690:

(1) "Convening" means:

(a) Gathering in a physical location;

(b) Using electronic, video or telephonic technology to be able to communicate contemporaneously among participants;

(c) Using serial electronic written communication among participants; or

(d) Using an intermediary to communicate among participants.

[*(1)*] **(2)** "Decision" means any determination, action, vote or final disposition upon a motion, proposal, resolution, order, ordinance or measure on which a vote of a governing body is required, at any meeting at which a quorum is present.

(3) "Deliberation" means discussion or communication that is part of a decision-making process.

[*(2)*] **(4)** "Executive session" means any meeting or part of a meeting of a governing body which is closed to certain persons for deliberation on certain matters.

[*(3)*] **(5)** "Governing body" means the members of any public body which consists of two or more members, with the authority to make decisions for or recommendations to a public body on policy or administration.

[*(4)*] **(6)** "Public body" means the state, any regional council, county, city or district, or any municipal or public corporation, or any board, department, commission, council, bureau, committee or subcommittee or advisory group or any other agency thereof.

[*(5)*] **(7)(a)** "Meeting" means the convening of a governing body of a public body for which a quorum is required in order to make a decision or to deliberate toward a decision on any matter.

(b) "Meeting" does not include any on-site inspection of any project or program[*. "Meeting" also does not include*] **or** the attendance of members of a governing body at any national, regional or state association to which the public body or the members belong.

SECTION 2. ORS 192.690 is amended to read:

192.690. (1) ORS 192.610 to 192.690 do not apply to **any of the following:**

(a) [*the*] Deliberations of the Psychiatric Security Review Board[,] **or** the State Board of Parole and Post-Prison Supervision[,]**.**

(b) Deliberations of state agencies conducting hearings on contested cases in accordance with the provisions of ORS chapter 183[,]**.**

(c) Deliberations of [*The review by*] the Workers' Compensation Board or the Employment Appeals Board of similar hearings on contested cases[,]**.**

(d) Meetings of the state lawyers assistance committee operating under the provisions of ORS 9.568[,]**.**

(e) Meetings of the personal and practice management assistance committees operating under the provisions of ORS 9.568[,]**.**

(f) Meetings of [*the*] county child abuse multidisciplinary teams required to review child abuse cases in accordance with the provisions of ORS 418.747[,]**.**

(g) Meetings of [*the*] child fatality review teams required to review child fatalities in accordance with the provisions of ORS 418.785[,]**.**

(h) Meetings of [*the*] peer review committees in accordance with the provisions of ORS 441.055[,]**.**

(i) Mediation conducted under ORS 36.252 to 36.268[,]**.**

(j) Any judicial proceeding[,]**.**

(k) Meetings of the Oregon Health and Science University Board of Directors or its designated committee regarding candidates for the position of president of the university or regarding sensitive business, financial or commercial matters of the university not customarily provided to competitors related to financings, mergers, acquisitions or joint ventures or related to the sale or other disposition of, or substantial change in use of, significant real or personal property, or related to health system strategies[,]**.**

(L) [*or to*] Oregon Health and Science University faculty or staff committee meetings.

(m) Communications between or among members of a governing body that are:

(A) Purely factual or educational in nature and that convey no deliberation or decision on any matter that might reasonably come before the governing body;

(B) Not related to any matter that, at any time, could reasonably be foreseen to come before the governing body for deliberation and decision; or

(C) Nonsubstantive in nature, such as communication relating to scheduling, leaves of absence and other similar matters.

(2) Because of the grave risk to public health and safety that would be posed by misappropriation or misapplication of information considered during such review and approval, ORS 192.610 to 192.690 shall not apply to review and approval of security programs by the Energy Facility Siting Council pursuant to ORS 469.530.

(Training on public meetings law)

SECTION 3. (1)(a) The Oregon Government Ethics Commission shall annually prepare training on the requirements of ORS 192.610 to 192.690 and best practices to enhance compliance with those requirements. The commission may delegate the preparation and presentation of trainings to another organization, except that the commission must approve the content of training prepared by another organization prior to presentation of the training.

(b) At the discretion of the commission, trainings prepared under this section may be presented in live sessions or be made available for viewing online. Training sessions may be presented to multiple governing bodies at any one time and may be presented in a prerecorded format.

(2)(a) Every member of a governing body of a public body with total expenditures for a fiscal year of $1 million or more shall attend or view training prepared under this section

at least once during the member's term of office and shall verify the member's attendance using the method prescribed by the commission.

(b) A member of a governing body who, under paragraph (a) of this subsection, is not required to attend training is nevertheless encouraged to attend training given under this section.

(3) The commission shall, at least once every five years, adjust the expenditure threshold for mandatory training described in subsection (2)(a) of this section to account for changes in inflation and shall by rule establish a new threshold, rounded to the nearest $100,000, for mandatory training attendance under this section.

(4) This section does not apply to governing bodies of state government, as defined in ORS 174.111.

SECTION 4. Section 3 of this 2023 Act becomes operative on January 1, 2024.

(Expansion of Oregon Government Ethics Commission oversight of public meetings law)

SECTION 5. (1) A person who believes that a governing body has acted in violation of ORS 192.610 to 192.690 may, within 30 days of the alleged violation, file a written grievance with the public body whose governing body is alleged to have violated ORS 192.610 to 192.690, setting forth the specific facts and circumstances that the person asserts amounted to a violation of ORS 192.610 to 192.690. The grievance must state the identity of the person filing the grievance and any other information required by the Oregon Government Ethics Commission by rule.

(2) A public body receiving a written grievance filed under this section shall, within 21 days of the receipt of the grievance, provide a written response to the person:

(a) Acknowledging receipt of the grievance; and

(b)(A) Denying that the facts and circumstances as set forth in the grievance accurately reflect the conduct of the governing body and setting forth the facts and circumstances as determined by the public body and the reasons why those facts and circumstances do not amount to a violation of ORS 192.610 to 192.690;

(B) Admitting that the facts and circumstances as set forth in the grievance accurately reflect the conduct of the governing body but denying that those facts and circumstances amount to a violation of ORS 192.610 to 192.690; or

(C) Admitting that the conduct of the governing body amounted to a violation of ORS 192.610 to 192.690 and setting forth the steps the governing body will take to cure the violation, including but not limited to:

(i) Rescinding the decision taken by the governing body in violation of ORS 192.610 to 192.690; or

(ii) Acknowledging in a properly noticed and conducted public meeting held within 45 days of the governing body's original decision that:

(I) The original decision was made in violation of ORS 192.610 to 192.690;

(II) Good cause exists for the governing body to not rescind the decision; and

(III) The governing body's practices will be modified to ensure future violations of ORS 192.610 to 192.690 do not occur.

(3) The public body shall send a copy of the written grievance and the public body's response under this section to the Oregon Government Ethics Commission at the time the public body responds to the person who filed the grievance.

SECTION 6. ORS 192.685 is amended to read:

192.685. (1) Notwithstanding ORS 192.680, complaints of violations of [*ORS 192.660*] **any provision of ORS 192.610 to 192.690** alleged to have been committed by public officials may be made to the Oregon Government Ethics Commission for review and investigation as provided by ORS 244.260 and for possible imposition of civil penalties as provided by ORS 244.350.

(2) A complainant may not file a complaint with the commission under this section unless the complainant has complied with the written grievance procedures described in section 5 of this 2023 Act and:

(a) Has received a response from the public body that denies that a violation of ORS 192.610 to 192.690 occurred;

(b) Has received a response from the public body that admits that a violation of ORS 192.610 to 192.690 occurred that the public body has failed to take adequate steps to cure; or

(c) Has not received a response from the public body within the time prescribed for a response under section 5 of this 2023 Act.

(3) A complainant shall submit documentation of the complainant's actions taken under section 5 of this 2023 Act and the public body's response as described in subsection (2) of this section, if any. The commission shall dismiss any complaint filed under this section that does not satisfy the requirements of subsection (2) of this section.

[*(2)*] **(4) If a complaint satisfies the requirements of subsection (2) of this section,** the commission may interview witnesses, review minutes and other records and [*may*] obtain and consider any other information pertaining to [*executive sessions*] **meetings** of the governing body of a public body for purposes of determining whether a violation of ORS [*192.660*] **192.610 to 192.690** occurred. Information related to an executive session conducted for a purpose authorized by ORS 192.660 shall be made available to the Oregon Government Ethics Commission for its investigation but shall be excluded from public disclosure.

[*(3)*] **(5)** If the commission chooses not to pursue a complaint of a violation brought under subsection (1) of this section at any time before conclusion of a contested case hearing, the public official against whom the complaint was brought may be entitled to reimbursement of reasonable costs and attorney fees by the public body to which the official's governing body has authority to make recommendations or for which the official's governing body has authority to make decisions.

SECTION 7. ORS 244.260 is amended to read:

244.260. (1)(a) Any person may file with the Oregon Government Ethics Commission a signed **or electronically signed** written complaint alleging that there has been a violation of **either:**

(A) Any provision of this chapter or of any rule adopted by the commission under this chapter. The complaint shall state the person's reason for believing that a violation occurred and include any evidence relating to the alleged violation.

(B) ORS 192.610 to 192.690. The complaint shall state the particulars of meetings of a governing body that were not in compliance with ORS 192.610 to 192.690 and shall state the person's reason for believing that a violation occurred. The person shall include any evidence relating to the alleged violation with the complaint.

(b) If at any time the commission has reason to believe that there has been a violation of a provision of this chapter or of a rule adopted by the commission under this chapter, the commission may proceed under this section on its own motion as if the commission had received a complaint.

(2)(a) Not later than two business days after receiving a complaint under this section, the commission shall notify the person who is the subject of the complaint.

(b) Before approving a motion to proceed under this section without a complaint, the commission shall provide notice to the person believed to have committed the violation of the time and place of the hearing at which the motion will be discussed. If the commission decides to proceed on its own motion, the commission shall give notice to the person not later than two business days after the motion is approved.

(c) The commission shall give notice of the complaint or motion under paragraph (a) or (b) of this subsection. The notice must describe the nature of the alleged violation. The notice must include copies of all materials submitted with a complaint. If the commission will consider a motion to proceed without a complaint, the notice must provide copies of all materials that the commission will consider at the hearing on the motion.

(d) Information that the commission considers before approving a motion to proceed on its own motion under this section and any correspondence regarding the motion or potential violation is

confidential. The executive director of the commission and the commission members and staff may not make any public comment or publicly disclose any materials relating to the motion pending the commission's approval to proceed. A person who intentionally violates this paragraph is subject to a civil penalty in an amount not to exceed $1,000. Any person aggrieved as a result of a violation of this paragraph by the executive director or a member of the commission or its staff may file a petition in a court of competent jurisdiction in the county in which the petitioner resides in order to enforce the civil penalty provided in this paragraph.

(3) After the commission receives a complaint or decides to proceed on its own motion, the executive director of the commission shall undertake action in the Preliminary Review Phase to determine whether there is cause to undertake an investigation. If the person who is the subject of the action is a member of the Legislative Assembly, the executive director shall determine whether the alleged violation involves conduct protected by Article IV, section 9, of the Oregon Constitution.

(4)(a) The Preliminary Review Phase begins on the date the complaint is filed or the date the commission decides to proceed on its own motion and ends on the date the executive director completes the statement of the facts determined during the phase under paragraph (d) of this subsection. The Preliminary Review Phase may not exceed 60 days unless a complaint is filed under this section with respect to a person who is a candidate for elective public office, the complaint is filed within 61 days before the date of an election at which the person is a candidate for nomination or election and a delay is requested in writing by the candidate. If the candidate makes a request under this paragraph, the Preliminary Review Phase must be completed not later than 60 days after the date of the election.

(b) During the Preliminary Review Phase, the executive director of the commission may seek, solicit or otherwise obtain any books, papers, records, memoranda or other additional information, administer oaths and take depositions necessary to determine whether there is cause to undertake an investigation or whether the alleged violation involves conduct protected by Article IV, section 9, of the Oregon Constitution.

(c) The Preliminary Review Phase is confidential. The executive director of the commission and any commission members and staff may acknowledge receipt of a complaint but may not make any public comment or publicly disclose any materials relating to a case during the Preliminary Review Phase. A person who intentionally violates this paragraph is subject to a civil penalty in an amount not to exceed $1,000. Any person aggrieved as a result of a violation of this paragraph by the executive director or a member of the commission or its staff may file a petition in a court of competent jurisdiction in the county in which the petitioner resides in order to enforce the civil penalty provided in this paragraph.

(d)(A) At the end of the Preliminary Review Phase, the executive director of the commission shall prepare a statement of the facts determined during the phase, including appropriate legal citations and relevant authorities. Before presentation to the commission, the executive director's statement shall be reviewed by legal counsel to the commission.

(B) Following the conclusion of the Preliminary Review Phase, the executive director of the commission shall attend an executive session of the commission where the executive director shall present the statement of the facts and summarize the results of the Preliminary Review Phase to the commission and recommend to the commission whether there is cause to undertake an investigation or whether the commission should instead dismiss the complaint or rescind its motion.

(C) At the executive session, the commission shall consider the recommendation of the executive director and make the final determination as to whether there is cause to undertake an investigation or whether the commission should instead dismiss the complaint or rescind its motion.

(D) All case related materials and proceedings shall be open to the public after the commission makes a finding of cause to undertake an investigation, dismisses a complaint or rescinds a motion.

(e) The time limit imposed in this subsection and the commission's inquiry are suspended if a court has enjoined the executive director or the commission from continuing the inquiry.

(5)(a) If the commission determines that there is not cause to undertake an investigation or that the alleged violation of this chapter involves conduct protected by Article IV, section 9, of the Oregon Constitution, the commission shall dismiss the complaint or rescind its motion and formally enter the dismissal or rescission in its records. If the commission considers the recommendation of the executive director in an executive session but the commission does not affirmatively vote to undertake an investigation, dismiss the complaint or rescind its motion, the nonaction taken by the commission shall be considered a dismissal of the complaint or a rescission of its motion. The commission shall notify the person who is the subject of action under this section of the dismissal or rescission. After dismissal or rescission, the commission may not take further action involving the person unless a new and different complaint is filed or action on the commission's own motion is undertaken based on different conduct.

(b) If the commission makes a finding of cause to undertake an investigation, the commission shall undertake action in the Investigatory Phase. The commission shall notify the person who is the subject of the investigation, identify the issues to be examined and confine the investigation to those issues. If the commission finds reason to expand the investigation, the commission shall move to do so, record in its minutes the issues to be examined before expanding the scope of its investigation and formally notify the complainant, if any, and the person who is the subject of the investigation of the expansion and the scope of the investigation.

(6)(a) The Investigatory Phase begins on the date the commission makes a finding of cause to undertake an investigation and ends on the date the commission dismisses the complaint, rescinds its own motion, issues a settlement order, moves to commence a contested case proceeding or takes other action justified by the findings. Except as provided in this subsection, the Investigatory Phase may not exceed 180 days unless a delay is stipulated to by both the person who is the subject of action under this section and the commission with the commission reserving a portion of the delay period to complete its actions.

(b) During the Investigatory Phase, the commission may seek any additional information, administer oaths, take depositions and issue subpoenas to compel attendance of witnesses and the production of books, papers, records, memoranda or other information necessary to complete the investigation. If any person fails to comply with any subpoena issued under this paragraph or refuses to testify on any matters on which the person may be lawfully interrogated, the commission shall follow the procedure described in ORS 183.440 to compel compliance.

(c) The time limit imposed in this subsection and the commission's investigation:

(A) May be suspended if there is a pending criminal investigation that relates to the issues arising out of the underlying facts or conduct at issue in the matter before the commission and the commission determines that it cannot adequately complete its investigation until the pending criminal investigation is complete; [*or*]

(B) May be suspended if a suit is commenced under ORS 192.680 concerning the same meetings of a governing body that are the subject of the investigation by the commission, until a final adjudication of the suit has been made; or

[*(B)*] **(C)** Are suspended if a court has enjoined the commission from continuing its investigation.

(d) At the end of the Investigatory Phase, the commission shall take action by order. The action may include:

(A) Dismissal, with or without comment;

(B) Continuation of the investigation for a period not to exceed 30 days for the purpose of additional fact-finding;

(C) Moving to a contested case proceeding;

(D) Entering into a negotiated settlement; or

(E) Taking other appropriate action if justified by the findings.

(e) The commission may move to a contested case proceeding if the commission determines that the information presented to the commission is sufficient to make a preliminary finding of**:**

(A) A violation of any provision of this chapter or of any rule adopted by the commission under this chapter**; or**

(B) A violation of any provision of ORS 192.610 to 192.690.

(7) A person conducting any inquiry or investigation under this section shall:

(a) Conduct the inquiry or investigation in an impartial and objective manner; and

(b) Provide to the executive director or the commission all favorable and unfavorable information the person collects.

(8) The commission shall report the findings of any inquiry or investigation in an impartial manner. The commission shall report both favorable and unfavorable findings and shall make the findings available to:

(a) The person who is the subject of the inquiry or investigation;

(b) The appointing authority, if any;

(c) The Attorney General, if the findings relate to a state public official;

(d) The appropriate district attorney, if the findings relate to a local public official; [*and*]

(e) The Commission on Judicial Fitness and Disability, if the findings relate to a judge**; and**

(f) The governing body of a public body, if the inquiry or investigation concerns an alleged violation of ORS 192.610 to 192.690 and the person who is the subject of the inquiry or investigation is a member of that governing body.

(9) Hearings conducted under this chapter must be held before an administrative law judge assigned from the Office of Administrative Hearings established under ORS 183.605. The procedure shall be that for a contested case under ORS chapter 183.

(10) The Oregon Government Ethics Commission may not inquire into or investigate any conduct that occurred more than four years before a complaint is filed or a motion is approved under subsection (1) of this section.

(11) This section does not prevent the commission and the person alleged to have violated any provision of this chapter or any rule adopted by the commission under this chapter from stipulating to a finding of fact concerning the violation and consenting to an appropriate penalty. The commission shall enter an order based on the stipulation and consent.

(12) At any time during proceedings conducted under this section, the commission may enter into a negotiated settlement with the person who is the subject of action under this section.

(13) As used in this section:

(a) "Cause" means that there is a substantial, objective basis for believing that an offense or violation may have been committed and the person who is the subject of an inquiry may have committed the offense or violation.

(b) "Governing body" has the meaning given that term in ORS 192.610.

[*(b)*] **(c)** "Pending" means that a prosecuting attorney is either actively investigating the factual basis of the alleged criminal conduct, is preparing to seek or is seeking an accusatory instrument, has obtained an accusatory instrument and is proceeding to trial or is in trial or in the process of negotiating a plea.

SECTION 7a. If Senate Bill 207 becomes law, section 1, chapter 68, Oregon Laws 2023 (Enrolled Senate Bill 207) (amending ORS 244.260), is repealed and ORS 244.260, as amended by section 7 of this 2023 Act, is amended to read:

244.260. (1)(a) Any person may file with the Oregon Government Ethics Commission a signed or electronically signed written complaint alleging that there has been a violation of either:

(A) Any provision of this chapter or of any rule adopted by the commission under this chapter. The complaint shall state the person's reason for believing that a violation occurred and include any evidence relating to the alleged violation.

(B) ORS 192.610 to 192.690. The complaint shall state the particulars of meetings of a governing body that were not in compliance with ORS 192.610 to 192.690 and shall state the person's reason for believing that a violation occurred. The person shall include any evidence relating to the alleged violation with the complaint.

(b) If at any time the commission has reason to believe that there has been a violation of a provision of this chapter **or ORS 192.660** or [*of*] a rule adopted by the commission under this chap-

ter, the commission may proceed under this section on its own motion as if the commission had received a complaint.

(2)(a) Not later than two business days after receiving a complaint under this section, the commission shall notify the person who is the subject of the complaint.

(b) Before approving a motion to proceed under this section without a complaint, the commission shall provide notice to the person believed to have committed the violation of the time and place of the hearing at which the motion will be discussed. If the commission decides to proceed on its own motion, the commission shall give notice to the person not later than two business days after the motion is approved.

(c) The commission shall give notice of the complaint or motion under paragraph (a) or (b) of this subsection. The notice must describe the nature of the alleged violation. The notice must include copies of all materials submitted with a complaint. If the commission will consider a motion to proceed without a complaint, the notice must provide copies of all materials that the commission will consider at the hearing on the motion.

(d) Information that the commission considers before approving a motion to proceed on its own motion under this section and any correspondence regarding the motion or potential violation is confidential. The executive director of the commission and the commission members and staff may not make any public comment or publicly disclose any materials relating to the motion pending the commission's approval to proceed. A person who intentionally violates this paragraph is subject to a civil penalty in an amount not to exceed $1,000. Any person aggrieved as a result of a violation of this paragraph by the executive director or a member of the commission or its staff may file a petition in a court of competent jurisdiction in the county in which the petitioner resides in order to enforce the civil penalty provided in this paragraph.

(3) After the commission receives a complaint or decides to proceed on its own motion, the executive director of the commission shall undertake action in the Preliminary Review Phase to determine whether there is cause to undertake an investigation. If the person who is the subject of the action is a member of the Legislative Assembly, the executive director shall determine whether the alleged violation involves conduct protected by Article IV, section 9, of the Oregon Constitution.

(4)(a) The Preliminary Review Phase begins on the date the complaint is filed or the date the commission decides to proceed on its own motion and ends on the date the executive director completes the statement of the facts determined during the phase under paragraph (d) of this subsection. The Preliminary Review Phase may not exceed 60 days unless a complaint is filed under this section with respect to a person who is a candidate for elective public office, the complaint is filed within 61 days before the date of an election at which the person is a candidate for nomination or election and a delay is requested in writing by the candidate. If the candidate makes a request under this paragraph, the Preliminary Review Phase must be completed not later than 60 days after the date of the election.

(b) During the Preliminary Review Phase, the executive director of the commission may seek, solicit or otherwise obtain any books, papers, records, memoranda or other additional information, administer oaths and take depositions necessary to determine whether there is cause to undertake an investigation or whether the alleged violation involves conduct protected by Article IV, section 9, of the Oregon Constitution.

(c) The Preliminary Review Phase is confidential. The executive director of the commission and any commission members and staff may acknowledge receipt of a complaint but may not make any public comment or publicly disclose any materials relating to a case during the Preliminary Review Phase. A person who intentionally violates this paragraph is subject to a civil penalty in an amount not to exceed $1,000. Any person aggrieved as a result of a violation of this paragraph by the executive director or a member of the commission or its staff may file a petition in a court of competent jurisdiction in the county in which the petitioner resides in order to enforce the civil penalty provided in this paragraph.

(d)(A) At the end of the Preliminary Review Phase, the executive director of the commission shall prepare a statement of the facts determined during the phase, including appropriate legal citations and relevant authorities. Before presentation to the commission, the executive director's statement shall be reviewed by legal counsel to the commission.

(B) Following the conclusion of the Preliminary Review Phase, the executive director of the commission shall attend an executive session of the commission where the executive director shall present the statement of the facts and summarize the results of the Preliminary Review Phase to the commission and recommend to the commission whether there is cause to undertake an investigation or whether the commission should instead dismiss the complaint or rescind its motion.

(C) At the executive session, the commission shall consider the recommendation of the executive director and make the final determination as to whether there is cause to undertake an investigation or whether the commission should instead dismiss the complaint or rescind its motion.

(D) All case related materials and proceedings shall be open to the public after the commission makes a finding of cause to undertake an investigation, dismisses a complaint or rescinds a motion.

(e) The time limit imposed in this subsection and the commission's inquiry are suspended if a court has enjoined the executive director or the commission from continuing the inquiry.

(5)(a) If the commission determines that there is not cause to undertake an investigation or that the alleged violation of this chapter involves conduct protected by Article IV, section 9, of the Oregon Constitution, the commission shall dismiss the complaint or rescind its motion and formally enter the dismissal or rescission in its records. If the commission considers the recommendation of the executive director in an executive session but the commission does not affirmatively vote to undertake an investigation, dismiss the complaint or rescind its motion, the nonaction taken by the commission shall be considered a dismissal of the complaint or a rescission of its motion. The commission shall notify the person who is the subject of action under this section of the dismissal or rescission. After dismissal or rescission, the commission may not take further action involving the person unless a new and different complaint is filed or action on the commission's own motion is undertaken based on different conduct.

(b) If the commission makes a finding of cause to undertake an investigation, the commission shall undertake action in the Investigatory Phase. The commission shall notify the person who is the subject of the investigation, identify the issues to be examined and confine the investigation to those issues. If the commission finds reason to expand the investigation, the commission shall move to do so, record in its minutes the issues to be examined before expanding the scope of its investigation and formally notify the complainant, if any, and the person who is the subject of the investigation of the expansion and the scope of the investigation.

(6)(a) The Investigatory Phase begins on the date the commission makes a finding of cause to undertake an investigation and ends on the date the commission dismisses the complaint, rescinds its own motion, issues a settlement order, moves to commence a contested case proceeding or takes other action justified by the findings. Except as provided in this subsection, the Investigatory Phase may not exceed 180 days unless a delay is stipulated to by both the person who is the subject of action under this section and the commission with the commission reserving a portion of the delay period to complete its actions.

(b) During the Investigatory Phase, the commission may seek any additional information, administer oaths, take depositions and issue subpoenas to compel attendance of witnesses and the production of books, papers, records, memoranda or other information necessary to complete the investigation. If any person fails to comply with any subpoena issued under this paragraph or refuses to testify on any matters on which the person may be lawfully interrogated, the commission shall follow the procedure described in ORS 183.440 to compel compliance.

(c) The time limit imposed in this subsection and the commission's investigation:

(A) May be suspended if there is a pending criminal investigation that relates to the issues arising out of the underlying facts or conduct at issue in the matter before the commission and the commission determines that it cannot adequately complete its investigation until the pending criminal investigation is complete;

(B) May be suspended if a suit is commenced under ORS 192.680 concerning the same meetings of a governing body that are the subject of the investigation by the commission, until a final adjudication of the suit has been made; or

(C) Are suspended if a court has enjoined the commission from continuing its investigation.

(d) At the end of the Investigatory Phase, the commission shall take action by order. The action may include:

(A) Dismissal, with or without comment;

(B) Continuation of the investigation for a period not to exceed 30 days for the purpose of additional fact-finding;

(C) Moving to a contested case proceeding;

(D) Entering into a negotiated settlement; or

(E) Taking other appropriate action if justified by the findings.

(e) The commission may move to a contested case proceeding if the commission determines that the information presented to the commission is sufficient to make a preliminary finding of:

(A) A violation of any provision of this chapter or of any rule adopted by the commission under this chapter; or

(B) A violation of any provision of ORS 192.610 to 192.690.

(7) A person conducting any inquiry or investigation under this section shall:

(a) Conduct the inquiry or investigation in an impartial and objective manner; and

(b) Provide to the executive director or the commission all favorable and unfavorable information the person collects.

(8) The commission shall report the findings of any inquiry or investigation in an impartial manner. The commission shall report both favorable and unfavorable findings and shall make the findings available to:

(a) The person who is the subject of the inquiry or investigation;

(b) The appointing authority, if any;

(c) The Attorney General, if the findings relate to a state public official;

(d) The appropriate district attorney, if the findings relate to a local public official;

(e) The Commission on Judicial Fitness and Disability, if the findings relate to a judge; and

(f) The governing body of a public body, if the inquiry or investigation concerns an alleged violation of ORS 192.610 to 192.690 and the person who is the subject of the inquiry or investigation is a member of that governing body.

(9) Hearings conducted under this chapter must be held before an administrative law judge assigned from the Office of Administrative Hearings established under ORS 183.605. The procedure shall be that for a contested case under ORS chapter 183.

(10) The Oregon Government Ethics Commission may not inquire into or investigate any conduct that occurred more than four years before a complaint is filed or a motion is approved under subsection (1) of this section.

(11) This section does not prevent the commission and the person alleged to have violated any provision of this chapter **or ORS 192.660** or any rule adopted by the commission under this chapter from stipulating to a finding of fact concerning the violation and consenting to an appropriate penalty. The commission shall enter an order based on the stipulation and consent.

(12) At any time during proceedings conducted under this section, the commission may enter into a negotiated settlement with the person who is the subject of action under this section.

(13) As used in this section:

(a) "Cause" means that there is a substantial, objective basis for believing that an offense or violation may have been committed and the person who is the subject of an inquiry may have committed the offense or violation.

(b) "Governing body" has the meaning given that term in ORS 192.610.

(c) "Pending" means that a prosecuting attorney is either actively investigating the factual basis of the alleged criminal conduct, is preparing to seek or is seeking an accusatory instrument, has

obtained an accusatory instrument and is proceeding to trial or is in trial or in the process of negotiating a plea.

SECTION 7b. If Senate Bill 207 becomes law, the amendments to ORS 244.260 by section 7a of this 2023 Act become operative on January 1, 2024.

SECTION 8. ORS 192.680 is amended to read:

192.680. (1) A decision made by a governing body of a public body in violation of ORS 192.610 to 192.690 shall be voidable. The decision shall not be voided if the governing body of the public body reinstates the decision while in compliance with ORS 192.610 to 192.690. A decision that is reinstated is effective from the date of its initial adoption.

(2) Any person affected by a decision of a governing body of a public body may commence a suit in the circuit court for the county in which the governing body ordinarily meets, for the purpose of requiring compliance with, or the prevention of violations of ORS 192.610 to 192.690, by members of the governing body, or to determine the applicability of ORS 192.610 to 192.690 to matters or decisions of the governing body.

(3) Notwithstanding subsection (1) of this section, if the court finds that the public body made a decision while in violation of ORS 192.610 to 192.690, the court shall void the decision of the governing body if the court finds that the violation was the result of intentional disregard of the law or willful misconduct by a quorum of the members of the governing body, unless other equitable relief is available. The court may order such equitable relief as it deems appropriate in the circumstances. The court may order payment to a successful plaintiff in a suit brought under this section of reasonable attorney fees at trial and on appeal, by the governing body, or public body of which it is a part or to which it reports.

(4) If the court makes a finding that a violation of ORS 192.610 to 192.690 has occurred under subsection (2) of this section and that the violation is the result of willful misconduct by any member or members of the governing body, that member or members shall be jointly and severally liable to the governing body or the public body of which it is a part for the amount paid by the body under subsection (3) of this section.

(5) Any suit brought under subsection (2) of this section must be commenced within 60 days following the date that the decision becomes public record.

(6) The provisions of this section shall be the exclusive remedy for an alleged violation of ORS 192.610 to 192.690**, except that this subsection does not apply to proceedings of the Oregon Government Ethics Commission**.

SECTION 9. ORS 244.255 is amended to read:

244.255. (1) The Oregon Government Ethics Commission shall estimate in advance the expenses that it will incur during a biennium in carrying out the provisions of ORS 171.725 to 171.785**,** [*and*] 171.992 **and 192.610 to 192.690** and this chapter. The commission shall also determine what percentage of the expenses should be borne by the following two groups of public bodies:

(a) Public bodies in state government; and

(b) Local governments, local service districts and special government bodies that are subject to the Municipal Audit Law.

(2) The commission shall charge each public body for the public body's share of the expenses described in subsection (1) of this section for the biennium. The amount to be charged each public body shall be determined as follows:

(a) The commission shall determine the rate to be charged public bodies in state government. The same rate shall be applied to each public body described in this paragraph. To determine the amount of the charge for each public body, the commission shall multiply the rate determined under this paragraph by the number of public officials serving the public body.

(b) The commission shall set the charge for local governments, local service districts and special government bodies that are subject to the Municipal Audit Law so that each local government, local service district or special government body described in this paragraph pays an amount of the total expenses for the group that bears the same proportion to the total expenses that the amount

charged to the local government, local service district or special government body for the municipal audit fee under ORS 297.485 bears to the total amount assessed for the municipal audit fee.

(3) Each public body shall pay to the credit of the commission the charge described in this section as an administrative expense from funds or appropriations available to the public body in the same manner as other claims against the public body are paid.

(4) All moneys received by the commission under this section shall be credited to the Oregon Government Ethics Commission Account established under ORS 244.345.

(5) The commission shall adopt rules specifying the methods for calculating and collecting the rates and charges described in this section.

(6) As used in this section:

(a) "Local government" and "local service district" have the meanings given those terms in ORS 174.116.

(b) "Public body" has the meaning given that term in ORS 174.109.

(c) "Public official," notwithstanding ORS 244.020 (15), means any person who, on the date the commission charges the public body under this section, is serving the public body as an officer or employee.

(d) "Special government body" has the meaning given that term in ORS 174.117.

(e) "State government" has the meaning given that term in ORS 174.111.

SECTION 10. ORS 244.270 is amended to read:

244.270. (1) If the Oregon Government Ethics Commission finds that an appointed public official has violated any provision of this chapter or any rule adopted under this chapter, **or has violated any provision of ORS 192.610 to 192.690 with intentional disregard of the law or willful misconduct,** the finding is prima facie evidence of unfitness where removal is authorized for cause either by law or pursuant to section 6, Article VII (Amended) of the Oregon Constitution.

(2) If the commission finds that a public official has violated any provision of this chapter or any rule adopted under this chapter, **or has violated any provision of ORS 192.610 to 192.690,** the commission shall notify the public body, as defined in ORS 174.109, that the public official serves. The notice shall describe the violation and any action taken by the commission. The commission shall provide the notice not later than 10 business days after the date the commission takes final action against the public official.

SECTION 11. ORS 244.290 is amended to read:

244.290. (1) The Oregon Government Ethics Commission shall:

(a) Prescribe forms for statements required by this chapter and provide the forms to persons required to file the statements under this chapter or pursuant to a resolution adopted under ORS 244.160.

(b) Develop a filing, coding and cross-indexing system consistent with the purposes of this chapter.

(c) Prepare and publish reports the commission finds are necessary.

(d) Accept and file any information voluntarily supplied that exceeds the requirements of this chapter.

(e) Make statements and other information filed with the commission available for public inspection and copying during regular office hours, and make copying facilities available at a charge not to exceed actual cost.

(f) Not later than February 1 of each odd-numbered year, report to the Legislative Assembly any recommended changes to provisions of ORS 171.725 to 171.785 or this chapter.

(2) The commission shall adopt rules necessary to carry out its duties under ORS 171.725 to 171.785, 171.992[, *192.660 and 192.685*] **and 192.610 to 192.690** and this chapter, including rules to:

(a) Create a procedure under which items before the commission may be treated under a consent calendar and voted on as a single item;

(b) Exempt a public official who is otherwise required to file a statement pursuant to ORS 244.050 from filing the statement if the regularity, number and frequency of the meetings and actions

of the body over which the public official has jurisdiction are so few or infrequent as not to warrant the public disclosure;

(c) Establish an administrative process whereby a person subpoenaed by the commission may obtain a protective order;

(d) List criteria and establish a process for the commission to use prosecutorial discretion to decide whether to proceed with an inquiry or investigation;

(e) Establish a procedure under which the commission shall conduct accuracy audits of a sample of reports or statements filed with the commission under this chapter or ORS 171.725 to 171.785;

(f) Describe the application of provisions exempting items from the definition of "gift" in ORS 244.020;

(g) Specify when a continuing violation is considered a single violation or a separate and distinct violation for each day the violation occurs; and

(h) Set criteria for determining the amount of civil penalties that the commission may impose.

(3) The commission may adopt rules that:

(a) Limit the minimum size of, or otherwise establish criteria for or identify, the smaller classes that qualify under the class exception from the definition of "potential conflict of interest" under ORS 244.020;

(b) Require the disclosure and reporting of gifts or other compensation made to or received by a public official or candidate;

(c) Establish criteria for cases in which information relating to notices of actual or potential conflicts of interest shall, may not or may be provided to the commission under ORS 244.130; or

(d) Allow the commission to accept the filing of a statement containing less than all of the information required under ORS 244.060 and 244.070 if the public official or candidate certifies on the statement that the information contained on the statement previously filed is unchanged or certifies only as to any changed material.

(4) Not less frequently than once each calendar year, the commission shall:

(a) Consider adoption of rules the commission deems necessary to implement or interpret provisions of this chapter relating to issues the commission determines are of general interest to public officials or candidates or that are addressed by the commission or by commission staff on a recurring basis; and

(b) Review rules previously adopted by the commission to determine whether the rules have continuing applicability or whether the rules should be amended or repealed.

(5) The commission shall adopt by rule an electronic filing system under which statements required to be filed under ORS 244.050 and 244.217 must be filed, without a fee, with the commission in an electronic format.

(6) The commission shall make available in a searchable format for review by the public using the Internet:

(a) Statements filed under ORS 244.050 and 244.217;

(b) Advisory opinions issued by the commission or the executive director of the commission;

(c) Findings issued by the commission under ORS 244.260 in instances where the commission determines that there has been a violation of a provision of this chapter or of any rule adopted by the commission under this chapter. Nothing in this paragraph requires the commission to make publicly available materials that are otherwise exempt from public disclosure or that are required to be kept confidential by the commission; and

(d) Lobbyist registration statements and revisions and updates to lobbyist registration statements filed under ORS 171.740. The information required under this paragraph must be available in a searchable format for review by the public using the Internet not later than one calendar day after the lobbyist files the information with the commission.

SECTION 12. ORS 244.350 is amended to read:

244.350. (1) The Oregon Government Ethics Commission may impose civil penalties not to exceed:

(a) Except as provided in paragraphs (b), (c) and (d) of this subsection, $5,000 for violation of any provision of this chapter or any resolution adopted under ORS 244.160.

(b) $25,000 for violation of ORS 244.045.

(c) $10,000 for willfully violating ORS 244.040.

(d) Two times the amount of the penalty provision for violating a nondisclosure agreement that is contained within each nondisclosure agreement entered into in violation of ORS 244.049.

(2)(a) Except as provided in paragraph (b) of this subsection, the commission may impose civil penalties not to exceed $1,000 for violation of any provision of ORS [*192.660*] **192.610 to 192.690**.

(b) A civil penalty may not be imposed under this subsection if the violation occurred as a result of the governing body of the public body acting upon the advice of the public body's counsel.

(3) The commission may impose civil penalties not to exceed $250 for violation of ORS 293.708. A civil penalty imposed under this subsection is in addition to and not in lieu of a civil penalty that may be imposed under subsection (1) of this section.

(4)(a) The commission may impose civil penalties on a person who fails to file the statement required under ORS 244.050 or 244.217. In enforcing this subsection, the commission is not required to follow the procedures in ORS 244.260 before finding that a violation of ORS 244.050 or 244.217 has occurred.

(b) Failure to file the required statement in timely fashion is prima facie evidence of a violation of ORS 244.050 or 244.217.

(c) The commission may impose a civil penalty of $10 for each of the first 14 days the statement is late beyond the date set by law, or by the commission under ORS 244.050, and $50 for each day thereafter. The maximum penalty that may be imposed under this subsection is $5,000.

(5) In lieu of or in conjunction with finding a violation of law or any resolution or imposing a civil penalty under this section, the commission may issue a written letter of reprimand, explanation or education.

(6)(a) A civil penalty imposed under this section for a violation of ORS 192.610 to 192.690 is a personal liability of each member of the governing body on whom the penalty is imposed and may not be paid for or indemnified by the governing body or public body that the member is associated with.

(b) As used in this subsection, "governing body" and "public body" have the meanings given those terms in ORS 192.610.

MISCELLANEOUS

SECTION 13. Sections 3 and 5 of this 2023 Act and ORS 192.695 are added to and made a part of ORS 192.610 to 192.690.

SECTION 14. Notwithstanding any other law limiting expenditures, the limitation on expenditures established by section 1, chapter 61, Oregon Laws 2023 (Enrolled House Bill 5021), for the biennium beginning July 1, 2023, as the maximum limit for payment of expenses from fees, moneys or other revenues, including Miscellaneous Receipts and reimbursements from federal service agreements, but excluding lottery funds and federal funds not described in section 1, chapter 61, Oregon Laws 2023 (Enrolled House Bill 5021), collected or received by the Oregon Government Ethics Commission, is increased by $1,365,307.

SECTION 15. The unit captions used in this 2023 Act are provided only for the convenience of the reader and do not become part of the statutory law of this state or express any legislative intent in the enactment of this 2023 Act.

EFFECTIVE DATE

SECTION 16. This 2023 Act takes effect on the 91st day after the date on which the 2023 regular session of the Eighty-second Legislative Assembly adjourns sine die.

Passed by House June 8, 2023

Repassed by House June 25, 2023

.....
Timothy G. Sekerak, Chief Clerk of House

.....
Dan Rayfield, Speaker of House

Passed by Senate June 24, 2023

.....
Rob Wagner, President of Senate

Received by Governor:

.....M.,....., 2023

Approved:

.....M.,....., 2023

.....
Tina Kotek, Governor

Filed in Office of Secretary of State:

.....M.,....., 2023

.....
Secretary of State

Enrolled
House Bill 3223

Sponsored by Representatives PHAM H, JAVADI, Senators GELSER BLOUIN, MANNING JR; Representative LEVY E, Senator CAMPOS

CHAPTER .....

AN ACT

Relating to dental assistants; and prescribing an effective date.

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

SECTION 1. Section 2 of this 2023 Act is added to and made a part of ORS chapter 679.

SECTION 2. (1) In adopting rules related to the requirements for certification as a dental assistant, including any type of expanded function dental assistant, the Oregon Board of Dentistry may require an applicant for certification to pass a written examination. If passage of a written examination is required for certification as a dental assistant, including any type of expanded function dental assistant, the board may accept the results of any examination that is:

(a)(A) Administered by a dental education program in this state that is accredited by the Commission on Dental Accreditation of the American Dental Association, or its successor organization, and approved by the board by rule;

(B) Administered by a dental education program in this state that is approved by the Commission for Continuing Education Provider Recognition of the American Dental Association, or its successor organization, and approved by the board by rule; or

(C) An examination comparable to an examination described in subparagraph (A) or (B) of this paragraph that is administered by a testing agency approved by the board by rule; and

(b) Offered in plain language in English, Spanish and Vietnamese.

(2) The board may not require an applicant for certification as a dental assistant, including any type of expanded function dental assistant, to complete more than one written examination for certification as that type of dental assistant.

SECTION 3. Section 2 of this 2023 Act applies to applications for certification as a dental assistant, including any type of expanded function dental assistant, submitted on or after the operative date specified in section 4 of this 2023 Act.

SECTION 4. (1) Section 2 of this 2023 Act becomes operative on July 1, 2025.

(2) The Oregon Board of Dentistry may take any action before the operative date specified in subsection (1) of this section that is necessary to enable the board to exercise, on and after the operative date specified in subsection (1) of this section, all of the duties, functions and powers conferred on the board by section 2 of this 2023 Act.

SECTION 5. (1) The Oregon Board of Dentistry shall convene an advisory committee of at least seven members to study the dental assistant workforce shortage and to review the requirements for dental assistant certification in other states. The committee shall provide

advice to the board on a quarterly basis on how to address the dental assistant workforce shortage in this state.

(2)(a) In appointing members to the advisory committee, the board shall prioritize diversity of geographic representation, background, culture and experience.

(b) A majority of the members appointed to the committee must have experience working as dental assistants.

SECTION 6. This 2023 Act takes effect on the 91st day after the date on which the 2023 regular session of the Eighty-second Legislative Assembly adjourns sine die.

Passed by House March 16, 2023

Repassed by House June 24, 2023

.....
Timothy G. Sekerak, Chief Clerk of House

.....
Dan Rayfield, Speaker of House

Passed by Senate June 24, 2023

.....
Rob Wagner, President of Senate

Received by Governor:

.....M.,....., 2023

Approved:

.....M.,....., 2023

.....
Tina Kotek, Governor

Filed in Office of Secretary of State:

.....M.,....., 2023

.....
Secretary of State

Enrolled
House Bill 5011

Introduced and printed pursuant to House Concurrent Resolution 23 (2023) (at the request of Oregon Department of Administrative Services)

CHAPTER .....

AN ACT

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

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

SECTION 1. Notwithstanding any other law limiting expenditures, the amount of $4,268,886 is established for the biennium beginning July 1, 2023, as the maximum limit for payment of expenses from fees, moneys or other revenues, including Miscellaneous Receipts, but excluding lottery funds and federal funds, collected or received by the Oregon Board of Dentistry.

SECTION 2. This 2023 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2023 Act takes effect July 1, 2023.

Passed by House May 24, 2023

.....
Timothy G. Sekerak, Chief Clerk of House

.....
Dan Rayfield, Speaker of House

Passed by Senate June 23, 2023

.....
Rob Wagner, President of Senate

Received by Governor:

.....M.,....., 2023

Approved:

.....M.,....., 2023

.....
Tina Kotek, Governor

Filed in Office of Secretary of State:

.....M.,....., 2023

.....
Secretary of State

Enrolled
House Bill 5044

Introduced and printed pursuant to House Concurrent Resolution 23 (2023) (at the request of Oregon Department of Administrative Services)

CHAPTER .....

AN ACT

Relating to state financial administration; and declaring an emergency.

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

SECTION 1. For the purpose of carrying out the provisions of ORS 291.055 (1)(e), the following new or increased fees, adopted by the Oregon Board of Dentistry and approved by the Oregon Department of Administrative Services, are approved:

(1)	**Dental therapist application fee.....**	**$ 180**
(2)	**Dental therapist biennial licensure fee.....**	**$ 230**

SECTION 2. This 2023 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2023 Act takes effect July 1, 2023.

Passed by House May 24, 2023

.....
Timothy G. Sekerak, Chief Clerk of House

.....
Dan Rayfield, Speaker of House

Passed by Senate June 23, 2023

.....
Rob Wagner, President of Senate

Received by Governor:

.....M.,....., 2023

Approved:

.....M.,....., 2023

.....
Tina Kotek, Governor

Filed in Office of Secretary of State:

.....M.,....., 2023

.....
Secretary of State

AADB 140th Annual Meeting

Loews Hollywood Hotel
1755 North Highland Avenue
Hollywood, CA 99028

Preliminary Program

October 19 - 21, 2023

American Association of Dental Boards

President James A. Sparks, DDS

AADB Thanks Our Program Committee Chair:

James A. Sparks, DDS (OK)

Vice Chair:

Dale Chamberlain, DDS (MT)

Yvonne Bach (KY)

Brian Barnett (MO)

Sherry Campbell, RDH, CDHC (AL)

Bobby Carmen, DDS (OK)

Cliff Feingold, DDS (NC)

Martin Gillis, DDS (Liverpool)

Kristna Gomez, (AZ)

Arthur Chen-Shu Jee, DMD (MD)

Frank Maggio, DDS (IL)

Michael O'Hara, JD, PhD (NE)

Laura Richoux, RDH (MS)

American Association of Dental Boards

1701 Pennsylvania Ave NW, Suite 200
Washington, DC 20006

200 East Randolph Street, Suite 5100
Chicago, IL 60601

About AADB

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

Our Mission

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

About AADB's Annual Meeting

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

Meeting Agenda

Thursday, October 19

Please note the times listed below are in Pacific Time

4:00 p.m. - 7:00 p.m.	**Registration**
6:00 p.m. - 8:00 p.m.	**AADB Board of Directors' Dinner** *By invitation only*

Friday, October 20

Please note the times listed below are in Pacific Time

6:45 a.m. - 6:00 p.m.	**Registration**
8:00 a.m. - 9:00 a.m.	**AADB Board of Directors Meeting – *Breakout*** James A. Sparks, DDS AADB President
8:00 a.m. - 9:00 a.m.	**New Member Orientation – *Breakout***
9:00 a.m. - 10:00 a.m.	**Program Committee Meeting – *Breakout*** James A. Sparks, DDS AADB President
10:00 a.m. - 11:00 a.m.	**Investigator Caucus Meeting – *Breakout*** W. Blake Strickland Executive Director Board of Dental Examiners of Alabama *This closed session is for AADB member Dental Board Investigators.*
10:00 a.m. - 11:00 a.m.	**Hygienist Caucus Meeting – *Breakout*** Laura Richoux, RDH AADB Caucus Chair *This closed session is for AADB member hygienists who serve or have served on a board of dentistry.*
11:00 a.m. - 12:00 p.m.	**State/Territory Board Leadership Caucus Meeting – *Breakout*** Dale Chamberlain, DDS AADB President-Elect *This closed session is for AADB member Presidents, Vice-Presidents, and State and Territory Dental Board Staff.*

12:00 p.m. - 12:10 p.m. **AADB President's Opening Remarks**
James A. Sparks, DDS
AADB President

12:10 p.m. - 12:25 p.m. **Chief Executive Officer's Welcome & Report**

12:25 p.m. - 12:45 p.m. **2023 Candidate Speeches for positions on the AADB Board of Directors**

12:45 p.m. - 1:00 p.m. **Treasurer's Report**
Clifford Feingold, DDS
AADB Treasurer

1:00 p.m. - 2:00 p.m. **Workforce Shortages**
Katherine Landsberg
Director, Government Relations
DANB

2:00 p.m. - 2:20 p.m. **Sponsorship Recognition**

2:20 p.m. - 3:20 p.m. **Important Data and Trends for Regulators to Know from Dental Support Organizations**
Andrew M. Smith
Executive Director
Association of Dental Support Organizations

3:20 p.m. - 3:45 p.m. **ADEA Update**
Gülsün Gül, DDS, MBA, MPH, MS
Chief Policy Officer, Office of Policy & Education Research
American Dental Education Association (ADEA)

3:45 p.m. - 4:15 p.m. **AADB Representative Reports**

CDEL: Barbara Mousel, DDS (NORTH)
Donald P. Bennett, DDS (SOUTH)
Catherine Watkins, DDS (SOUTH)
Maurice Miles, DDS (WEST)

CODA: Carolyn Brown, DMD (SOUTH)
Maxine Feinberg, DDS (EAST)
Burrell Tucker, DDS (WEST)
Bruce Kinney, DDS (APPEALS - WEST)

JCNDE: Mary A. Starsiak, RN, DDS (NORTH)
Julie W. McKee, DMD (SOUTH)
Jeetendra Patel, DDS (SOUTH)
Mark Zajkowski, DDS, MD (EAST)

DANB: Frank A. Maggio, DDS (NORTH)

4:15 p.m. - 5:15 p.m. **Legislation for General Anesthesia and Sedation in the Dental Office**
Erin Baker,
Executive Director
American Society of Dentist Anesthesiologists (ASDA)

5:15 p.m. - 5:30 p.m.	**Business Meeting - Report from the Bylaws Committee** Frank A. Maggio, DDS Chair of AADB
5:30 p.m. - 6:00 p.m.	**Exhibits & Networking Break**
6:00 p.m. - 7:30 p.m.	**Presidential Reception** *Registered attendees are invited to join President James A. Sparks, DDS, the AADB Board of Directors, AADB team, and invited speakers for light hors d'oeuvres and drinks.*

Saturday, October 21

*****Please note the times listed below are in Pacific Time*****

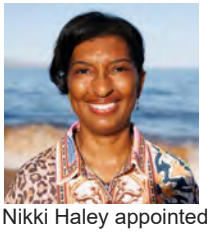
8:00 a.m. - 11:00 a.m.	**Registration**
8:00 a.m. - 9:00 a.m.	**Regional Caucus Meetings** ***North Caucus – Breakout*** ***South Caucus – Breakout*** ***East Caucus – Breakout*** ***West Caucus – Breakout***
9:00 a.m. - 9:15 a.m.	**Exhibits & Networking Break**
9:15 a.m. - 9:30 a.m.	**Voting & Business Meeting**
9:30 a.m. - 9:45 a.m.	**Caucus Reports** **North:** Frank Maggio, DDS, AADB Caucus Chair **South**: Melodie Jones, DMD, AADB Caucus Chair **East**: Jim Goldsmith, DMD, AADB Caucus Chair **West**: Ryan Edmonson, AADB Caucus Chair
9:45 a.m. - 10:45 a.m.	**Attorney Round Table** Lori Lindley Senior Assistant Attorney General Oregon Board of Dentistry Susan Rogers Executive Director and General Counsel Oklahoma State Board of Dentistry Bobby D. White CEO/Legal Counsel North Carolina State Board of Dental Examiners
10:45 a.m. - 11:30 a.m.	**AADB Forum: State/Territory Board Issues - *Breakout*** Frank Maggio, DDS AADB Member and Moderator

	*This closed session is for individual voting members. State/Territory Board staff are encouraged to attend. If you have questions about your membership, please email **info@dentalboards.org**.*
11:30 a.m. - 11:45 a.m.	**Exhibits & Networking Break**
11:45 a.m. - 12:45 p.m.	**Impaired Practitioner Programs** William T. Kane, DDS, MDA, PC Chairman of the Dentist Well-Being Committee Missouri Dental Association
12:45 p.m. - 1:30 p.m.	**Members' Luncheon**
	AADB Citizen of the Year Award Presentation Frank Maggio, DDS (2022 AADB Citizen of the Year)
	Recognition of New Members
	Recognition of the AADB Board of Directors
1:30 p.m. - 2:00 p.m.	**OPEN**
2:00 p.m. - 3:00 p.m.	**Regulation of Teledentistry** AAO / AGD - tentative
3:00 p.m. - 4:00 p.m.	**Dental Compacts**
4:00 p.m.	**Adjournment**

Biographies as received on 7/12/2023

Donald P. Bennett, DDS, AADB Representative (CDEL)

Dr. Bennett is a 1985 graduate of the Louisiana State University School of Dentistry and has been in private practice for 37 years. He is a continuous tri-partite member of the ADA, LDA, and NODA, as well as the Past President of the New Orleans Dental Association. Dr. Bennett was the 2020 recipient of the New Orleans Dental Association Honor Dentist award, Past General Chairman of the New Orleans Dental Conference, Member of the Louisiana State Board of Dentistry since 2016 and current President. He is the current examiner for CITA and CDCA and member of the CITA Board of Directors and Quality Assurance Committee and a Fellow in the ACD and ICD.



Carolyn Brown, DDS, AADB Representative (CODA)

Dr. Carolyn Brown was appointed by the American Association of Dental Boards to serve as a Commissioner on the Commission on Dental Accreditation for the term 2021-2025. Dr. Brown received her undergraduate degree from Columbia College, Columbia, SC. She is a 1994 graduate of the Medical University of SC (MUSC) James B. Edwards College of Dental Medicine and was recognized with the 2021 Distinguished Alumna Award. Following 22 years of private practice, Dr. Brown is currently a staff dentist in the Dental Service at the Columbia Veterans Affairs Health Care System, Columbia, SC. She is a fellow of the American College of Dentists. Dr. Brown is an alumnus of the ADA Institute for Diversity in Leadership (2016-2017 Class). In 2015, SC Governor Nikki Haley appointed Dr. Brown to the SC Board of Dentistry. As past president and current board member serving under Governor Henry McMaster, Dr. Brown is the recipient of the Exemplary Service Award of the SC State Board of Dentistry. She is a member of the Admissions Committee of the MUSC James B. Edwards College of Dental Medicine. Dr. Brown is a Federal Dental Services member of the American Dental Association and continues to serve in various capacities of organized dentistry.

Dale Chamberlain, DDS, President-Elect

AADB President-Elect, Dr. Dale Chamberlain, DDS, is an oral & maxillofacial surgery specialist in Helena. Dr. Chamberlain has been in private practice in Helena since 2012. He received his DDS degree from Creighton University in 1988. From 1989-2011, Chamberlain had a private practice in Lewistown. While in Lewistown he also set up the dental program and worked two days a month at NEXUS, a methamphetamine treatment center, for five years.

Dr. Chamberlain was awarded the Shampaine-Low Award by the CDCA-WREB-CITA in January.

Maxine Feinberg, DDS, AADB Representative (CODA)

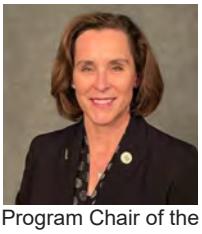
Dr. Feinberg graduated from New York University College of Arts and Sciences in 1977 and NYU's College of Dentistry in 1980. She returned to NYU after her residency in anesthesiology and working as a general dentist and treating patients confined in nursing homes to complete her certificate in Periodontics in 1984.

Dr. Feinberg is a past president of the New Jersey Dental Association and the New Jersey State Board of Dentistry., where she served for 9 years. She has been a delegate in both the ADA and New Jersey Dental Associations House of Delegates. She initiated the New Jersey Give Kids A Smile campaign in 2002 and 2003. She remains active in both her component dental society and the NJDA.

Gülsün Gül, DDS, MBA, MPH, MS, Chief Policy Officer, Office of Policy & Education Research (ADEA)

Dr. Gülsün Gül is the Chief Policy Officer, The Office of Policy & Education Research at ADEA. Dr. Gül served as Interim Division Head of Medically Complex Patient Management (MCP), and Division Head of Public Health at Tufts University School of Dental Medicine. She held preclinic, clinic, undergrad, and post-graduate faculty positions in the Departments of Public Health, Pediatric Dentistry, and Comprehensive Care; she served as a faculty mentor in school-based public health programs. Dr. Gul also held responsibilities as Corporate Director for Hospital Operations and Project consultant to many private and non-profit institutions, including Bayindir Health Care Systems, Mother Children Education Foundation (ACEV), Istanbul, Turkey, and Health Care City Dental Clinic Project Dubai, Harvard Medical International. She also worked as a pediatric dentist and an assistant clinical investigator Department of Oral Sciences at Forsyth Faculty Associates, The Forsyth Institute. She is a recipient of the Richard Allard Award (2009) by the Massachusetts Dental Society for aiding families who suffered from abuse and neglect. She also received the Jonathan M. Tisch College Citizenship and Public Affairs Fellowship award (2006). Dr. Gül is a graduate of the ADEA Emerging Leaders Program (2018) and the ADEA Leadership Institute (2022). She is a member of the American Academy of Pediatric Dentistry, District of Colombia Dental Society, American Dental Association, American Academy of Developmental Medicine and Dentistry, Special Care Dentistry Association, and American Dental Education Association.

Dr. Gül received her dental degree from Hacettepe University, School of Dentistry, Ankara, Turkey. In addition, she received her MBA from Suffolk Sawyer School of Management, an MPH degree from Tufts Medical School, a Certificate of Advanced Graduate Study in Pediatric Dentistry, and an MS from Tufts Dental School, Boston, MA.



Melodie Jones, DMD, AADB Caucus Chair (South)

Dr. Melodie Anderson Jones serves as a Board Member on the Board of Dental Examiners of Alabama. She is also a Member of the State Committee on Public Health for the Alabama Department of Public Health and serves as Chair of the Council on Dental Health for the Alabama Department of Public Health.

Dr. Jones is a life member of the American Dental Association, the Alabama Dental Association, and the Second District Dental Society serving as an active member since 1992. She has served as President, President-elect, Secretary-Treasurer, and Program Chair of the Second District Dental Society. She has served as a delegate to the House of Delegates of the Alabama Dental Association and a member of the Board of Trustees of the Alabama Dental Association.

Dr. Jones has served on the Oral Health Coalition of Alabama and the Council on Dental Health of the Alabama Department of Public Health.
Dr. Jones has practiced general dentistry for over 30 years providing comprehensive dental care to patients of all ages. Dr. Jones holds a Bachelor of Science Degree in Chemistry from Auburn University and a Doctor of Dental Medicine Degree from the University of Alabama School of Dentistry, class of 1992. Dr. Jones is on the Executive Alumni Council of the University of Alabama School of Dentistry Alumni Association and is currently the Secretary-Treasurer of the Alumni Association.

Frank Maggio, DDS, AADB Member and Moderator

The AADB Board Member Forum will be facilitated by Frank A. Maggio, DDS. This lively, interactive session will provide the General Assembly an opportunity to discuss regulatory concerns and other important topics encountered by state boards in a spontaneous, free-flowing setting. Participate in the AADB Board Member Forum by asking questions, discussing challenges, and sharing your successful practices and innovations.

Julie McKee, DMD, AADB Representative (JCNDE)

Dr. McKee received a degree in Biology from the University of Kentucky and received a Dental Degree from the University of Louisville in 1983. She practiced General Dentistry for 10 years in Mount Sterling, Kentucky and worked in state government, focusing on healthcare policy and regulation. Dr. McKee has managed a four-county district health department for 12 years and held the position of State Dental Director since 2007. She was awarded the Presidential Award of the Kentucky Dental Association in the fall of 2020 and the President's Award for Outstanding Merit in Public Health Dentistry, Association of State and Territorial Dental Directors, in April 2022.

Jeetendra Patel, DDS, AADB Representative (JCNDE)

Dr. Jeetendra Patel received his BS in 1995 from the Louisiana State University-Shreveport (LSU-S) in Biology and his DDS from the LSU School of Dentistry in 2001. He also completed a 1-year hospital-based residency (GPR) at the Veterans Affairs Hospital in Biloxi, MS. In 2019, Dr. Patel was appointed by the Governor of Louisiana, John Bel Edwards, to serve on the Louisiana State Board of Dentistry. In December 2021, Dr. Patel was appointed as a Commissioner to the Joint Commission on National Dental Examinations (JCNDE). Besides being on the State Board and JCNDE, Dr. Patel has been in private practice since 2003 and currently owns a dental practice in Monroe, Louisiana. Dr. Patel was born in Birmingham, England and lived there for 10 years before moving to the United States in 1982. He has lived in Louisiana for 39 years.

Laura Richoux, RDH, Dental Hygiene Member

Laura Richoux is a dental hygienist on the Mississippi Gulf Coast. After graduating from the University of Mississippi Medical Center's Dental Hygiene program, she practiced her first four years in South Louisiana and has spent the last fifteen years practicing in Mississippi. Laura served as the Dental Hygienist at Large on the Mississippi State Board of Dental Examiners for six years and is currently serving as the Dental Hygienist member of the American Association of Dental Boards.

James A. Sparks, DDS, AADB President

Dr. James A. Sparks is a dentist in private practice in Oklahoma City, Oklahoma. A graduate of Oklahoma University College of Dentistry, class of 1986, where he is and has been part-time faculty in Oral Diagnosis and Radiology ever since, and is currently a Clinical Associate Professor. He was elected to six terms (18 years) on the Oklahoma Board of Dentistry and served as President for 8 years. Currently, Dr. Sparks is serving as President of the American Association of Dental Boards.

Mary A. Starsiak, RN, DDS, AADB Representative (JCNDE)

Dr. Mary A. Starsiak is a graduate of Loyola University Dental School in 1984. Her undergraduate degree is a BSN, RN from the College of St. Teresa associated with the Mayo Clinic in Rochester Minnesota. She worked as an ICU nurse during dental school plus a few years after and maintains her RN license today. She is the daughter of a general dentist and a sister of an oral surgeon. She has her own private practice of general dentistry since 1984.

She serves on the Joint Commission on National Dental Exams as an AADB representative at this time being a member of AADB. She is a Past President of the Central Regional Testing Agency (CRDTS) and has served on the CRDTS Steering Committee and Officer track leading up to President. She has served as a member of the State of Illinois Board of Dentistry from 2009 and served as its chair from 2012-2014 and 2016-2017. She has served as a Board Examiner for the CDCA-WREB-CITA; and Central Regional Testing Agency (CRDTS)

She is the Regent of the International College of Dentistry District VIII and served as the Program Chair for the Chicago Dental Society Midwinter Meeting 2022. She has served on numerous Boards and Committees including the Illinois State Dental Society; Chicago Dental Society; was a Founding member of the Chicago Dental Society Foundation; The American Dental Association Council of Communication; Odontographic Society of Chicago and President of the Dental Arts Club of Chicago. She has also served on the Resurrection Healthcare Foundation Board along with the Saints Mary and Elizabeth Medical Center Advisory Board.

She is a fellow of the American College of Dentists, the International College of Dentists, the Academy of Dentistry International, the Pierre Fauchard Academy, the Academy of General Dentistry, and the Odontographic Society. She has been awarded the Raffaele Suriano Award in 2014 from the University of Illinois/Loyola Alumni Society for her work with geriatric patients. She was a past dentist/ consultant at Chicagoland Methodist Senior Services since 1994.

Catherine Watkins, DDS, AADB Representative (CDEL)

Dr. Watkins attended the University of North Carolina at Chapel Hill where she earned a Master's Degree in Geriatric Dentistry and a PH.D. in Oral Epidemiology.

Dr. Watkins serves as the dentist for the special management patients at dental care. From June 2003 until September 2004, she established the Special Needs Dental Program at Wake Forest University Baptist Hospital Medical Center in Winston-Salem, North Carolina. Dr. Watkins was an assistant professor in the Department of Preventive and Community Dentistry at the College of Dentistry at the University of Iowa from August 1995 to June 2003. For over 20 years her dental practice and training have focused on Geriatric Dentistry. Dr. Watkins has authored numerous research articles related to oral health among older adults. She was recently recognized as a diplomate of the American Board of Special Care Dentistry. She is committed to improving the quality of oral health care for seniors and currently works as an oral health consultant for the Sjogren's Support Group of the Triad.

Mark Zajkowski, DDS, AADB Representative (JCNDE)

Dr. Mark Zajkowski is an oral & maxillofacial surgeon practicing in South Portland, Maine. He is a graduate of the UCLA School of Dentistry, Harvard Medical School and the Isenberg School of Business at the University of Massachusetts, Amherst. He completed his surgical residency at the Massachusetts General Hospital in 1999.

Mark currently serves as the Chair of the Maine Board of Dental Practice and serves on the board of OMSNIC, the leading malpractice carrier for oral surgeons. He has also served as an examiner, director and President of the American Board of Oral and Maxillofacial Surgery and President of the Maine Dental Association. He has also remained active in many committees with AAOMS and the Joint Commission.

His clinical interests include dentoalveolar surgery, cleft lip and palate reconstruction, head and neck pathology, outpatient anesthesia, and patient safety.

Registration:

Registration opened on June 15, 2023.

The Early Bird registration fee for the AADB 140th Annual Meeting is **$595** for AADB members and **$795** for non-members.

Prices increase on July 15, 2023.

Refund Policy:

Notification of cancellation must be submitted in writing to srojas@dentalboards.org. Cancellations are subject to a $75 cancellation charge. No refunds will be given after August 15, 2023. Substitutions are allowed at any time but must be submitted in writing and must be of the same membership status.

Continuing Education:

The ACE Program is a service of the AADB to assist dental boards in identifying quality continuing education courses to help protect the public. ACE accreditation may not be accepted by particular boards of dentistry. Questions or comments can be directed to the AADB at info@dentalboards.org.

ADA C·E·R·P® | Continuing Education Recognition Program

The American Association of Dental Boards is an ADA CERP Recognized Provider. ADA CERP is a service of the American Dental Association to assist dental professionals in identifying quality providers of continuing dental education. ADA CERP does not approve or endorse individual courses or instructors, nor does it imply acceptance of credit hours by boards of dentistry. The American Association of Dental Boards designates this activity for 8.25 continuing education credits. Concerns or complaints about a CE provider may be directed to the provider or to ADA CERP at www.ada.org/cerp.

Unauthorized recording policy

The American Association of Dental Boards is committed to providing a professional environment that is open to the free expression of views and ideas and cultivating a learning community. Recording conversations, phone calls, images, or organizational meetings with any recording device (including but not limited to a cellular telephone, PDA, digital recording device, digital camera, etc.) unless all parties to the conversation give their consent in advance is hereby prohibited. A violation of this policy will result in corrective action which can include being removed from the conference.

Caucuses by State

North	South	East	West
Illinois	Alabama	Connecticut	Alaska
Indiana	Arkansas	Delaware	Arizona
Iowa	Florida	District of Columbia	California
Kansas	Georgia	Maine	Colorado
Michigan	Kentucky	Maryland	Hawaii
Minnesota	Louisiana	Massachusetts	Idaho
Missouri	Mississippi	New Hampshire	Montana
Nebraska	North Carolina	New Jersey	Nevada
North Dakota	Puerto Rico	New York	New Mexico
Ohio	South Carolina	Pennsylvania	Oregon
Oklahoma	Tennessee	Rhode Island	Utah
South Dakota	Texas	Vermont	Washington
Wisconsin	Virginia	West Virginia	Wyoming
	Virgin Island		

AADB Board of Directors

James A. Sparks, DDS, President
5804 Northwest Expressway Street
Warr Acres, OK 73132

Dale Chamberlain, DDS, President-Elect
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Helena, MT 59602

Arthur Chen-Shu Jee, DMD, Vice President
13934 Baltimore Avenue
Laurel, Maryland 20707

Clifford Feingold, DDS, Treasurer
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Asheville, NC 2880

Bobby J. Carmen, DDS, MAGD, Secretary
1141 Sonoma Park Drive
Norman, OK 73072

Yvonne Bach, Public Member
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Brian Barnett, Administrator Member
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Jefferson City, MO 65102

Laura Richoux, RDH, Dental Hygiene Member
600 East Amite Street, Suite 100
Jackson, MS 39201

Tonia Socha-Mower, MBA, EdD, Chief Executive Officer
AADB
200 East Randolph Street, Suite 5100
Chicago, IL 60601

BYLAWS OF THE
AMERICAN ASSOCIATION OF DENTAL BOARDS

PREAMBLE

We, the members of the American Association of Dental Boards, in conformity with the Charter granted September 10th, 1883~~96~~, at Washington, D.C., and renewed in 1944, and in order to encourage the highest standards of dental education, and to promote a higher and more uniform standard of qualifications for dental practitioners and uniformity of methods in the conduct, operation and workings of the dental examining boards, and uniformity in the legislation in the several states, do ordain and establish these Bylaws, for the government of the American Association of Dental Boards.

Section 1 – Name

The name of this organization ~~shall be~~ the American Association of Dental Boards, Henceforth, American Association of Dental boards shall be 'tradename' named FEDERATION OF STATE DENTAL BOARDS, hereinafter referred to as "the Association" or "this Association."

Section 2 - ~~Central Office~~ Incorporation and Office Location

The AADB is incorporated as a non-profit organization in Washington, D.C. The registered office of this Association shall be known as the Central Office and shall be located in such city as shall be determined by the Board of Directors. Branch offices of this Association may be established in such localities and at such times as are deemed necessary by the Board of Directors.

Section 3 - Definition of Terms

In these Bylaws, terms within the dental professional regulatory community are defined as follows:

"Agency": a licensing jurisdiction: a state, a territory, or the District of Columbia of the United States of America which is given jurisdiction over the regulation of business activities within its borders including the authority for licensing, registering and regulating the professional conduct of dentists, dental hygienists**,** and other dental personnel. The term "agency" is also meant to include any entity outside of the United States of America which has similar authority for licensure and regulation and which may contract with the AADB for consultation services or for other purposes.

"Affiliate": Association or Organization Supporting or Promoting AADB and its Mission, as an example, (and not limited to) – Testing agencies, Licensing agencies, State Dental Associations, State Hygiene associations, dental specialties recognized by NCDSCB (National Commission Recognition Dental Specialties and Certifying Boards), etc. Not eligible for 'Affiliate' membership are 'sole for profit' organizations, management organizations, and organizations not involved with licensing, regulation, nor certifications (see Individual Membership 5.5).

~~"Associate Agency": a specialty board recognized by the American Dental Association; a regional organization comprised of two or more Member Agencies; or an agency whose purpose is to certify dental auxiliaries in dentistry.~~

"Dental Board": any collective body of dentists and others, such as public members or other dental personnel, which serves as the licensing and regulatory authority for dental personnel within a licensing jurisdiction. These collective bodies of dentists and others are variously referred to as boards of dentistry, boards of dental hygiene,

boards of dental examiners, or by other designations by licensing jurisdictions**,** and the term "dental board" encompasses these various designations.

"Member-Governed Organization": an organization in which the members have the ultimate authority over the operation of the organization. A member-governed organization is one that holds regular annual meetings of its members, has its activities governed by the membership through an elected Board of Directors, and has delegated certain powers to its Board of Directors.

"Dental Board Member": a dentist, a dental hygienist**,** or public member who has been appointed or elected to serve on a licensure or regulatory body empowered to regulate the dental profession within a licensing jurisdiction.

Section 4 - Objectives

~~The objectives of this Association shall be:~~ The AADB supports America's State Dental Boards in their duty to protect the public through licensing, disciplining, and regulating Dentists, Hygienists, and other auxiliary personnel in Dentistry. To further these goals, AADB shall:

A. Promote and provide a forum for training, communications, and collaboration among all Dental Boards and Dental Board Members, Dental Board Administrators, Staffs, Dental Board Attorneys, and Dental Board Investigators.

B. Promote continuing education, re-education, and remediation of dentists, hygienists, and the auxiliary groups who have as their purpose, optimum oral health and welfare of the public.

C. ~~To~~ Assist Dental Boards and ~~all~~ Agencies in continually improving methods of testing and evaluating candidates for licensure, and re-licensure ensuring the quality of oral health care standards will be constantly and uniformly raised through services such as the Accredited Continuing Education (ACE) program.

D. Encourage further study in research, dental school accreditation, specialty recognition accreditation, and discussion of the needs and problems of dental education and licensure.

E. Provide ~~counsel and guidance~~ information on regulatory best practices, innovative ideas, and other resources to Dental Boards and Legislators in amending, revising, and enforcing the dental practice acts of each state in the interest of the public welfare.

F. Strengthening Dental Boards by providing advocacy, education to other organizations, and governmental entities seeking information regarding key and critical issues in Dentistry.

G. Initiate and develop programs and projects to enhance the efficiency and effectiveness of Dental Boards in organizing, monitoring, and discipline management of licensing, regulations, and certifications.

Section 5 – Membership

Section 5.1: The AADB shall be a Member-Governed organization in accordance with Section 29-401.50 of the District of Columbia Official Code.

Section 5.2: ~~The Association is composed of members and participants: Members and Life Members, Associate Members and Associate Life Members, Agencies and Associate Agencies.~~ Application for membership shall be submitted to AADB for consideration and approval by a majority vote of the Board of Directors.

Member categories are:

1. Current Dental Board Members.
2. Past Dental Board Members.
3. Life Members.
4. Current State Dental Board Executive Directors or Administrators.
5. Current State Dental Board Investigators or Supervisory Staff.
6. Attorneys Representing State Dental Boards.
7. Affiliate - Individuals or participating agencies, associations, and organizations that support or provide service to the American Association of Dental Boards.
8. Affiliate - Life Members.

Section 5.3: Any Member (listed above 5.2) may be appointed to serve on a committee within the AADB. Current Dental Board Members, Past Dental Board Members, and Life Members may participate in AADB business meetings, general assembly votes, and hold office as a Board of Director. ~~Governing members are the Members and Life Members of the AADB and may vote and hold office. Agencies are "participating" organizations which have access to the programs and services of the organization.~~

Section 5.4: 1. A Member or Life Member is a person who serves or has served on or is an administrator or board attorney of an Agency and chooses to participate in and pays dues to this Association. They may vote and hold office. 2. A Member may become a Life Member of this Association if the person fulfills one of the following:

A. The person has served as President of this Association.

B. The person has maintained membership in this Association as a Member for at least ten consecutive years immediately before applying for Life Membership and has reached the age of 70.

C. The person has maintained membership in this Association as a Member for at least six consecutive years and has paid a fee that the Board of Directors shall have the authority to set consistent with the fiscal health of the Association.

Section 5.5: An ~~Associate~~ Affiliate Member is a person or organization who fulfills one of the following:

A. The person is ~~employed to~~ an examiner on behalf of dental boards such as a proctor, monitor, consultant examiner**,** or auxiliary, is an examiner for a specialty board recognized by the National Commission on Recognition of Dental Specialties and Certifying Boards ~~American Dental Association (ADA)~~ or other comparable organizations, or is employed as an administrator by an ~~Associate~~ Affiliate Agency and who does not qualify for membership in this Association as a Member.

B. The person is employed as an administrator or psychometrician by an Agency, a regional organization comprised of two or more Agencies**,** or an allied dental organization or testing agency.

C. The person is an educator serving as a full or part-time faculty member of a school or program accredited by the Commission on Dental Accreditation and who does not qualify for membership in this Association as a Member.

D. The person is recognized as an honorary member of this Association by a vote of the membership for having performed meritorious service to this Association or to dentistry. The Board of Directors may nominate a person to this membership for any felicitous reason.

E. The person is recognized as a disabled/retired member of this Association and who has maintained membership in the Association as a Member for at least ten consecutive years and has retired due to

physical disability.

F. Organizations/agencies involved with licensing, testing, certifying, and the mission of AADB that do not qualify as a member (See Section 3).

An ~~Associate~~ Affiliate Member may become an ~~Associate~~ Affiliate Life Member of this Association if the person fulfills one of the following:

A. The person has maintained membership in this Association in some combination of membership categories for at least ten (10) consecutive years and has reached the age of 70.

B. The person has maintained some combination of membership categories for at least six consecutive years and has paid a fee that the Board of Directors shall have the authority to set consistent with the fiscal health of the Association.

Section 5.6: Membership Applications and Membership Changes Applications for all classes of membership in this Association shall be submitted to the ~~Chief Executive Officer~~ Membership Committee. Questions regarding membership guidelines should be submitted to Membership Committee. Following approval by the Board of Directors and in accordance with the adopted policies of this Association, the report of Membership shall be presented to the General Assembly.

Section 5.7: Removal

A. The Board of Directors, by majority vote of the members present and voting, may remove from membership any Member, Agency, or other member delinquent in payment of dues by more than 60 days after being notified at their last known address either by email, text or regular mail. If a Member, Agency**,** or other member is delinquent in the payment of dues by more than 90 days, those Members, Agency, or ~~Associate~~ Affiliate Members for whom the dues were not remitted will cease to be members of this Association.

B. The General Assembly, by affirmative vote of two-thirds of the Members and Life Members present and voting, after appropriate notice and hearing, may suspend or expel any member for cause, including but not limited to the following:

1. Violation of any provision of the Code of Ethics.
2. Suspension, revocation, or other termination of a license.
3. Any act or conduct which may cause disrespect for or lack of public confidence in the dental profession or dental board.
4. Any member who no longer serves on or is an administrator or board attorney of an Agency and is in a position consulting or defending clients against a board.
5. Violation of any provision of these Bylaws or any rule, regulation, or order adopted pursuant to these Bylaws.

C. Notification: An individual who has been suspended for a period or removed "for cause" as stated in Chapter V section 50, be notified that a statement setting forth the grounds for removal or suspension shall have been mailed by registered or certified mail to such member at his last recorded address at least fifteen (15) days before final action is taken thereon, and which shall be accompanied by a notice of the time and place of the meeting at which such vote shall take place. The individual shall be given an opportunity to present a defense at the time and place mentioned in such notice. Notwithstanding the provisions set forth in this Section, a member shall be terminated, after reasonable notice, for non-payment of dues.

D. Removal of a Board of Director from Office: Violations as noted on 5.7(b) for Proposed removal of a

member with cause, shall require a 2/3 vote of all remaining Board of Directors (See Section 10.2).

Section 5.8: Agency Participation. Agency participation will be governed by the following rules:

A. Dental Boards who participate in the AADB:

1. Are the founding Dental Boards of AADB or
2. Have made an application to the AADB and have been approved by the Board of Directors by a two-thirds vote. Members of the AADB, as defined in the Bylaws, shall be drawn from the Agencies.

B. ~~Associate~~ Any Affiliate Agency to participate in the AADB shall have made an application to the AADB and have been approved by the Board of Directors by a two-thirds vote.

C. An Agency or ~~Associate~~ Affiliate Agency to be in good standing shall remain current with their dues to this Association.

Section 6 - Membership Privileges

Section 6.1: Members and Life Members shall enjoy all rights and privileges of this Association.

Section 6.2: Affiliate ~~Associate~~ Members and Affiliate ~~Associate~~ Life Members shall enjoy all rights and privileges of this Association, including participation on committees, but excluding the ability to vote ~~except those of voting~~ with the general assembly, attend AADB business meetings, and hold~~ing~~ office as a Director.

Section 7 – Governance

Section 7.1: The AADB shall be a Member Governed organization in accordance with Section 29-401.50 of the District of Columbia Official Code.

Section 7.2: General Assembly: The Legislative body of the AADB shall be the General Assembly composed of the Members and Life Members with voting privileges that are present at any Annual Meeting or other business meeting.

Section 7.3: Board of Directors: The administrative body of this Association shall be the Board of Directors, referred to as "the Board," as provided in Chapter IX of the Bylaws. The Board of Directors shall be composed of President, ~~President-Elect~~, Vice President, ~~Secretary, -Treasurer~~ Secretary/Treasurer, Dental Hygienist Member, Administrator Member**,** Public Member, Immediate Past President, and (2) additional Directors-at-Large.

Section 8 - General Assembly

Section 8.1: Composition. The General Assembly of this association shall be composed of Members and Life Members with voting privileges present at any Annual or other business meeting of the Association for which they are properly registered.

Section 8.2: Powers. The General Assembly shall:

A. Possess the legislative powers of this Association.

B. Determine the policies which govern this Association.

C. Have the power to enact, amend and repeal the Bylaws of this Association.

D. Elect Honorary Members of this Association.

E. Approve all memorials and resolutions in the name of this Association.

F. Elect the Board of Directors and AADB representatives on the various councils and commissions.

Section 8.4: Duties. The General Assembly shall:

A. Elect the officers of the Association.

B. Elect Association representatives to serve on the ADA Council on Dental Education and Licensure, the Commission on Dental Accreditation, on the Appeals Board of the ADA Commission on Dental Accreditation, and on the ADA Joint Commission on National Dental Examinations.

C. Receive reports from the Board of Directors on the status of the association including but not limited to; membership, programs and finances, and other reports or studies requested by the General Assembly.

Section 9 - Board of Directors Section 9.1: Composition. The Board of Directors:

A. The voting membership of the Board of Directors shall consist of a Nine (9) member Board: the President, ~~President-Elect~~ Vice President, ~~Secretary~~ Secretary/Treasurer, Dental Hygienist Member, Administrator Member, ~~and~~ Public Member, Immediate Past President, and (2) additional Directors-at-Large.

B. The Chief Executive Officer serves on the Board of Directors as a non-voting member with a voice and without a vote. By a motion and majority vote, the Chief Executive Office may be excluded from an Executive session of the Board of Directors.

C. Quorum and voting. A quorum of the Board of Directors shall consist of five of the Board members. Proxy voting is not permitted.

1. Regular meetingsof the Board of Directors shall be held with notice of the date, time, place, or purpose of the meeting; provided, that at the beginning of each one-year period, the Board of Directors may provide a single notice of all regularly scheduled meetings for that year, or for a lesser period, without having to give notice of each meeting individually.
2. Special meetings of the Board of Directors shall be preceded by at least 2 days notice of the date, time, and place of the meeting. The notice need not describe the purpose of the special meeting.
3. The President, or ~~20% of any~~ three (3) voting members of the Board of Directors ~~members~~ then in office, may call and give notice of a meeting of the Board of Directors.
4. Oral notice of meetings of the Board of Directors is acceptable notice.
5. The President will only vote at the Board of Directors meetings if there is a need to break a tie.

Section 9.2: Powers. The Board of Directors shall:

A. Be the administrative body of the Association, vested with full power to conduct all business of the Association, subject to the Bylaws.

B. Have the power to establish rules and regulations consistent with these Bylaws, to govern its organization, procedures**,** and conduct.

C. Have the power to establish ad interim policies when the General Assembly is not in session and when such policies are essential to the management of the Association.

D. Have the power, through a majority vote and with notification to the President or Chief Executive Officer, to call special meetings of the Executive Council.

Section 9.3: Duties. The Board of Directors shall:

A. Provide for the maintenance and supervision of the ~~Central~~ AADB Office and all property or offices owned or operated by the Association.

B. Appoint qualified persons to the office of Chief Executive Officer, determine the extent of their duties, regulate the operation of their office, determine compensation, and have full control of all other matters pertaining to the office.

C. Conduct, annually, an evaluation of the Chief Executive Officer, utilizing an acceptable procedure based upon job specifications established for the position. A committee appointed by the President and confirmed by the Board of Directors shall complete the evaluation of the central office as outlined in the AADB Operations Manual. The Board of Directors shall meet with the Chief Executive Officer to discuss the evaluation.

D. Determine the time and place for the convening of the Annual Meeting and any other meetings of the General Assembly.

E. Determine meeting registration fees for members and non-members of the Association. The Board of Directors may, at its discretion, waive meeting registration fees for invited guests.

F. Approve the program for meetings of the General Assembly.

G. Review applications for membership and approval and report actions to the General Assembly.

H. Render reports of its actions to the Association at each Annual Meeting.

I. Adopt a final budget and report to the General Assembly.

J. Convene prior to the Annual Meeting of the General Assembly and, as needed, between Annual Meetings. Meetings of the Board of Directors shall be at times and places designated by the President. Such meetings shall be open to members of the Association, and, with the consent of the Board of Directors, any member may be heard on matters under consideration.

K. Review reports of representatives and committees before such reports are presented to the General Assembly. The Board of Directors may, at its discretion, comment on any report that it reviews.

L. Call special meetings of the Association at its discretion or upon receipt of a petition from ten or more Member Agencies. A notice containing the purpose for a special meeting, plus location and time, shall be mailed to all members at least thirty (30) days prior to said meeting.

M. Nominate, to the General Assembly, candidates for Honorary Membership.

N. Designate, if able, a member of the Association as the "AADB Citizen of the Year" from nominees recommended by the Award Selection Committee.

O. Appoint a Membership Committee to retain current members and recruit new members. It shall develop written material to be sent to all prospective members as well as form letters for responding to frequently asked questions. It shall also maintain contact with each state board's and regional testing agency's appointed AADB liaison person.

P. Have the ability to remove any representative to another dental group if they conclude with just cause, that the representative is either unwilling or unable to fulfill the duties and responsibilities expected of that position.

Q. Set fees, consistent with the fiscal health of the Association, for life membership under Chapter V, Section 40, B, and C.

R. Convene a reference committee, as deemed necessary, at meetings of the General Assembly.

Section 10 - Emergency Authority

Section 10.1: In the event of an Emergency (as defined below) the Board of Directors shall have the authority to:

A. Moddify lines of authority or succession to accommodate the death or incapacity of any Officer, Board member, employee, or agent.

B. Relocate the Central Office and support facilities, or designate an alternative Central Office or support facilities, or authorize an Officer to do so.

C. Take such other action as it deems necessary and prudent to continue the operations of the AADB and protect its assets.

Section 10.2: An “Emergency” shall include, but not be limited to, an Act of God, fire, earthquake, flood, hurricane, explosion, the action of the elements, war, act of terrorism, riot, mob violence, sabotage, inability to procure or a general shortage of labor, equipment, facilities, materials or supplies in the open market, failure of transportation, strike, lockout, action of labor unions, a taking by eminent domain, requisition, laws, orders of government, national health emergency, or any other unanticipated cause, whether similar or dissimilar to the foregoing, not within the reasonable control of the AADB and which materially interferes with the operations of the AADB. This authority shall include the power to remove any director, by a ~~majority~~ 2/3 vote of all the remaining directors, whom the Board deems, in its sole discretion, to be harmful to the good name, reputation, standing, or operations of the AADB.

Section 10.3: In the event that the Board of Directors exercises any powers pursuant to this Chapter, it shall give notice to the membership as soon as reasonably practicable of such exercise.

Section 11 – Elected Officers

Section 11.1: Elected Officers. The elected officers of this Association shall be ~~eight (8)~~ nine (9) in number; the President, ~~President-Elect,~~ Vice President, ~~Secretary,~~ Secretary/Treasurer, Dental Hygienist Member, Public Member, Administrator Member, Immediate Past-President, two (2) Members-at-large each of whom shall be elected as provided in these Bylaws.

Section 11.2: Eligibility. Only Members and Life Members shall be eligible to serve as elected officers.

Section 11.3: Appointed Officers. The appointed officer of this Association shall be the Chief Executive Officer who shall be appointed by the Board of Directors as provided in Chapter XII of the Bylaws.

Section 11.4: Nominations. AADB Officer positions, except Immediate Past President, President, and Vice President are 'open' to any Members in good standing. Anyone interested in being a candidate on the AADB Board of Directors shall submit a letter of intent, the position sought, and a CV six (6) weeks prior to the Annual Meeting.

Nominations for ~~President-Elect, Vice President,~~ ~~Secretary,~~ Secretary/Treasurer, Dental Hygiene Member ~~and~~, Public Member, and two (2) Members-at-large shall be presented by the Nominating Committee. Nominations for the Administrator Member shall come from the American Association of Dental Administrators shall present to Executive Board two (2) names for consideration, whereby the Executive Board will select a candidate that will be presented to General Assembly. Likewise, for Hygiene member, the American Dental Hygiene Association shall recommend two (2) candidates to Executive Board, one of which will be presented for nomination to General Assembly. This does not limit floor nominations of either Administrator or Hygienist as. Additional nominations from the floor shall be accepted for all positions except the ~~President-elect~~ Immediate Past President, President and Vice President. ~~Nominations from the floor for the elected officers will come from the appropriate caucus that should be represented by that office.~~ During the Annual Meeting, nominations from the floor are "open", that is any member, in good standing, may present for other Officer positions. He/she//other is required to have a nominee and two (2) seconds and submit a CV to the Nominating Committee and General Assembly to each of the Caucus Chairs prior to the election. ~~The Nominating Committee shall present a ballot in which each Caucus is represented on the Board of Directors.~~ A nominee from the floor for the position of Administrator member, shall be required to be both a member of the American Association of Dental Administrators and the American Association of Dental Boards. Elections shall be held in adherence with the American Association of Dental Boards Operating Manual of the Nominating Committee. Contested elections will allow opposing candidates ~~5~~ 3-minute speeches to the assembly and shall be available in person to caucuses.

Section 11.5: Elections. The elected officers shall be elected by the General Assembly at the Annual Meeting. If there is more than one nomination for any office, the election shall be by secret ballot. The candidate receiving the majority of the votes shall be declared the elected officer. When more than two candidates have been nominated, a candidate receiving a majority of the ballots cast shall be elected. In the event no candidate receives a majority on the first ballot, the candidate with the fewest votes shall be removed from the ballot and the remaining candidates shall be balloted upon again. This process shall be repeated until one (1) candidate receives a majority of the votes cast.

Section 11.6: Tenure of Office. The elected officers shall serve for a term of ~~two (2)~~ one (1) year~~s~~ or until their successors are elected and installed. Elected officers may serve up to two – ~~two~~ one (1)-year terms.

Section 11.7: Officer Installation. All elected officers shall be installed at the close of the Annual Meeting of the General Assembly whereby their term begins at the conclusion of the Annual Meeting.

Section 11.8: Vacancy. A. If a vacancy occurs in the unexpired term of an officer, the exception being the Administrator Member, between Annual Meetings; the President shall request the Nominating Committee to identify three candidates. The President, with the approval of the Board of Directors, shall select one of the three candidates to fill ~~the officer's position~~ vacancy on the Board of Directors. If the office of the President becomes vacant, the President-Elect will serve out the remaining term of the President and their intended term.B. If vacancy occurs in the unexpired term of the Administrator Member between Annual Meetings, the President shall appoint,

after consultation with the President of the American Association of Dental Administrators and with the consent of the Board of Directors, an administrator to serve the unexpired term of the Administrator Member. Therefore, if a Board of Director is unable to fulfill his or her term and that position is vacated, all remaining members of the Board of Directors will elevate to the next Officer position, and the newly appointed officer will serve as Secretary/Treasurer.

Section 11.9: Distribution. The Association is divided into four Geographic Caucuses as defined below: Each of these Caucuses shall elect a chairperson to represent and preside over the Caucus. Each Caucus shall elect from its membership a representative to be a committee member on the Nominating Committee. The Caucus chair is not prohibited from being elected concurrently to serve on the Nominating Committee.

East	**West**	**North**	**South**
Connecticut	Alaska	Illinois	Alabama
Delaware	Arizona	Indiana	Arkansas
District of Columbia	California	Iowa	Florida
Maine	Colorado	~~Kansas~~	Georgia
Maryland	Hawaii	Michigan	Kentucky
Massachusetts	Idaho	Minnesota	Louisiana
New Hampshire	Montana	Missouri	Mississippi
New Jersey	Nevada	Nebraska	North Carolina
New York	New Mexico	North Dakota	Puerto Rico
Pennsylvania	Oregon	Ohio	South Carolina
Rhode Island	Utah	~~Oklahoma~~	Tennessee
Vermont	Washington	South Dakota	~~Texas~~
West Virginia	Wyoming	Wisconsin	Virginia
	Kansas		Virgin Islands
	Oklahoma		
	Texas		

Section 11.10 Duties.

A. **President.** The President shall:

1. Be the primary contact for day-to-day activities and issues of AADB and communicate to the Board of Directors.

2. Be the voice of the AADB or designate a representative in all public forums.

3. Preside at all meetings of the General Assembly and the Board of Directors preserving order and decorum and enforcing rules of the Association.

4. Have watchful supervision over the Association.

5. Serve as a non-voting member of all committees and vote during Board of Directors meeting only in case of deciding vote (tie) (See j.).

6. Call special meetings of the General Assembly as provided for in these Bylaws.

7. Call meetings of the Board of Directors as needed or upon the request of the majority of members.

8. Appoint all committees, subject to recommendations and approval of the Board of Directors.

9. Deliver an address to the General Assembly at the Annual Meeting.

10. Cast the deciding vote in case of a tie in either the General Assembly or Board of Directors.

11. Serve, or designate a qualified member to serve, as the official representative of the Association in contact with governmental, civic, business, and professional organizations with the approval of the Board of Directors.

12. Enter into contracts in the name of the Association, upon authorization by the Board of Directors. At least one other officer must also sign any contract. Perform such other duties as custom and parliamentary procedure require. All fiscal contracts should be signed by President, Secretary/Treasurer, and Chief Executive Officer.

13. Appoint, with the consent of the Board of Directors, a replacement representative to another group to fulfill the remainder of that term, from which a representative has been removed.

14. Appoint a Parliamentarian.

15. Serve as Program Chair for Annual and Mid-Year Meetings.

~~**President-Elect.** The President-Elect shall:~~

~~1. Serve on the Board of Directors and as a non-voting member of all committees.~~

~~2. Assist the President at the President's request.~~

~~3. Advance to the office of President should that office become vacant between Annual Meetings.~~

~~4. Be installed as President at the next Annual Meeting following his election.~~

~~5. Serve as Program Vice Chair for the Mid-Year and Annual Meetings.~~

B. **Vice President.** The Vice President shall:

1. Assist the President at the President's request.

2. Assist the President~~-Elect~~ with the Mid-Year and Annual Meeting Planning.

3. Serve on the Board of Directors and as a non-voting member of all committees.

4. Advance to the office of President should that office become vacant between Annual Meetings.

5. Be installed as President at the next Annual Meeting.

6. Serve as Program Vice Chair for the Mid-Year and Annual Meetings.

7. Preside over meetings in the absence of the President.

~~**Secretary:** The Secretary shall have charge of all such additional books and papers as the Board may direct, and shall, in general, perform all such duties as are incidental to the office of Secretary including:~~

~~Shall record or cause to be recorded the minutes of all meetings of the Association and the Board of Directors;~~

~~Shall be responsible for notification of officers of Board of Directors meetings and Members of the General Assembly meetings;~~

~~Shall preserve correspondence, reports, records, Bylaws, and the Policy and Procedure Manual of the Association in a permanent file.~~

C. **Secretary/Treasurer:** The Secretary/Treasurer shall be responsible for all the funds, property, and other assets of the Corporation and for an accounting of these and shall, in general, perform all duties that are consistent with the office of Secretary/Treasurer of a not-for-profit corporation:

1. Shall be responsible for the funds of the Association.
2. Shall keep or cause to be kept an accurate record of all Association receipts and disbursements.
3. Shall assist in the direction of all financial affairs.
4. Shall present financial reports to the Board of Directors as requested.
5. Shall present an annual written report to the General Assembly members at the annual meeting.
6. Shall serve as a non-voting member of the Finance Committees.
7. Shall ~~record or cause to be recorded~~ maintain with CEO the minutes of all meetings of the Association and the Board of Directors.
8. Shall be responsible with CEO for notification of officers of Board of Directors meetings and Members of the General Assembly meetings.
9. Shall preserve correspondence, reports, records, Bylaws, and the Policy and Procedure Manual of the Association in a permanent file.
10. Monitor tax filings in a timely manner.
11. Monitor audits of the organization incorporating best business practices.

D. **Dental Hygienist Member.** The Dental Hygienist Member shall:

1. Be a dental hygienist.
2. Serve as a member of the Program Committee.
3. Serve as a member of the Membership Committee.
4. Serve as a member of the Bylaws Committee.

E. **Administrator Member**

Number and Title. One (1) administrator shall be elected as the Administrator Member to serve as a member of the Board of Directors.

Eligibility. Only a person who is a dues-paying member of both the American Association of Dental Administrators and a dues-paying Member of the American Association of Dental Boards shall be eligible to serve as the Administrator Member.

Duties. The Administrator Member shall:

1. Serve as a member of the Program Committee.

2. Serve as a member of the Membership Committee.

3. Serve as a member of the Sponsor Committee.

4. Serve as Chair of the Administrators' Committee.

F. Public Member

Number and Title. One (1) public member of an Agency shall be elected as the Public Member to serve as a member of the Board of Directors.

Eligibility. Only a dues-paying public member of the American Association of Dental Boards shall be eligible to serve as the Public Member.

Duties. The Public Member shall:

1. Serve as a member of the Membership Committee.

2. Serve as a member of the Sponsor Committee

G. Immediate Past-President. Provide smooth transition of office, provide institutional and historical perspectives, support President's and Boards' agenda, and mentorship to new Board members.

H. Members-at-large (2). Provide energy, perspective, and support to AADB, the President, and the Board of Directors.

Section 12 - Appointed Officer

Section 12.1: Number and Title. The appointed officer of this Association shall be the Chief Executive Officer.

Section 12.2: Appointment or Removal. The Chief Executive Officer shall be appointed by the Board of Directors. The CEO may be removed with a vote of 2/3 of the Board of Directors present at the meeting.

Section 12.3: Chief Executive Officer. Chief Executive Officer shall:

A. Serve as Chief Executive Officer of the Central Office and any branch offices and as Assistant Secretary.

B. Attend meetings of the General Assembly and the Board of Directors.

C. Keep and publish minutes of meetings of the General Assembly and the Board of Directors with coordination and review of the Secretary/Treasurer.

D. Be custodian of all records, books, papers, and funds belonging to the Association.

E. Conduct correspondence on behalf of the Association including sending notifications of meetings, notifying officers of their election, and notifying committee members of their appointments and duties.

F. Keep a record of all members and guests present at each meeting of the General Assembly.

G. Charge, upon the books of the Association, the dues of all categories of dues-paying members.

H. Demand and receive all funds due the Association including bequests and donations.

I. Act as custodian for all monies, securities, and deeds belonging to this Association and hold, invest, distribute, or convey such funds or instruments, in the name of the Association, at the direction of the Board of Directors or the General Assembly. All disbursements shall be made by check signed by the Chief Executive Officer or the President.

J. Submit all financial records to the Board of Directors or its auditor at the request of the Board of Directors.

1. Upon request up-to-date fiscal reports at each Board of Directors meeting.

2. Submit corporate tax filing in a timely matter and report directly to Secretary/Treasurer.

3. Submit quarterly accounting report to the Board of Directors.

4. Conduct a timely external audit of AADB finances incorporating best business practices.

K. Render a written report of the Association's financial position thirty (30) days before the Annual Meeting.

L. Maintain an up-to-date copy of the Bylaws.

M. Provide general publicity for meetings of the General Assembly and other important activities of the Association.

N. Coordinate and support activities of all committees of the Association.

O. Report activities of the Central Office during meetings of the Board of Directors.

P. Employ such persons as are necessary for the orderly operation of the Central Office subject to restrictions in the budget approved by the Board of Directors.

Q. Draft an annual budget for review by the Finance Committee and approval by the Board of Directors that will be reported to the General Assembly.

R. Circulate notice of any meeting of the Board of Directors called by the President or requested by ~~a 20%~~ any three (3) ~~of~~ members of the Board of Directors. Notice shall be circulated at least thirty (30) days in advance of a face-to-face meeting and 48 hours in advance of an electronic meeting, or as by rules stated in the Boards of Directors operational manual.

S. Present to the Board of Directors an Annual Report of the status of the Association, outlining accomplishments and making recommendations for the advancement of objectives of the Association.

T. Perform such other duties as prescribed by the Board of Directors.

Section 13 - Standing Committees

Section 13.1: Names. Standing Committees of this Association shall be the Program Committee, the Bylaws Committee, the Nominating Committee, Finance Committee, the Award Selection Committee, the Membership Committee, the Sponsor Committee, and the Administrators' Committee.

Section 13.2: Duties.

A. The Program Committee shall be responsible for the program and other arrangements for the Annual Meeting and other meetings of the Association. For each meeting, the Program Committee shall appoint a

Registration Committee and may appoint a Local Arrangements Committee to offer assistance. The Local Arrangements Committee shall report to the Program Committee. The Registration Committee shall help the Program Committee by overseeing the registration of attendees at the AADB Annual and Mid-Year Meetings.

B. The Bylaws Committee shall continually review and recommend changes to the Bylaws in order to keep them current with the Association's program. The Constitution and Bylaws Committee shall also review changes proposed by others for appropriateness of wording. The Bylaws Committee shall seek input from membership on any changes.

C. The Nominating Committee shall present recommendations for the slate of nominees for Association offices at the first session of the Annual Meeting. Nominations may be added from the floor in accordance with these Bylaws.

D. The Finance Committee shall review the accounting/financial functions and internal controls of the Association in order to protect and enhance the financial situation. The Committee will make recommendations regarding the Association's financial policies; financial statements and investment methodology to the Board of Directors. The Committee shall evaluate the budget prepared by the Chief Executive Officer and submit a recommended annual budget to the Board of Directors in advance of the Mid-Year Meeting.

E. The Award Selection Committee shall make recommendations to the Board of Directors of the Association to be considered for the "AADB Citizen of the Year" Award to be presented at the Annual Meeting. The criteria for determining who shall be nominated to receive this award will be outlined in a Committee Manual.

F. The Sponsor Committee shall be responsible for securing AADB corporate sponsors and promoting them to the AADB membership.

G. The Membership Committee shall promote membership in the AADB and recommend member services to the Board of Directors.

H. The Administrators' Committee shall make recommendations to the Program Committee for the Annual Meeting, and other meetings of the Association, and make recommendations to the Board of Directors on administrative needs.

Section 13.3. Reporting. Each standing committee shall report to the General Assembly at the Annual Meeting. The Constitution and Bylaws Committee and the Program Committee shall submit written reports to the Chief Executive Officer at least forty-five (45) days before the Annual Meeting. The Nominating Committee may report orally.

Matters that require action by the General Assembly shall be presented in reports, in resolution form.

Section 13.4. Composition and Appointments.

A. Standing Committees, except as otherwise provided for in these Bylaws, shall be composed of not less than three, Members, Life Members or ~~Associate~~ Affiliate Members or individuals of an Affiliate organization of this Association. Affiliate ~~Associate~~ Members may serve on a Standing Committee without vote.

B. The Nominating Committee shall be composed of six Members. Each Caucus shall elect from its caucus one member to serve on the Nominating Committee. The committee will include one member rotated from among the Dental Hygienists, Administrators and Public Members, for a one year term, appointed by the

Board of Directors. The chair shall be an AADB past-president appointed by the Board of Directors.

C. Terms of Committee members of a standing committee shall end with the close of the Annual Meeting. Committee Members, however, may be reappointed up to a maximum of five years to the same standing committee.

D. Committee Members of standing committees shall be appointed by the President with the approval of the Board of Directors and subject to the following restrictions:

    1. At least one member of the Bylaws Committee and the Program Committee shall be a carryover from the previous year.

    2. At least one new member shall be appointed to each standing committee each year.

Section 13.5. Vacancy. In the event of a vacancy in the membership of any standing committee, the President shall appoint a qualified person to fill the vacancy for the remainder of the unexpired term.

Section 13.6. Quorum. The majority of the members of a standing committee shall constitute a quorum for the transaction of business.

Section 13.7. Expenses. A standing committee shall not incur expenses without authorization of the Board of Directors.

Section 14 - Special Committees and Ad Hoc Committees

Section 14.1. Identification and Duties. A special committee may be created at any time by the General Assembly or the Board of Directors. The body that creates a special committee shall be responsible for describing the duties of that special committee.

Section 14.2. Reporting. A special committee shall report annually to either the General Assembly or the Board of Directors. If created by the General Assembly, the special committee shall report to the General Assembly. If created by the Board of Directors, the special committee may report to either the General Assembly or the Board of Directors. If the special committee reports only to the General Assembly, the report shall be provided to the Board of Directors for comment prior to presentation to the General Assembly.

Section 14.3. Composition and Appointments.
AD HOC committees extend the duration of tasked 'charge' or when task is determined not doable; therefore, ad hoc committees are not necessarily limited by any date.

Special committees shall be composed of not fewer than three committee members.

A. A special committee, unless renewed by either the General Assembly or the Board of Directors, shall terminate its activities at the close of the Annual Meeting.

B. If a special committee is mandated by the General Assembly, the General Assembly may, at its discretion, select its membership. If the General Assembly does not select Committee members for a special committee it mandates, or if the special committee is created by the Board of Directors, the President, with the approval of the Board of Directors, shall appoint its members.

Section 14.4. Quorum. The majority of members of a special committee shall constitute a quorum for the transaction of business.

Section 14.5. Expenses. A special committee shall not incur expenses without authorization of the Board of Directors.

Section 15 - Representatives to Other Dental Groups

Section 15.1. Identification. The Association shall appoint representatives to the ADA Council on Dental Education and Licensure, Commission on Dental Accreditation, the Appeals Board of the ADA Commission on Dental Accreditation and the ADA Joint Commission on National Dental Examinations. The number of representatives to be appointed and their terms shall correspond to definitions in the ADA Bylaws.

Section 15.2. Appointment Procedures. When a vacancy is available on either the ADA Council on Dental Education and Licensure, Commission on Dental Accreditation, the Appeals Board of the ADA Commission on Dental Accreditation, or the ADA Joint Commission on National Dental Examinations, ~~the President, with approval of the Board of Directors, shall nominate an Association representative~~. Nominations from the General Assembly shall ~~also~~ be accepted. All nominees, however, must be current State/Territory Board Members, past State/Territory Board Members, or Life ~~-~~Members of this Association. The General Assembly shall elect the representatives of the Association.

Section 15.3. Duties and Reporting. Representatives to any other groups shall be expected to maintain good attendance and service at their designated meetings, and they shall attend a minimum of one AADB meeting each year, and attend a minimum of one Annual AADB meeting every two years. Representatives to the ADA Council on Dental Education and Licensure, Commission on Dental Accreditation and the ADA Joint Commission on National Dental Examinations shall report as a committee to the General Assembly during the Annual Meeting. The representative on the ADA Appeals Board of the Commission on Dental Accreditation may report, within prescribed limits of confidentiality, but is not required to do so. Representatives to other groups shall report orally or by written report to the Board of Directors annually, or may report to the General Assembly as requested. Each representative to ADA Council or Commission shall report, in writing, or if requested by the Board, a yearly report in addition to the Annual report to the General Assembly.

Section 15.4. Other Appointments. Nothing in this chapter shall be interpreted to prohibit the President, with the approval of the Board of Directors, from making appointments to appropriate organizations other than those specified, as may, from time to time, be required.

Section 16 – Dues

Section 16.1. Dues: The annual dues shall be recommended by the Board of Directors and approved by the General Assembly.

Section 16.2 Loss of Membership. Any Member, Agency, ~~Associate~~ Affiliate Member or ~~Associate~~ Affiliate Agency whose dues remain unpaid for one year shall be dropped from membership after review by the Board and notification by the Chief Executive Officer.

Section 16.3. Reinstatement. Any Member, Agency, ~~Associate~~ Affiliate Member or ~~Associate~~ Affiliate Agency who has been dropped for non-payment of dues for at least two dues years shall be eligible for reinstatement to membership upon payment of current dues.

Section 16.4. Resignation. Any Member, Agency, ~~Associate~~ Affiliate Member or ~~Associate~~ Affiliate Agency in good standing, and who are not arrears in dues, may honorably resign from the Association. Upon application for reinstatement to membership, any Member, Agency, ~~Associate~~ Affiliate Member or ~~Associate~~ Affiliate Agency may be reinstated upon payment of the current year's dues.

Section 16.5. Honorary Members. Life Members, ~~Associate~~ Affiliate Life Members, and ~~Associate~~ Affiliate Members recognized as Honorary or Disabled/Retired Members of this Association shall not be subject to the payment of dues.

Section 17 - Meetings and Quorum of Assembly

Section 17.1. Meetings. The Association shall hold an Annual Meeting and such other meetings as may be designated by the Board of Directors. Special meetings may be held as provided in Section 9, Section 9.3, Sub-Section (L) of the Bylaws.
The Association shall:

A. record all minutes and maintain all records, documents and property of the AADB, including a roster of members;

B. shall publish for the Members the minutes of the Annual Meeting and a list of those selected to serve on the Board of Directors and all appointments;

C. shall inspect the Membership List, Association must prepare a list of members entitled to notice of meeting including (i) address of each member and (ii) number of votes each member is entitled to cast at meeting. Available for inspection by members two days after notice of meeting given until meeting. A member must be allowed a copy upon written demand showing "proper and relevant purposes. The Association may charge for the copies.

Section 17.2. Quorum. A Quorum of five (5) percent of the membership of the Association shall constitute a quorum for the transaction of business at any meeting of the Association

Section 17.3. Meeting by Electronic Means. The Annual Meeting may also be held, in whole or part, via the Internet or other communication technology. Any meeting of the General Assembly, the Board of Directors, or any Committee, held via the Internet or other communication technology, shall, at a

minimum, permit Members to hear or read the proceedings substantially concurrently with their occurrence, vote on matters submitted to Members, pose questions, and make comments.

Section 18 - Order of Business

Section 18.1. Annual Meeting. The President shall submit an agenda to the General Assembly, which may include but is not limited to reports from the president, Board of Directors, Chief Executive Officer, committees and task forces, election and installation of officers.

Section 18.2. Special Meetings. The business at a Special Meeting of this Association shall be confined to the specific objectives for which the meeting is called and of which the general membership is notified as provided in these Bylaws.

Section 18.3. Altering Order. The order of business at any meeting may be altered or suspended by a three-fourths (3/4) majority vote of voting members present.

Section 19 - Rules of Order

Section 19.1. Resolutions. Proposed policy statements or actions shall be presented to the General Assembly in the form of resolutions. A written copy of any proposed resolution shall be furnished to the Chief Executive Officer and Board of Directors for inclusion in the minutes. If possible, resolutions should be referred to the Board of

Directors for comment prior to their presentation to the General Assembly for action. If a resolution is brought up under new business, it will need a 2/3 vote of the General Assembly to be added to the agenda.

Section 19.2. Floor Privilege. No member shall speak longer than 5 minutes upon any subject until all present have had an opportunity to express themselves, and no member shall speak more than twice on the same subject except by permission of the General Assembly.

Section 19.3. Additional Rules. The rules contained in the current edition of the American Institute of Parliamentarians Standard Code of Parliamentary Procedures shall govern the deliberations of this Association in all cases in which they are applicable and not in conflict with the Bylaws.

Section 20 - Fiscal Year

The fiscal year of this Association shall be from July 1 to June 30 inclusive.

Section 21 - Indemnification

The Association shall indemnify and hold harmless each officer and each member of a committee, now or hereafter serving the Association, from and against any and all claims and liabilities to which the person may be or become subject, by reason of now or hereafter, being, or having heretofore been, an officer and/or a member of a committee of the Association, and/or by reason of alleged acts or omissions as an officer and/or a member of a committee as aforesaid, and shall reimburse each officer and/or committee member of the Association for all legal and other expenses reasonably incurred in connection with defending such claims or liabilities provided, however, that no officer or committee member shall be indemnified or reimbursed for any expense arising out of the officer's or committee member's own negligence or willful misconduct. The foregoing rights of officers and members of committees shall not be exclusive of other rights to which they may be entitled lawfully.

Section 22- Seal

This Association shall have a seal for the purpose of authenticating official documents of the Association. The seal may be broken, changed, or renewed at the pleasure of the Association.

Section 23 – Amendments

Section 23.1. The Bylaws may be amended by a two-thirds vote of the voting Members present at an Annual or Mid-Year Meeting, provided copies of the proposed amendment shall have been presented in writing to the voting members of the Association at least thirty (30) days prior to the meeting.

Section 23.2. An amendment to the Bylaws affecting a change in dues shall not be enacted upon at the Annual or Mid-Year Meeting at which introduced, except by unanimous consent unless the amendment has been circulated to the membership thirty (30) days prior to the Annual or Mid-Year Meeting.

Section 24 – Dissolution

If this Association shall be dissolved at any time, no part of its funds or property shall be distributed to, or among its members, but, after payment of all indebtedness of the Association, its surplus funds and properties shall be used for dental education and dental research in such manner as the then governing body of the Association may determine.

AADB shall provide a notice to the Attorney General of the District of Columbia that it intends to dissolve prior to

delivering articles of dissolution to the District. Property held in trust or otherwise dedicated to a charitable purpose may not be diverted from its purpose in a sale of assets unless the corporation obtains an appropriate court order to the extent required by and pursuant to the laws of the District on cy-près or otherwise dealing with the non-diversion of charitable assets.

Last approved by the General Assembly on October 31, 2021

39TH ANNUAL PRELIMINARY AGENDA

Loews Hollywood Hotel
1755 North Highland Ave.
Hollywood, CA 99028
October 18-19, 2023

WEDNESDAY, OCTOBER 18

8 AM – 8:30 AM	Breakfast
8:30 AM – 9 AM	Welcome and Introductions
9 AM – 12 PM	Presentations/Discussion (TBD)
12 PM – 1 PM	Lunch
1 PM – 2:45 PM	Presentations/Discussion (TBD) Continued
2:45 PM – 3 PM	Break
3 PM – 4:30 PM	State Board Roundtable
6 PM – 8 PM	Network Reception

THURSDAY, OCTOBER 19

8:30 AM – 9 AM	Breakfast
9 AM – 9:30 AM	AADA Committee Update
9:30 AM – 11 AM	Business Session
11 AM – 11:15 AM	Break
11:15 AM – 12 PM	Executive Director/Board Attorney Only Session
1 PM	Networking

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: August 14, 2023

TO: OBD Board Members

FROM: OBD Executive Director Stephen Prisby

SUBJECT: Establish agreement and formalize Oregon Wellness Program for all Licensees

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The Foundation for Medical Excellence administers the Oregon Wellness Program.

The Board has authorization to support this program with $80,000 over two years in the legislatively approved OBD 2023-2025 budget.

> Package 200: Oregon Wellness Program. This package increases Services and Supplies by $80,000 Other Funds to establish funding and support for the inclusion of OBD into the Oregon Wellness Program. The program is designed to provide confidential urgent mental health services to active clinical providers who self-refer.

Today the Board will review information, discuss the program and consider approving the Memo of Agreement (MOA) between the OBD and the Foundation for Medical Excellence. This agreement is modeled on the exact one the Oregon Medical Board has in place.

There are additional documents and representatives from the Foundation attending this meeting to answer any questions that the Board has on it.

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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

OFFICE OF THE SECRETARY OF STATE
CHERYL MYERS
ACTING SECRETARY OF STATE
& TRIBAL LIAISON

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OBD 1-2023
CHAPTER 818
OREGON BOARD OF DENTISTRY

FILING CAPTION: The Board is amending 13 rules, repealing 3 rules and creating 1 new rule.

EFFECTIVE DATE: 07/01/2023

AGENCY APPROVED DATE: 06/16/2023

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:
818-001-0002, 818-012-0005, 818-012-0007, 818-012-0030, 818-012-0032, 818-015-0005, 818-015-0007, 818-021-0012, 818-021-0015, 818-021-0017, 818-021-0030, 818-021-0040, 818-021-0060, 818-021-0070, 818-021-0076, 818-021-0084, 818-042-0040

AMEND: 818-001-0002

NOTICE FILED DATE: 03/29/2023

RULE SUMMARY: Removes reference to CPR to clarify BLS as the requirement.

CHANGES TO RULE:

818-001-0002
Definitions ¶

As used in OAR chapter 818:¶
(1) "Board" means the Oregon Board of Dentistry, the members of the Board, its employees, its agents, and its consultants.¶
(2) "Dental Practice Act" means ORS Chapter 679 and 680.010 to 680.170 and the rules adopted pursuant thereto.¶
(3) "Dentist" means a person licensed pursuant to ORS Chapter 679 to practice dentistry.¶
(4) "Dental Hygienist" means a person licensed pursuant to ORS 680.010 to 680.210 to practice dental hygiene.¶
(5) "Dental Therapist" means a person licensed to practice dental therapy under ORS 679.603.¶
(6) "Dental Therapy" means the provision of preventative dental care, restorative dental treatment and other educational, clinical and therapeutic patient services as part of a dental care team, including the services described under ORS 679.621.¶
(7) "Direct Supervision" means supervision requiring 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.¶
(8) "General Supervision" means supervision requiring 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.¶
(9)-"Indirect Supervision" means supervision requiring that a dentist authorize the procedures and that a dentist be on the premises while the procedures are performed.¶

(10)-"Informed Consent" means the consent obtained following a thorough and easily understood explanation to the patient, or patient's guardian, of the proposed procedures, any available alternative procedures and any risks associated with the procedures. Following the explanation, the licensee shall ask the patient, or the patient's guardian, if there are any questions. The licensee shall provide thorough and easily understood answers to all questions asked.¶
(11) "Licensee" means a dentist, hygienist or dental therapist.¶
(12) "Volunteer Licensee" is a dentist, hygienist or dental therapist licensed according to rule to provide dental health care without receiving or expecting to receive compensation.¶
(13) "Limited Access Patient" means a patient who, due to age, infirmity, or handicap is unable to receive regular dental hygiene treatment in a dental office.¶
(14)-"Specialty." The specialty definitions are added to more clearly define the scope of the practice as it pertains to the specialty areas of dentistry.¶
(a) "Dental Anesthesiology" is the specialty of dentistry that deals with the management of pain through the use of advanced local and general anesthesia techniques.¶
(b) "Dental Public Health" is the science and art of preventing and controlling dental diseases and promoting dental health through organized community efforts. It is that form of dental practice which serves the community as a patient rather than the individual. It is concerned with the dental health education of the public, with applied dental research, and with the administration of group dental care programs as well as the prevention and control of dental diseases on a community basis.¶
(c) "Endodontics" is the specialty of dentistry which is concerned with the morphology, physiology and pathology of the human dental pulp and periradicular tissues. Its study and practice encompass the basic and clinical sciences including biology of the normal pulp, the etiology, diagnosis, prevention and treatment of diseases and injuries of the pulp and associated periradicular conditions.¶
(d) "Oral and Maxillofacial Pathology" is the specialty of dentistry and discipline of pathology that deals with the nature, identification, and management of diseases affecting the oral and maxillofacial regions. It is a science that investigates the causes, processes, and effects of these diseases. The practice of oral pathology includes research and diagnosis of diseases using clinical, radiographic, microscopic, biochemical, or other examinations.¶
(e) "Oral and Maxillofacial Radiology" is the specialty of dentistry and discipline of radiology concerned with the production and interpretation of images and data produced by all modalities of radiant energy that are used for the diagnosis and management of diseases, disorders and conditions of the oral and maxillofacial region.¶
(f) "Oral and Maxillofacial Surgery" is the specialty of dentistry which includes the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region.¶
(g) "Oral Medicine" is the specialty of dentistry responsible for the oral health care of medically complex patients and for the diagnosis and management of medically-related diseases, disorders and conditions affecting the oral and maxillofacial region.¶
(h) "Orofacial Pain" Orofacial Pain is the specialty of dentistry that encompasses the diagnosis, management and treatment of pain disorders of the jaw, mouth, face, head and neck. The specialty of Orofacial Pain is dedicated to the evidenced-based understanding of the underlying pathophysiology, etiology, prevention, and treatment of these disorders and improving access to interdisciplinary patient care.-¶
(i) "Orthodontics and Dentofacial Orthopedics" is the specialty of dentistry concerned with the supervision, guidance and correction of the growing or mature dentofacial structures, including those conditions that require movement of teeth or correction of malrelationships and malformations of their related structures and the adjustment of relationships between and among teeth and facial bones by the application of forces and/or the stimulation and redirection of functional forces within the craniofacial complex. Major responsibilities of orthodontic practice include the diagnosis, prevention, interception and treatment of all forms of malocclusion of the teeth and associated alterations in their surrounding structures; the design, application and control of functional and corrective appliances; and the guidance of the dentition and itssupporting structures to attain and maintain optimum occlusal relations in physiologic and esthetic harmony among facial and cranial structures.¶
(j) "Pediatric Dentistry" is an age defined specialty that provides both primary and comprehensive preventive and therapeutic oral health care for infants and children through adolescence, including those with special health care needs.¶
(k) "Periodontics" is the specialty of dentistry which encompasses the prevention, diagnosis and treatment of diseases of the supporting and surrounding tissues of the teeth or their substitutes and the maintenance of the health, function and esthetics of these structures and tissues.¶
(l) "Prosthodontics" is the specialty of dentistry pertaining to the restoration and maintenance of oral functions, comfort, appearance and health of the patient by the restoration of natural teeth and/or the replacement of missing teeth and contiguous oral and maxillofacial tissues with artificial substitutes.¶
(15) "Full-time" as used in ORS 679.025 and 680.020 is defined by the Board as any student who is enrolled in an

institution accredited by the Commission on Dental Accreditation of the American Dental Association or its successor agency in a course of study for dentistry, dental hygiene or dental therapy.¶
(16)-For purposes of ORS 679.020(4)(h) the term "dentist of record" means a dentist that either authorized treatment for, supervised treatment of or provided treatment for the patient in clinical settings of the institution described in 679.020(3).¶
(17) "Dental Study Group" as used in ORS 679.050, OAR 818-021-0060 and OAR 818-021-0070 is defined as a group of licensees who come together for clinical and non-clinical educational study for the purpose of maintaining or increasing their competence. This is not meant to be a replacement for residency requirements.¶
(18) "Physical Harm" as used in OAR 818-001-0083(2) is defined as any physical injury that caused, partial or total physical disability, incapacity or disfigurement. In no event shall physical harm include mental pain, anguish, or suffering, or fear of injury.¶
(19) "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.¶
(20) "BLS for Healthcare Providers or its Equivalent" the BLS~~/CPR~~ certification standard is the American Heart Association's BLS Healthcare Providers Course or its equivalent, as determined by the Board. This initial BLS~~/CPR~~ course must be a hands-on course; online BLS~~/CPR~~ courses¶
will not be approved by the Board for initial BLS~~/CPR~~ certification: After the initial BLS~~/CPR~~ certification, the Board will accept a Board-approved BLS for Healthcare Providers or its equivalent Online Renewal course for license renewal. A BLS~~/CPR~~ certification card with an expiration date must be received from the BLS~~/CPR~~ provider as documentation of BLS~~/CPR~~ certification. The Board considers the BLS~~/CPR~~ expiration date to be the last day of the month that the BLS~~/CPR~~ instructor indicates that the certification expires.
Statutory/Other Authority: ORS 679, 680
Statutes/Other Implemented: ORS 679.010, 680.010

AMEND: 818-012-0005

NOTICE FILED DATE: 03/29/2023

RULE SUMMARY: Changes effective date of implant rule and splits Botulinum Type A /dermal filler requirement into 10 hours each.

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 ~~and dermal fillers~~ to treat ~~a~~ conditions that ~~is~~are within the ~~scope of the practice of dentistry~~oral and maxillofacial region after completing a minimum of ~~2~~10 hours in a hands on clinical course(s), ~~which includes both Botulinum Toxin Type A and~~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. ¶
(4~~5~~) 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 a Commission on Dental Accreditation (CODA) accredited graduate 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) ~~or by a Commission on Dental Accreditation (CODA) approved graduate dental education program~~.¶
(5~~6~~) 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 J~~ul~~anuary 1, 202~~2~~4).
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: 818-012-0007

NOTICE FILED DATE: 03/29/2023

RULE SUMMARY: Amending title of rule to add "of Vaccines" for clarification

CHANGES TO RULE:

818-012-0007
Procedures, Record Keeping and Reporting of Vaccines
(1) Prior to administering a vaccine to a patient of record, the dentist must follow the "Model Standing Orders" approved by the Oregon Health Authority (OHA) for administration of vaccines and the treatment of severe adverse events following administration of a vaccine. ¶
(2) The dentist must maintain written policies and procedures for handling and disposal of used or contaminated equipment and supplies. ¶
(3) The dentist or designated staff must give the appropriate Vaccine Information Statement (VIS) to the patient or legal representative with each dose of vaccine covered by these forms. The dentist or designated staff must ensure that the patient or legal representative is available and has read, or has had read to them, the information provided and has had their questions answered prior to the dentist administering the vaccine. The VIS given to the patient must be the most current statement. ¶
(4) The dentist or designated staff must document in the patient record: ¶
(a) The date and site of the administration of the vaccine; ¶
(b) The brand name, or NDC number, or other acceptable standardized vaccine code set, dose, manufacturer, lot number, and expiration date of the vaccine; ¶
(c) The name or identifiable initials of the administering dentist; ¶
(d) The address of the office where the vaccine(s) was administered unless automatically embedded in the electronic report provided to the OHA ALERT Immunization System; ¶
(e) The date of publication of the VIS; and¶
(f) The date the VIS was provided and the date when the VIS was published.¶
(5) If providing state or federal vaccines, the vaccine eligibility code as specified by the OHA must be reported to the ALERT system.¶
(6) A dentist who administers any vaccine must report, the elements of Section (3), and Section (4) of this rule if applicable, to the OHA ALERT Immunization System within 14 days of administration. ¶
(7) The dentist must report adverse events as required by the Vaccine Adverse Events Reporting System (VAERS), to the Oregon Board of Dentistry within 10 business days and to the primary care provider as identified by the patient.¶
(8) A dentist who administers any vaccine will follow storage and handling guidance from the vaccine manufacturer and the Centers for Disease Control and Prevention (CDC).¶
(9) Dentists who do not follow this rule can be subject to discipline for failure to adhere to these requirements.
Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679

AMEND: 818-012-0030

NOTICE FILED DATE: 03/29/2023

RULE SUMMARY: Adds in requirement to comply with health care interpreter law and clarifies patient records rule.

CHANGES TO RULE:

818-012-0030
Unprofessional Conduct ¶

The Board finds that in addition to the conduct set forth in ORS 679.140(2), unprofessional-¶
conduct includes, but is not limited to, the following in which a licensee does or knowingly-¶
permits any person to:¶
(1) Attempt to obtain a fee by fraud, or misrepresentation.¶
(2) Obtain a fee by fraud, or misrepresentation.¶
(a) A licensee obtains a fee by fraud if the licensee knowingly makes, or permits any person to make, a material, false statement intending that a recipient, who is unaware of the truth, rely upon the statement.¶
(b) A licensee obtains a fee by misrepresentation if the licensee obtains a fee through making or permitting any person to make a material, false statement.¶
(c) Giving cash discounts and not disclosing them to third party payers is not fraud or misrepresentation.¶
(3) Offer rebates, split fees, or commissions for services rendered to a patient to any person other than a partner, employee, or employer.¶
(4) Accept rebates, split fees, or commissions for services rendered to a patient from any person other than a partner, employee, or employer.¶
(5) Initiate, or engage in, with a patient, any behavior with sexual connotations. The behavior can include but is not limited to, inappropriate physical touching; kissing of a sexual nature; gestures or expressions, any of which are sexualized or sexually demeaning to a patient;-¶
inappropriate procedures, including, but not limited to, disrobing and draping practices that reflect a lack of respect for the patient's privacy; or initiating inappropriate communication, verbal or written, including, but not limited to, references to a patient's body or clothing that are-¶
sexualized or sexually demeaning to a patient; and inappropriate comments or queries about the professional's or patient's sexual orientation, sexual performance, sexual fantasies, sexual problems, or sexual preferences.¶
(6) Engage in an unlawful trade practice as defined in ORS 646.605 to 646.608.¶
(7) Fail to present a treatment plan with estimated costs to a patient upon request of the patient or to a patient's guardian upon request of the patient's guardian.¶
(8) Misrepresent any facts to a patient concerning treatment or fees.¶
(9)~~(a)~~ Fail to ~~provide a patient or patient's guardian within 14 days of written request:¶~~
~~(A) Legible copies of records; and¶~~
~~(B) Duplicates of study models, radiographs of the same quality as the originals, and photographs if they have been paid for.¶~~
~~(b) The licensee may require the patient or guardian to pay in advance a fee reasonably calculated to cover the costs of making the copies or duplicates. The licensee may charge a fee not to exceed $30 for copying 10 or fewer pages of written material and no more than $0.50 per page for pages 11 through 50 and no more than $0.25 for each additional page (including records copied from microfilm), plus any postage costs to mail copies requested and actual costs of preparing an explanation or summary of information, if requested. The actual cost of duplicating radiographs may also be charged to the patient. Patient records or summaries may not be withheld from the patient because of any prior unpaid bills, except as provided in (9)(a)(B) of this rule.~~release patient records pursuant to OAR 818-012-0032. ¶
(10) Fail to identify to a patient, patient's guardian, or the Board the name of an employee, employer, contractor, or agent who renders services.¶
(11) Use prescription forms pre-printed with any Drug Enforcement Administration number, name of controlled substances, or facsimile of a signature.¶
(12) Use a rubber stamp or like device to reproduce a signature on a prescription form or sign a blank prescription form.¶
(13) Order drugs listed on Schedule II of the Drug Abuse Prevention and Control Act, 21 U.S.C. Sec. 812, for office use on a prescription form.¶
(14) Violate any Federal or State law regarding controlled substances.¶
(15) Becomes addicted to, or dependent upon, or abuses alcohol, illegal or controlled drugs, or mind altering substances, or practice with an untreated substance use disorder diagnosis that renders the licensee unable to

safely conduct the practice of dentistry, dental hygiene or dental therapy.-¶
(16) Practice dentistry, dental hygiene or dental therapy in a dental office or clinic not owned by an Oregon licensed dentist(s), except for an entity described under ORS 679.020(3) and dental hygienists practicing pursuant to ORS 680.205(1)(2).¶
(17) Make an agreement with a patient or person, or any person or entity representing patients or persons, or provide any form of consideration that would prohibit, restrict, discourage or otherwise limit a person's ability to file a complaint with the Oregon Board of Dentistry; to truthfully and fully answer any questions posed by an agent or representative of the Board; or to participate as a witness in a Board proceeding.¶
(18) Fail to maintain at a minimum a current BLS for Healthcare Providers certificate or its equivalent.-¶
(19) Conduct unbecoming a licensee or detrimental to the best interests of the public, including conduct contrary to the recognized standards of ethics of the licensee's profession or conduct that endangers the health, safety or welfare of a patient or the public.¶
(20) Knowingly deceiving or attempting to deceive the Board, an employee of the Board, or an agent of the Board in any application or renewal, or in reference to any matter under investigation by the Board. This includes but is not limited to the omission, alteration or destruction of any record in order to obstruct or delay an investigation by the Board, or to omit, alter or falsify any information in patient or business records.¶
(21) Knowingly practicing with a physical or mental impairment that renders the Licensee unable to safely conduct the practice of dentistry, dental hygiene or dental therapy.-¶
(22) Take any action which could reasonably be interpreted to constitute harassment or retaliation towards a person whom the licensee believes to be a complainant or witness.¶
(23) Fail to register with the Prescription Drug Monitoring Program (PDMP) in order to have access to the Program's electronic system if the Licensee holds a Federal Drug Enforcement Administration (DEA) registration.¶
(24) Fail to comply with ORS 413.550-413.558, regarding health care interpreters.
Statutory/Other Authority: ORS 679, 680
Statutes/Other Implemented: ORS 679.140(1)(c), 679.140(2), 679.170(6), 680.100

AMEND: 818-012-0032

NOTICE FILED DATE: 03/29/2023

RULE SUMMARY: Clarifies what information should be included in patient records.

CHANGES TO RULE:

818-012-0032
Diagnostic Records ¶

(1) Licensees shall provide duplicates of physical diagnostic records ~~that have been paid for~~ to patient or patient's guardian within 14 calendar days of receipt of written request.¶
(~~A~~a) Physical records include ~~silver emulsion radiographs, physical study models, paper charting and chart notes;~~¶
(A) Legible copies of paper charting and chart notes, and;¶
(B) Duplicates of silver emulsion radiographs of the same quality as the originals, duplicates of physical study models, and photographs if they have been paid for.¶
(~~B~~b) Licensees may require the patient or patient's guardian to pay in advance the fee reasonably calculated to cover costs of making the copies or duplicates.¶
(~~1~~2) Licensee may charge a fee not to exceed $30 for copying 10 or fewer pages of written material and no more than $0.50 per page for 11-50 and no more than $0.25 for each additional page, including cost of microfilm plus any postage costs to mail copies requested and actual costs of preparing an explanation or summary of information, if requested. The actual costs of duplicating radiographs may also be charged to the patient.¶
(~~2~~3) Licensees shall provide duplicates of digital patient records within 14 calendar days of receipt of written request by the patient or patient's guardian.¶
(~~A~~a) Digital records include any patient diagnostic image, study model, test result or chart record in digital form.¶
(~~B~~b) Licensees may require the patient or patient's guardian to pay for the typical retail cost of the digital storage device, such as a CD, thumb drive, or DVD as well as associated postage.¶
(~~C~~c) Licensees shall not charge any patient or patient's guardian to transmit requested digital records over email if total records do not exceed 25 Mb.¶
~~(D) A clinical day is defined as a day during which the dental clinic treated scheduled patients.¶~~
(~~E~~d) Licensees may charge up to $5 for duplication of digital records up to 25Mb and up to $30 for more than 25Mb.¶
(~~F~~e) Any transmission of patient records shall be in compliance with the Health Insurance Portability and Accountability Act (HIPAA Act) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act).¶
(~~G~~f) Duplicated digital records shall be of the same quality as the original digital file.¶
(~~3~~4) If a records summary is requested by patient or patient's guardian, the actual cost of creating this summary and its transmittal may be billed to the patient or patient's guardian.¶
(5) Patient records or summaries may not be withheld from the patient because of any prior unpaid bills, except as provided in (1)(a)(B) of this rule.
Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679

AMEND: 818-015-0005

NOTICE FILED DATE: 03/29/2023

RULE SUMMARY: Clarifies acceptable advertising for licensees.

CHANGES TO RULE:

818-015-0005
General Provisions ¶

(1) "To advertise" means to publicly communicate information about a licensee's professional services or qualifications for the purpose of soliciting business.¶
(2) Advertising shall not be false, deceptive, misleading or not readily subject to verification and shall not make claims of professional superiority which cannot be substantiated by the licensee, who shall have the burden of proof.¶
(3) Advertising shall not make a representation that is misleading as to the credentials, education, or the licensing status of a licensee. Licensee may not claim a degree, credential, or distinction granted by a professional organization or institution of higher learning that has not been earned.¶
(4) A licensee who authorizes another to disseminate information about the licensee's professional services to the public is responsible for the content of that information unless the licensee can prove by clear and convincing evidence that the content of the advertisement is contrary to the licensee's specific directions.¶
(5) A dentist shall adhere to the Doctors' Title Act, ORS 676.110 (Use of title "doctor").
Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679.140(2)(e)

REPEAL: 818-015-0007

NOTICE FILED DATE: 03/29/2023

RULE SUMMARY: Repealing this rule.

CHANGES TO RULE:

~~818-015-0007~~
~~Specialty Advertising ¶~~

~~(1) A dentist may only advertise as a specialist in an area of dentistry which is recognized by the Board and in which the dentist is licensed or certified by the Board.¶~~
~~(2) The Board recognizes the following specialties:¶~~
~~(a) Endodontics;¶~~
~~(b) Oral and Maxillofacial Surgery;¶~~
~~(c) Oral and Maxillofacial Radiology;¶~~
~~(d) Oral and Maxillofacial Pathology;¶~~
~~(e) Orthodontics and Dentofacial Orthopedics;¶~~
~~(f) Pediatric Dentistry;¶~~
~~(g) Periodontics;¶~~
~~(h) Prosthodontics;¶~~
~~(i) Dental Public Health;¶~~
~~(j) Dental Anesthesiology;¶~~
~~(k) Oral Medicine;¶~~
~~(l) Orofacial Pain.¶~~
~~(3) A dentist whose license is not limited to the practice of a specialty under OAR 818-021-0017 may advertise that the dentist performs or limits practice to specialty services even if the dentist is not a specialist in the advertised area of practice so long as the dentist clearly discloses that the dentist is a general dentist or a specialist in a different specialty. For example, the following disclosures would be in compliance with this rule for dentists except those licensed pursuant to 818-021-0017: "Jane Doe, DDS, General Dentist, practice limited to pediatric dentistry." "John Doe, DMD, Endodontist, practice includes prosthodontics."~~
~~Statutory/Other Authority: ORS 679~~
~~Statutes/Other Implemented: ORS 679.140(2)(e)~~

AMEND: 818-021-0012

NOTICE FILED DATE: 03/29/2023

RULE SUMMARY: Clarifies specialties recognized by the Board in rule.

CHANGES TO RULE:

818-021-0012
Specialties Recognized ¶

~~(1) A dentist may advertise that the dentist is a dentist anesthesiologist, endodontist, oral and maxillofacial pathologist, oral and maxillofacial surgeon, oral and maxillofacial radiologist, oral medicine dentist, orofacial pain dentist, orthodontist and dentofacial orthopedics, pediatric dentist, periodontist, prosthodontist or dental public health dentist, only if the dentist is licensed or certified by the Board in the specialty in accordance with Board rules.¶~~
~~(2) A dentist may advertise that the dentist specializes in or is a specialist in dental anesthesiology, e~~The Board recognizes the following specialties:¶
(1) Dental Anesthesiology;¶
(2) Dental Public Health;¶
(3) Endodontics~~, e~~;¶
(4) Oral and ~~m~~Maxillofacial ~~p~~Pathology~~, e~~;¶
(5) Oral and ~~m~~Maxillofacial ~~surgery, e~~Radiology;¶
(6) Oral and ~~m~~Maxillofacial ~~radiology, e~~Surgery;¶
(7) Oral ~~m~~Medicine~~, e~~;¶
(8) Orofacial ~~p~~Pain~~, e~~;¶
(9) Orthodontics and ~~d~~Dentofacial ~~o~~Orthopedics~~, p~~;¶
(10) Pediatric ~~d~~Dentistry~~, p~~;¶
(11) Periodontics~~, p~~;¶
(12) Prosthodontics ~~or dental public health only if the dentist is licensed or certified by the Board in the specialty in accordance with Board rules~~.
Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679.140

AMEND: 818-021-0015

NOTICE FILED DATE: 03/29/2023

RULE SUMMARY: Removes reference to repealed rule.

CHANGES TO RULE:

818-021-0015
Certification as a Specialist ¶

The Board may certify a dentist as a specialist if the dentist:¶
(1) Holds a current Oregon dental license;¶
(2) Is a diplomate of or a fellow in a specialty board accredited or recognized by the American Dental Association; or¶
(3) Has completed a post-graduate program approved by the Commission on Dental Accreditation of the American Dental Association~~; or¶~~
~~(4) Was qualified to advertise as a specialist under former OAR 818-010-0061~~.
Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679.140(2)(d)

AMEND: 818-021-0017

NOTICE FILED DATE: 03/29/2023

RULE SUMMARY: Adding one hour pain management requirement to be consistent with other rules.

CHANGES TO RULE:

818-021-0017
Application to Practice as a Specialist ¶

(1) A dentist who wishes to practice as a specialist in Oregon, who does not have a current Oregon license, in addition to meeting the requirements set forth in ORS 679.060 and 679.065, shall submit to the Board satisfactory evidence of:¶
(a) Having graduated from a school of dentistry accredited by the Commission on Dental Accreditation of the American Dental Association and active licensure as a general dentist in another state. Licensure as a general dentist must have been obtained as a result of the passage of any clinical Board examination administered by any state or regional testing agency;¶
(b) Certification of having passed the dental examination administered by the Joint Commission on National Dental Examinations or Canadian National Dental Examining Board Examination; and¶
(c) Proof of satisfactory completion of a post-graduate specialty program accredited by the Commission on Dental Accreditation of the American Dental Association.-¶
(d) Passing the Board's jurisprudence examination.¶
(e) Completion of a one-hour pain management course specific to Oregon provided by the Pain Management Commission of the Oregon Health Authority (Effective July 1, 2022).¶
(2) A dentist who graduated from a dental school located outside the United States or Canada who wishes to practice as a specialist in Oregon, who does not have a current Oregon license, in addition to meeting the requirements set forth in ORS 679.060 and 679.065, shall submit to the Board satisfactory evidence of:¶
(a) Completion of a post-graduate specialty program of not less than two years at a dental school accredited by the Commission on Dental Accreditation of the American Dental Association, proficiency in the English language, and evidence of active licensure as a general dentist in another state obtained as a result of the passage of any clinical Board examination administered by any state or regional testing agency; or¶
(b) Completion of a post-graduate specialty program of not less than two years at a dental school accredited by the Commission on Dental Accreditation of the American Dental Association, proficiency in the English language and certification of having successfully passed the clinical examination administered by any state or regional testing agency within the five years immediately preceding application; and¶
(c) Certification of having passed the dental examination administered by the Joint Commission on National Dental Examinations or Canadian National Dental Examining Board Examination; and¶
(d) Passing the Board's jurisprudence examination; and¶
(e) Completion of a one-hour pain management course specific to Oregon provided by the Pain Management Commission of the Oregon Health Authority (Effective July 1, 2022).¶
(3) An applicant who meets the above requirements shall be issued a specialty license upon:¶
(a) Passing a specialty examination approved by the Board within the five years immediately preceding application; or¶
(b) Passing a specialty examination approved by the Board greater than five years prior to application; and¶
(A) Having conducted licensed clinical practice in the applicant's postdoctoral dental specialty in Oregon, other states or in the Armed Forces of the United States, the United States Public Health Service or the United States Department of Veterans Affairs for a minimum of 3,500 hours in the five years immediately preceding application. Licensed clinical practice could include hours devoted to teaching the applicant's dental specialty by dentists employed by a dental education program in a CODA-accredited dental school, with verification from the dean or appropriate administration of the institution documenting the length and terms of employment, the applicant's duties and responsibilities, the actual hours involved in teaching clinical dentistry in the specialty applicant is applying for, and any adverse actions or restrictions; and;¶
(B) Having completed 40 hours of continuing education in accordance with the Board's continuing education requirements contained in these rules within the two years immediately preceding application.¶
(4) Any applicant who does not pass the first examination for a specialty license may apply for a second and third regularly scheduled specialty examination. If the applicant fails to pass the third examination for the practice of a recognized specialty, the applicant will not be permitted to retake the particular specialty examination until he/she has attended and successfully passed a remedial program prescribed by a dental school accredited by the Commission on Dental Accreditation of the American Dental Association and approved by the Board.¶

(5) Licenses issued under this rule shall be limited to the practice of the specialty only.
Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679.140, 679.060, 679.065, 679.070, 679.080 679.090

REPEAL: 818-021-0030

NOTICE FILED DATE: 03/29/2023

RULE SUMMARY: Repeal outdated exam rule.

CHANGES TO RULE:

~~818-021-0030~~
~~Dismissal from Examination~~
~~[Reserved]~~
~~Statutory/Other Authority: ORS 679, 680~~
~~Statutes/Other Implemented: ORS 679.070, 680.060~~

REPEAL: 818-021-0040

NOTICE FILED DATE: 03/29/2023

RULE SUMMARY: Repeal outdated exam rule.

CHANGES TO RULE:

~~818-021-0040~~
~~Examination Review Procedures~~
~~[Reserved]~~
~~Statutory/Other Authority: ORS 183, 192~~
~~Statutes/Other Implemented: ORS 183.310(2)(b), 192.501(4)~~

AMEND: 818-021-0060

NOTICE FILED DATE: 03/29/2023

RULE SUMMARY: Removes examination requirement, clarifies certificate of completion details and also changes effective date of dental implant rule.

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 ~~includes an examination and the dentist passes the examination~~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 implants must complete at least seven (7) hours of continuing education related to the placement of dental implants every licensure renewal period (Effective J~~ul~~anuary 1, 202~~2~~4).
Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679.250(9)

AMEND: 818-021-0070

NOTICE FILED DATE: 03/29/2023

RULE SUMMARY: Removes examination requirement and clarifies certificate of completion details.

CHANGES TO RULE:

818-021-0070
Continuing Education - Dental Hygienists ¶

(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.)¶
(c) Correspondence courses, videotapes, distance learning courses or similar self-study course, provided that the course ~~includes an examination and the dental hygienist passes the examination~~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.¶
(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).
Statutory/Other Authority: ORS 679 680
Statutes/Other Implemented: ORS 679.250(9)

AMEND: 818-021-0076

NOTICE FILED DATE: 03/29/2023

RULE SUMMARY: Removes examination requirement and clarifies certificate of completion details.

CHANGES TO RULE:

818-021-0076
Continuing Education - Dental Therapists
(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.)¶
(c) Correspondence courses, videotapes, distance learning courses or similar self-study course, provided that the course ~~includes an examination and the dental therapist passes the examination~~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.¶
(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.
Statutory/Other Authority: ORS 679, ORS 679.603, ORS 679.609
Statutes/Other Implemented: ORS 679.603, ORS 679.609

ADOPT: 818-021-0084

NOTICE FILED DATE: 03/29/2023

RULE SUMMARY: Implementing a new rule to be in compliance with HB 4096 (2022), for temporary volunteer practice limited to 30 days or less per year

CHANGES TO RULE:

818-021-0084
Temporary Voluntary Practice Approval
(1) A dentist, dental therapist or dental hygienist may practice, without compensation and in connection with a coordinating organization or other entity, the health care profession that the health care practitioner is authorized to practice for a maximum of 30 days each calendar year without licensure requirement. Compensation is defined as something given or received as payment including but not limited to bartering, tips, monies, donations, or services.¶
(2) A dentist, dental therapist or dental hygienist is not required to apply for licensure or other authorization from the Board in order to practice under this rule.¶
(3) To practice under this rule, a dentist, dental therapist or dental hygienist shall submit, at least 10 days prior to commencing practice in this state, to the Board:¶
(a) Out-of State volunteer application;¶
(b) Proof that the practitioner is in good standing and is not the subject of an active disciplinary action;¶
(c) An acknowledgement that the practitioner may provide services only within the scope of practice of the health care profession that the practitioner is authorized to practice and will provide services pursuant to the scope of practice of Oregon or the health care practitioner's licensing agency, whichever is more restrictive;¶
(d) An attestation from dentist, dental therapist or dental hygienist that the practitioner will not receive compensation for practice in this state;¶
(e) The name and contact information of the dental director of the coordinating organization or other entity through which the practitioner will practice; and¶
(f) The dates on which the practitioner will practice in this state.¶
Failure to submit (a)-(e) above will result in non-approval.¶
(4) Misrepresentation as to information provided in the application for the temporary practice approval may be grounds to open a disciplinary investigation that may result in discipline under OAR 818-012-0060.¶
(5) Practitioner acknowledges they are subject to the laws and rules governing the health care profession in Oregon and that the practitioner is authorized to practice and are subject to disciplinary action by the Board.¶
(6) A practitioner who is authorized to practice in more than one other jurisdiction shall provide to the Board proof from the National Practitioner Data Bank and their other state licensing Board that the practitioner is in good standing and not subject to any active disciplinary actions in any jurisdiction in which the practitioner is authorized to practice.
Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679

AMEND: 818-042-0040

NOTICE FILED DATE: 03/29/2023

RULE SUMMARY: Clarifies that dental assistants can perform teeth whitening.

CHANGES TO RULE:

818-042-0040
Prohibited Acts
No licensee may authorize any dental assistant to perform the following acts:¶
(1) Diagnose or plan treatment.¶
(2) Cut hard or soft tissue.¶
(3) Any Expanded Function duty (OAR 818-042-0070 and OAR 818-042-0090) or Expanded Orthodontic Function duty (OAR 818-042-0100) or Restorative Functions (OAR 818-042-0095 or Expanded Preventive Duty (OAR 818-042-0113 and OAR 818-042-0114) or Expanded Function Anesthesia (OAR 818-042-0115) without holding the appropriate certification.¶
(4) Correct or attempt to correct the malposition or malocclusion of teeth except as provided by OAR 818-042-0100.¶
(5) Adjust or attempt to adjust any orthodontic wire, fixed or removable appliance or other structure while it is in the patient's mouth.¶
(6) Administer any drug except as allowed under the indirect supervision of a Licensee, such as fluoride, topical anesthetic,-desensitizing agents, topical tooth whitening agents, over the counter medications per package instructions or drugs administered pursuant to OAR 818-026-0050(5)~~(a)~~, OAR 818-026-0060(12), OAR 818-026-0065(12), OAR 818-026-0070(12) and as provided in OAR 818-042-0070, OAR 818-042-0090 and OAR 818-042-0115.¶
(7) Prescribe any drug.¶
(8) Place periodontal packs.¶
(9) Start nitrous oxide.¶
(10) Remove stains or deposits except as provided in OAR 818-042-0070.¶
(11) Use ultrasonic equipment intra-orally except as provided in OAR 818-042-0100.¶
(12) Use a high-speed handpiece or any device that is operated by a high-speed handpiece intra-orally except as provided in OAR 818-042-0095, and only for the purpose of adjusting occlusion, contouring, and polishing restorations on the tooth or teeth that are being restored.¶
(13) Use lasers, except laser-curing lights.¶
(14) Use air abrasion or air polishing.¶
(15) Remove teeth or parts of tooth structure.¶
(16) Cement or bond any fixed prosthesis or orthodontic appliance including bands, brackets, retainers, tooth moving devices, or orthopedic appliances except as provided in OAR 818-042-0100.¶
(17) Condense and carve permanent restorative material except as provided in OAR 818-042-0095.¶
(18) Place any type of retraction material subgingivally except as provided in OAR 818-042-0090.¶
(19) Apply denture relines except as provided in OAR 818-042-0090(2).¶
(20) Expose radiographs without holding a current Certificate of Radiologic Proficiency issued by the Board (OAR 818-042-0050 and OAR 818-042-0060) except while taking a course of instruction approved by the Oregon Health Authority, Oregon Public Health Division, Office of Environmental Public Health, Radiation Protection Services, or the Oregon Board of Dentistry.¶
(21) Use the behavior management techniques known as Hand Over Mouth (HOM) or Hand Over Mouth Airway Restriction (HOMAR) on any patient.¶
(22) Perform periodontal assessment.¶
(23) Place or remove healing caps or healing abutments, except under direct supervision.¶
(24) Place implant impression copings, except under direct supervision.¶
(25) Any act in violation of Board statute or rules.
Statutory/Other Authority: ORS 680, ORS 679
Statutes/Other Implemented: ORS 679.020, 679.025, 679.250

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

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TEMPORARY ADMINISTRATIVE ORDER
INCLUDING STATEMENT OF NEED & JUSTIFICATION

OBD 2-2023
CHAPTER 818
OREGON BOARD OF DENTISTRY

FILED
07/10/2023 9:04 AM
ARCHIVES DIVISION
SECRETARY OF STATE
& LEGISLATIVE COUNSEL

FILING CAPTION: The Board is increasing some fees which are included in the approved 2023-25 Budget.

EFFECTIVE DATE: 08/01/2023 THROUGH 01/05/2024

AGENCY APPROVED DATE: 06/16/2023

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Filed By:
Stephen Prisby
Rules Coordinator

NEED FOR THE RULE(S):

The Oregon Board of Dentistry is primarily funded by application fees and license renewal fees paid to it. A fee increase us needed to fund its continuing operations.

JUSTIFICATION OF TEMPORARY FILING:

The 2023 Legislative Session ended close to the start of the new 2023-2025 Biennium. A temporary rule is allowed so the Oregon Board of Dentistry (OBD) can implement fee increases that were approved by the Legislature with HB 5011. The rule will be made permanent before the expiration date of the temporary rule. The fee increases are needed to cover the ongoing costs and expenses of the OBD. The last fee increase was in 2015 . The OBD is funded primarily (96%) by its Licensees, so the fee increase is needed and justified to cover the OBD's related expenses in its operation.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

The OBD's 2023-2025 Budget document, budget materials presented in board meeting and presentations to the Oregon Legislature.

AMEND: 818-001-0087

RULE SUMMARY: The OBD has authorization from the Legislature to adopt and raise fees. The fee increases are included in the OBD budget bill, HB 5011 (2023). The fee increases are needed to continue funding the OBD at its current service level and through the 2023 -2025 budget biennium. There have been no fee increases since 2015 and the OBD is supported primarily (96% of all revenue) from fees collected from applicants and its licensees. This temporary rule will be made permanent before the end of 2023.

CHANGES TO RULE:

818-001-0087
Fees ¶

(1) The Board adopts the following fees:¶

(a) Biennial License Fees:¶
(A) Dental -$~~39~~44~~0~~;¶
(B) Dental - retired - $0;¶
(C) Dental Faculty - $3~~3~~8~~5~~;¶
(D) Volunteer Dentist - $0;¶
(E) Dental Hygiene -$2~~30~~55;¶
(F) Dental Hygiene - retired - $0;¶
(G) Volunteer Dental Hygienist - $0;¶
(H) Dental Therapy - $2~~30~~55;¶
(I) Dental Therapy - retired - $0;¶
(b) Biennial Permits, Endorsements or Certificates:¶
(A) Nitrous Oxide Permit - $40;¶
(B) Minimal Sedation Permit - $75;¶
(C) Moderate Sedation Permit - $75;¶
(D) Deep Sedation Permit - $75;¶
(E) General Anesthesia Permit - $140;¶
(F) Radiology - $75;¶
(G) Expanded Function Dental Assistant - $50;¶
(H) Expanded Function Orthodontic Assistant - $50;¶
(I) Instructor Permits - $40;¶
(J) Dental Hygiene Restorative Functions Endorsement - $50;¶
(K) Restorative Functions Dental Assistant - $50;¶
(L) Anesthesia Dental Assistant - $50;¶
(M) Dental Hygiene, Expanded Practice Permit - $75;¶
(N) Non-Resident Dental Background Check - $100.00;¶
(c) Applications for Licensure:¶
(A) Dental - General and Specialty - $~~3~~4~~4~~5;¶
(B) Dental Faculty - $~~3~~4~~0~~5;¶
(C) Dental Hygiene - $2~~1~~8~~0~~;¶
(D) Dental Therapy - $2~~1~~8~~0~~;¶
(E) Licensure Without Further Examination - Dental~~,~~ - $890.¶
(F) Licensure Without Further Examination - Dental Hygiene and Dental Therapy - $~~790.~~820¶
(d) Examinations:¶
(e) Jurisprudence - $0;¶
(f) Duplicate Wall Certificates - $50.¶
(2) Fees must be paid at the time of application and are not refundable.¶
(3) The Board shall not refund moneys under $5.01 received in excess of amounts due or to which the Board has no legal interest unless the person who made the payment orthe person's legal representative requests a refund in writing within one year of payment to the Board.
Statutory/Other Authority: ORS 679, 680
Statutes/Other Implemented: ORS 293.445, 679.060, 679.115, 679.120, 679.250, 680.050, 680.075, 680.200, 680.205, 679.615

Oregon
Tina Kotek, Governor

OBD Executive Director
Stephen Prisby

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: August 14, 2023

TO: OBD Board Members

FROM: OBD Executive Director Stephen Prisby

SUBJECT: Schedule Public Rulemaking Hearing

The OAR 818-001-0087 Fee rule was updated with approved fee increases and amended as a temporary rule at the June Board Meeting with an effective date of August 1, 2023.

The rule needs to be converted to a permanent rule before it expires on January 5, 2024. The rulemaking process takes various steps even though the fee increase is in the OBD's approved 2023 -2025 budget.

I recommend the Board hold a virtual public rulemaking hearing on this rule on October 4th so that the necessary Secretary of State filing and notices can be made per the OBD's regular rulemaking steps.

The Board will then have it on its October 27, 2023 Board Meeting agenda to take action and vote to make the rule permanent.

Oregon
Tina Kotek, Governor

OBD Executive Director
Stephen Prisby

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: August 7, 2023

TO: OBD Board Members

FROM: Stephen Prisby, OBD Executive Director

SUBJECT: Review and Approve amendment to OBD-DANB Agreement

The DANB agreement and proposed amendment are provided for your review and recommended approval.

Funding approved by Legislature In approved OBD Budget Bill (HB 5011)

Package 801: LFO Analyst Adjustments. This package includes several revenue and expenditure adjustments totaling an Other Funds expenditure limitation increase of $46,024 and a reduction of 0.38 FTE. The expenditure adjustments include the elimination of one vacant Business Operations Manager 2 (1.00 FTE) position, establishes funding for one previously unbudgeted Health Care Investigator (1.00 FTE), and reduces one Health Care Investigator from 1.00 FTE to 0.50 FTE beginning on January 1, 2024 (a reduction of 0.38 FTE in the 2023-25 biennium). The package also increases Other Funds expenditure limitation by $84,065 to outsource Dental Assistant Certifications to the Dental Assistant National Board (DANB); and includes an increase of $123,255 of Other Funds revenue received from DANB for Dental Assistant Certifications; and an increase of $365,150 Other Funds revenue for a fee increase across all fee types, effective July 1, 2023, to help support Package 200 and allow for the board to maintain an ending balance equivalent to three months of operating funds.

The OBD (which utilizes the OMB for accounting, budget and financial transactions) are all queued up to record the DANB transactions. OMB will make the appropriate entries to record the DANB revenue and the offsetting expense as per legislative directive.

The OBD & OMB has already started receiving monthly reports from DANB showing the monthly expense which will be recorded so entries can be recorded on OBD accounting and budget systems and documented appropriately

From: Katherine Landsberg <klandsberg@danb.org>
Sent: Thursday, June 22, 2023 2:38 PM
To: PRISBY Stephen * OBD <Stephen.PRISBY@obd.oregon.gov>
Cc: Aaron White <awhite@danb.org>
Subject: DANB Contract and Proposed Amendment

Dear Stephen,

As we discussed, I am sending you a copy of the DANB-OBD agreement executed in 2019, along with the amendment we are proposing to extend the term of that agreement through to June 30, 2025.

Please let me know if you have any questions.

My best,
Katherine

Katherine Landsberg
Director, Government Relations
klandsberg@danb.org
312-280-3431

OREGON BOARD OF DENTISTRY - DENTAL ASSISTING NATIONAL BOARD, INC.

AGREEMENT FOR THE PROVISION OF TESTING AND CERTIFICATE SERVICES

This Agreement is made by and between the Dental Assisting National Board, Inc. (DANB), hereafter called "DANB," an Illinois not-for-profit corporation that develops and administers testing programs from its offices at 444 N. Michigan Ave., Suite 900, Chicago, Illinois 60611 and the Oregon Board of Dentistry, hereafter called the "State," with offices at 1500 SW 1st Ave., Ste. # 770, Portland, OR 97201.

In consideration of the mutual promises and covenants between the parties contained in this Agreement, the sufficiency of which is hereby agreed to by the parties, and intending to be legally bound hereby, the parties agree as follows:

1. Description of the Services. DANB shall provide the Services for the State as described in this Section:

   a. Exams/Items

      (1) The Oregon Basic Dental Assisting (ORB) exam, containing between 100 and 125 multiple-choice items; and

      (2) The Oregon Expanded Functions – General Dental Assisting (ORXG) exam, containing between 90 and 100 multiple-choice items; and

      (3) The Oregon Expanded Duties – Orthodontic Dental Assisting (ORXO) exam, containing between 100-125 multiple-choice items, are the subject of this Agreement.

   b. Exam Development

      (1) DANB's Expanded Functions Dental Assistant (EFDA) exam committee, led by DANB's psychometric staff, will review the current exams, draft new items and recommend new exam versions based on the state's exam blueprint at least every five to seven years (or more often if the State requests changes due to updates to state requirements), for the exams in 1.a. DANB recommends that there be at least 5 total items to test each domain area of the exam blueprint to provide meaningful data to candidates about performance in each area if they fail the exam. Each time the exam is updated, the EFDA exam committee will also conduct a standard setting study and recommend a pass point to the State.

      (2) To develop the exam, the State will provide the approved exam blueprint(s) as requested by DANB or when updates are required based on changes to the state dental practice act.

      (3) Upon development of new versions of the exams in 1.a., DANB psychometric staff will meet with representatives appointed by the State by webinar for the State to provide review and approval of the new exam versions, exam items and exam pass points.

(4) A final review of the exams in 1.a. will be conducted by DANB's copyeditor prior to publication. DANB will maintain the existing item pool and related statistics on its computerized item banking system.

c. Issuance of State-Specific Certificates

DANB currently issues and will continue to issue the certificates for items1-11 below. Note: DANB began issuing the certificates for items 4-11 on July 1, 2016.

(1) Oregon Radiologic Proficiency (ORRad)

(2) Oregon Expanded Functions Dental Assistant (EFDA)

(3) Oregon Expanded Functions Orthodontic Dental Assistant (EFODA)

(4) Oregon Expanded Functions Orthodontic Dental Assistant (EFODA) by credential

(5) Oregon Expanded Functions Dental Assistant (EFDA) by credential

(6) Oregon Radiologic Proficiency by credential (ORRad)

(7) Oregon Expanded Functions Dental Assistant with Restorative Functions add-on (EFDA-RF)

(8) Oregon Expanded Functions Preventative Dental Assistant (EFPDA)

(9) Oregon Anesthesia Dental Assistant (AnA)

(10) Oregon Anesthesia Dental Assistant with IV Therapy (AnA-IV)

(11) Future certificates that the State approves and that DANB approves as well

d. Exam and Certification Applications

(1) DANB will develop annual exam and certificate applications. The State will provide final approval. Candidates can apply for, cancel and reschedule the exams and apply for certificates through DANB's website or submit paper applications by mail/fax.

(2) All DANB policies related to processing exam and certificate applications, managing candidate contact, and administering the exams will apply to the Oregon state-specific exams (listed in section 1.a.) and to the state-specific certificates issued by DANB on behalf of the State (listed in section 1.c.) Such DANB policies and procedures will be included in the candidate handbook and online and will be available to the State for its annual exam and certificate application packets review.

(3) DANB will establish, and may from time to time change, application processing fees and other related fees (including but not limited to exam cancellation and rescheduling fees) to be paid by candidates, outside of the specific exam fee. The specific Oregon state-specific exam and certificate fees are noted in Section 2 of this Agreement.

(4) The State will establish eligibility requirements that must be met to take the exams and earn the certificates listed in this Agreement.

(5) DANB will review and process exam and certificate applications, ensuring that each candidate has met the State-established eligibility requirements and paid the current application fees. DANB will also process and assess fees associated with requests from exam candidates to cancel their exam, extend the window within which the exam appointment can be made, etc. These fees will be equal to the fees that DANB charges its DANB national exam candidates for the same services.

d. Candidate Communication

(1) At the discretion or direction of the State, all inquiries regarding candidate eligibility and requirements will be directed to DANB. DANB will respond to candidate inquiries regarding test sites, exam administration and scoring. DANB's toll-free number 1-800-367-3262 and e-mail address danbmail@danb.org will be available for this program.

e. Exam Administration

(1) DANB will, through its contractual relationship with a testing vendor, support the proctored administration of the exams in 1.a. through a computer test delivery network employing security measures that meet or exceed industry standards. All candidates must present DANB-accepted identification at the test center, in order to be admitted to test.

(2) DANB will notify candidates when their applications have been processed and they are authorized to take the exam(s). Candidates must provide an email address as notifications will be made by email and will include instructions on how to schedule an exam appointment through the DANB website. Candidates will be provided with a 60-day period during which time their testing must occur.

(3) DANB and its testing vendor will make appropriate arrangements for reasonable testing accommodations that may be necessary to comply with the Americans with Disabilities Act.

(4) All improper behavior by a candidate relating in any way to the Oregon exams, whether occurring before, during or after an exam appointment will be reported by testing vendor personnel to DANB. Such incidents will be handled at the sole discretion of DANB pursuant to DANB's Discipline Policy and Procedures, and the State will be notified of any sanctions that may be imposed.

f. Exam Scoring and Score Reporting

(1) Candidates will receive printed preliminary exam results on-site at the testing center.

(2) At the State's discretion or direction, DANB will send, and/or post to the candidate's online DANB account, official exam results and certificates for each candidate.

(3) DANB will provide the State with monthly lists of passing and failing Oregon exam candidates, along with an annual cumulative listing, and a list of candidates who earned certificates listed in 1.c.

(4) Candidates may request duplicate exam results for five (5) years from the date the exam was administered and a duplicate certificate for the duration of this Agreement.

g. Retention

(1) DANB will maintain computerized records of candidates' performance on the exams indefinitely.

2. Fees paid to DANB by the exam/certificate candidates

a. Each exam candidate will pay a per-application exam fee according to the following schedule:

Term Period	ORB Exam Fee	ORXG Exam Fee	ORB & ORXG Administered Together Exam Fee	ORXO Exam Fee	ORB & ORXO Administered Together Exam Fee
Jan. 1, 2019 – Dec. 31, 2021	$275	$250	$350	$250	$350

Note: Exam Fees include a $75 nonrefundable application processing fee

b. Each certificate candidate will pay a per-application certificate fee according to the following schedule:

Term Period	ORRad	EFDA	EFODA	ORRad by Credential	EFDA by Credential	EFODA by Credential
July 1, 2016 – Dec. 31, 2021	$50	$50	$50	**$150** Application fee $75 Certificate fee $75	**$150** Application fee $100 Certificate fee $50	**$150** Application fee $100 Certificate fee $50

Term Period	EFDA-RF	EFPDA	AnA	AnA-IV
July 1, 2016 – Dec. 31, 2021	$50	$50	**$75** Application fee $25 Certificate fee $50	**$75** Application fee $25 Certificate fee $50

3. Fees paid to the State by DANB. DANB agrees to pay the State a fee of $15 for every certificate listed in 1.c. issued by DANB to the candidate.

4. Ownership Rights.

   a. The State hereby expressly agrees that all rights to and interests in any items written for the Oregon exams (listed in 1.a.) and any and all parts thereof and any materials produced by DANB prior to or under this Agreement, including but not limited to copyrights, are and will remain the sole property of DANB. The State hereby expressly agrees that all research data, manuscripts, marketing lists, data bases, diagrams, charts, tables, and other similar lists and materials obtained or developed by DANB prior to or as part of the Services are and will remain the sole property of DANB, and that any such materials in the possession of the State will be surrendered to DANB by the State immediately upon DANB's written request.

   b. DANB intellectual property will not be used by the State for any purpose other than those expressly allowed by the terms of this Agreement. Any use of DANB trademarks shall conform with DANB's Trademark Usage Guidelines, attached to this Agreement as Appendix A.

5. Confidentiality. The State hereby understands and agrees that the content of the Oregon exams (listed in 1.a.) is proprietary and strictly confidential information. The State understands and agrees that it will not release or disclose, directly or indirectly, in writing or orally, any exam item or any part of any exam item from the Oregon exams (listed in 1.a.) to any person or entity. The State further understands and agrees that the unauthorized receipt, retention, possession, copying or disclosure of any Oregon exam materials (listed in 1.a.), including but not limited to the content of any exam item, before, during, or after the administration of an Oregon exam (listed in 1.a.) may result in legal action.

6. Notices and Other Communications. Any notice which any party hereto gives to the other party hereunder shall be in writing and shall be deemed given when delivered in person to a representative of the party, or upon receipt after deposited in the United States certified or registered mail, return receipt requested or upon receipt if sent by recognized, national, overnight express mail, addressed to the party, at the address of such party set forth below, or at such other address as the party to whom notice is to be given has specified by notice hereunder to the party seeking to give such notice:

If to the State:	Stephen Prisby Executive Director Oregon Board of Dentistry 1500 SW 1st Ave., Ste. # 770 Portland, OR 97201
If to DANB:	Cynthia C. Durley, MEd, MBA Executive Director Dental Assisting National Board, Inc. 444 N. Michigan Avenue, Suite 900 Chicago, IL 60611

7. Representations and Warranties. The State represents and warrants that all exam items and other materials provided by the State to the DANB under this Agreement are original, or that appropriate permission to use such materials has been obtained, and that DANB's use of such materials in the delivery of the Oregon exams (listed in 1.a.) will not infringe any copyright or other proprietary right of any person, organization, corporation or agency. The responsibility for assuring that no infringement shall occur in connection with materials provided by the State rests solely and exclusively with the State.

8. Term and Termination.

   a. The term of this Agreement shall commence upon signature by duly authorized representatives of both DANB and the State and shall continue through December 31, 2021 unless terminated earlier upon written notice by either party as described below.
   b. Either party may terminate this agreement upon twelve (12) months written notice to the other party.

The dates and fees in this Agreement are contingent upon the execution of this Agreement by duly authorized representatives of both DANB and the State by April 1, 2019.

DENTAL ASSISTING NATIONAL BOARD, INC.

By: Cynthia C. Durley, MEd, MBA
Name

Title: Executive Director

Cynthia C Durley
Signature

2/28/19
Date

OREGON DENTAL BOARD

By: Stephen Prisby
Name

Title: Executive Director

Stephen Prisby
Signature

3/13/19

Amendment to Professional Services Contract

1. This Amendment modifies the Agreement for the Provision of Testing and Certificate Services, hereafter called "Agreement" signed by the Oregon Board of Dentistry (hereafter "State") on March 13, 2019, and by the Dental Assisting National Board, Inc. (hereafter "DANB") on February 28, 2019.

2. The Agreement is hereby amended as follows:

   Page 1: 1.a. Exam/Items
   Add a new subsection (4):
   (4) Notwithstanding the foregoing, the ORB exam may be discontinued by mutual agreement of the parties prior to the end of the term of the Agreement.

   Page 5: Section 3 – Fees paid to the State by DANB
   DANB agrees to pay the State, each month, a fee of $15 for every certificate listed in 1.c. issued by DANB to candidates. DANB agrees to submit to the State, at the time of payment, a summary that contains the number of individuals earning each certificate type (as listed in 1.c.), total per unit expense for each certificate type reflecting DANB's fulfillment of its services, and the cumulative expenses reflecting DANB's fulfillment of its services for that month.

   Page 5: Section 6 – Notices and Other Communications
   Notice to DANB shall be changed to reflect the following:

   Laura Skarnulis
   Chief Executive Officer
   Dental Assisting National Board, Inc.
   444 N. Michigan Avenue, Suite 900
   Chicago, IL 60611

   Page 6: Section 8a – Term and Termination
   The term of the Agreement shall be the period of January 1, 2022, through June 30, 2025, unless terminated earlier to comply with changes to Oregon statute, in which event the State shall notify DANB in writing of such termination. The agreement will automatically renew for one period of six months, unless terminated earlier to comply with changes to Oregon statute or a new agreement is entered into by both parties.

   Page 6: Add New Section 9
   9. Severability
   If any provision of this Agreement shall be held or made invalid by a court decision, statute, rule or otherwise, the remainder of this Agreement shall not be affected thereby.

3. Except as expressly amended above, all other terms and condition of the Agreement are still in full force and effect. DANB certifies that the representations, warranties and certifications contained in the Agreement are true and correct as of the effective date of this Amendment and with the same effect as though made at the time of this Amendment.

By signature below, the individual signing on behalf of DANB certifies under penalty of perjury that s/he is authorized to act on behalf of DANB, and the individual signing on behalf of the State certifies under penalty of perjury that s/he is authorized to act on behalf of the State.

DANB:	State:
By: _____	By: _____
Name: Laura Skarnulis	Name: _____
Title: Chief Executive Officer	Title: _____
Date: _____	Date: _____

STANDARD PROTOCOLS FOR VIOLATIONS OF THE DENTAL PRACTICE ACT AND GENERAL CONSENT ORDERS

In keeping with its obligation and mission to promote quality oral health care and protect all communities in the State of Oregon by equitably and ethically regulating dental professionals, the Oregon Board of Dentistry (OBD/Board) has updated the following recommended protocols for the most common violations of the Dental Practice Act.

The Board carefully considers the totality of the facts and circumstances in each individual case, with the safety of the public being paramount. To the extent not inconsistent with public protection, disciplinary actions shall be calculated to aid in the rehabilitation of the licensee.

These protocols serve as guidelines, and the Board acknowledges that there may be departures in individual cases depending upon mitigating or aggravating circumstances.

CIVIL PENALTIES

Licensee shall pay a $(**XX**) civil penalty, by a 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 (**XX**) days of the effective date of the Order.

> **NOTE:** The Board will allow licensed dentists a 30-day payment period for each civil penalty increment of $2,500.00.
>
> **NOTE:** The Board will allow licensed dental therapists a 30-day payment period for each civil penalty increment of $500.00.
>
> **NOTE:** The Board will allow licensed dental hygienists a 30-day payment period for each civil penalty increment of $500.00.

REFUND AND/OR RESTITUTION PAYMENTS

Licensee shall pay $(**XX**) *refund or restitution*, by a single payment, in the form of a cashier's, bank, or official check made payable to patient (PATIENT INITIALS) and delivered to the Board offices within (**XX**) days of the effective date of the Order.

> **NOTE:** The Board will allow licensed dentists a 30-day payment period for each restitution and/or refund increment of $2,500.00.
>
> **NOTE:** The Board will allow licensed dental therapists a 30-day payment period for each civil penalty increment of $500.00.
>
> **NOTE:** The Board will allow licensed dental hygienists a 30-day payment period for each civil penalty increment of $500.00.
>
> REFUND: To restore money paid by patient for treatment.
>
> RESTITUTION: Money to repair unacceptable treatment.

REIMBURSEMENT PAYMENTS

Licensee shall provide the Board with documentation verifying reimbursement payment made to (COMPANY NAME), patient (PATIENT INITIALS) insurance carrier, within (**XX**) days of the effective date of the Order.

> **NOTE:** The Board will allow licensed dentists a 30-day payment period for each reimbursement increment of $2,500.00.
>
> **NOTE:** The Board will allow licensed dental therapists a 30-day payment period for each reimbursement increment of $500.00.
>
> **NOTE:** The Board will allow licensed dental hygienists a 30-day payment period for each reimbursement increment of $500.00.

RESTRICTIONS

Licensee shall abide by any practice restriction(s) imposed by the Board until the Licensee receives written notice from the Board that the restriction(s) have been removed.

> **NOTE:** If a license becomes inactive (expired, retired, etc.) while restriction(s) are in place, and the license is subsequently reinstated, the restriction(s) shall remain in place pending further order of the Board.

REMEDIAL CONTINUING EDUCATION (CE) – BOARD ORDERED

Licensee shall submit documentation to the Board verifying successful completion of (**XX**) hours of (**XX**) (OPTIONS: Board approved, hands-on, mentored), CE in the area of (**XX**) within (**XX**) (OPTIONS: years, months) of the effective date of the Order, unless the Board grants an extension, and advises Licensee in writing. This ordered CE is in addition to the CE required for the licensure period(s) (**XX**) (i.e. April 1, XXXX to March 31, XXXX, or October 1, XXXX to September 30, XXXX).

FALSE/INACCURATE CERTIFICATION OR STATEMENTS ON DOCUMENTS OR RECORDINGS

Licensee may be disciplined and required to pay a $(**XX**) civil penalty, by a 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 (**XX**) days of the effective date of the Order.

> **NOTE:** The civil penalties are $2,000.00 for dentists, $1,000.00 for dental therapists, and $1,000.00 for dental hygienists.

FAILURE TO MEET CONTINUING EDUCATION (CE) STANDARDS

> **NOTE:** If Licensee completes <100% of the required CE, the Board will request a letter of explanation, review extenuating circumstances, and audit an additional two-year cycle. Discipline may be recommended after review of circumstances.
>
> **NOTE (ANESTHESIA PERMIT HOLDERS):** If Licensee fails to provide the CE required to maintain their anesthesia permit (i.e. for a CE audit), the Licensee will be notified that the permit has been removed from their license and will not be added back onto their license until documentation is provided to and accepted by the Board.

FAILURE TO MAINTAIN BASIC LIFE SUPPORT BASIC LIFE SUPPORT (BLS) FOR HEALTHCARE PROVIDERS

If Licensee fails to maintain BLS for Healthcare Providers for any period of time, the Board will request a letter of explanation and review extenuating circumstances. Licensee may be disciplined and may be required to pay a $(**XX**) civil penalty, by a 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 (**XX**) days of the effective date of the Order.

NOTE: If Licensee fails to maintain BLS for Healthcare Providers for one day to three months, discipline may be recommended after review of circumstances.

NOTE: If Licensee fails to maintain BLS for Healthcare Providers for three months to six months, the Licensee may be reprimanded and required to pay a $500.00 (DENTIST) civil penalty, a $250.00 (DENTAL THERAPIST) civil penalty, or a $250.00 (DENTAL HYGIENIST) civil penalty.

NOTE: If Licensee fails to maintain BLS for Healthcare Providers for longer than six months, the Licensee may be reprimanded and required to paya $1,000.00 (DENTIST) civil penalty, a $500.00 (DENTAL THERAPIST) civil penalty, or a $500.00 (DENTAL HYGIENIST) civil penalty.

NOTE (ANESTHESIA PERMIT HOLDERS): If an anesthesia permit holder fails to maintain BLS for Healthcare Providers for longer than six months, the Licensee may be reprimanded and pay a $1,500.00 (DENTIST) civil penalty or a $1,000.00 (DENTAL HYGIENIST) civil penalty. If Licensee fails to provide or maintain a current BLS for Healthcare Providers, the licensee will be notified that the permit has been removed from their license and will not be added back onto their license until documentation is provided to and accepted by the Board.

FAILURE TO MAINTAIN ADVANCED CARDIOVASCULAR LIFE SUPPORT (ACLS) AND/OR PEDIATRIC ADVANCED LIFE SUPPORT (PALS) CERTIFICATION.

If Licensee who is required to maintain an ACLS and/or PALS certification fails to maintain ACLS and/or PALS for any period of time, the Board will request a letter of explanation and review extenuating circumstances. Licensee may be disciplined and may be required to pay a $(**XX**) civil penalty, by a 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 (**XX**) days of the effective date of the Order.

NOTE: If Licensee fails to provide or maintain ACLS and/or PALS for one day to three months, discipline may be recommended after review of circumstances.

NOTE: If Licensee fails to provide or maintain ACLS and/or PALS for longer than three months, Licensee may be reprimanded and required to pay at minimum a $1,500.00 civil penalty.

NOTE: (ANESTHESIA PERMIT HOLDERS): If an anesthesia permit holder who is required to maintain an ACLS and/or PALS certification fails to provide or maintain a current ACLS and/or PALS, the licensee will be notified that the permit has been removed from their license and will not be added back on until documentation is provided to and accepted by the Board.

PRACTICING WITHOUT A CURRENT LICENSE

Licensee may be disciplined and required to pay a $(**XX**) civil penalty, by a 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 (**XX**) days of the effective date of the Order.

NOTE: A licensed dentist, who practiced any number of days without an active license will be issued a Notice of Proposed Disciplinary Action and offered a Consent Order incorporating a reprimand and a requirement to pay at minimum a $2,000.00 civil penalty.

NOTE: A licensed dental therapist who practiced any number of days without an active license or without a valid Collaborative Agreement, will be issued a Notice of Proposed Disciplinary Action and offered a Consent Order incorporating a reprimand and a requirement to pay at minimum a $1,000.00 civil penalty.

NOTE: A licensed dental hygienist who practiced any number of days without an active license will be issued a Notice of Proposed Disciplinary Action and offered a Consent Order incorporating a reprimand and requirement to pay at minimum a civil penalty of $1,000.00.

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

Licensee shall be disciplined and required to pay a $(**XX**) civil penalty, by a 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 (**XX**) days of the effective date of the Order.

NOTE: The civil penalties are $2,000.00 for the first offense. Increased civil penalties may be assessed in the event of repeated or egregious offenses.

FAILURE TO RESPOND WITHIN TEN DAYS TO A BOARD REQUEST FOR INFORMATION

Licensee may be disciplined and required to pay a $(**XX**) civil penalty, by a 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 (**XX**) days of the effective date of the Order.

> **NOTE:** The Board may issue a Notice of Proposed Disciplinary Action and offer a Consent Order, incorporating a reprimand and a $1,000.00 civil penalty, to a licensed dentist, who fails to respond within ten days to a Board request for information.
>
> **NOTE:** The Board may issue a Notice of Proposed Disciplinary Action and offer a Consent Order, incorporating a reprimand and a $500.00 civil penalty, to a licensed dental therapist, who fails to respond within ten days to a Board request for information.
>
> **NOTE:** The Board may issue a Notice of Proposed Disciplinary Action and offer a Consent Order, incorporating a reprimand and a $500.00 civil penalty, to a licensed dental hygienist, who fails to respond within ten days to a Board request for information.

FAILURE TO CONDUCT WEEKLY BIOLOGICAL TESTING OF STERILIZATION DEVICES

Failures are calculated as a percentage of required biological monitoring, based on the number of weeks per calendar year that patients were scheduled, multiplied by the number of testing devices in use.

Licensee may be disciplined and required to pay a $(**XX**) civil penalty, by a 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 (**XX**) days of the effective date of the Order.

Licensee may be required to submit documentation to the Board verifying successful completion of (**XX**) hours of Board approved continuing education in the area of infection control within (**XX**) (OPTIONS: years, months) of the effective date of the Order. This ordered continuing education is in addition to the continuing education required for the licensure period(s) (**XX**) (i.e. April 1, XXXX to March 31, XXXX or October 1, XXXX to September 30, XXXX).

For a period of one year of the effective date of the Order, Licensee may be required to submit, on a quarterly basis, the results of the previous month's weekly biological monitoring testing of sterilization devices. Periods of time Licensee is not practicing in Oregon shall not apply to reduction of the one-year requirement.

NOTE: Failure to complete ≤5% of required biological monitoring testing within the previous calendar year and current year-to-date will result in a Letter of Concern.

NOTE: Failure to complete >5% to 10% of required biological monitoring testing within a calendar year will result in the issuance of a Notice of Proposed Disciplinary Action and an offer of a Consent Order incorporating a reprimand.

NOTE: Failure to complete >10% to 20% of required biological monitoring testing within a calendar year will result in the issuance of a Notice and an offer of a Consent Order incorporating a reprimand, a $3,000.00 civil penalty, two hours of Board approved continuing education in the area of infection control within (**XX**), and quarterly submission of spore testing results for a period of one year from the effective date of the Order.

NOTE: Failure to complete >20% of required biological monitoring testing within a calendar year will result in the issuance of a Notice and an offer of a Consent Order incorporating a reprimand, a $6,000.00 civil penalty, four hours of Board approved continuing education in the area of infection control within (**XX**), and quarterly submission of spore testing results for a period of one year from the effective date of the Order.

FAILURE TO REGISTER WITH THE PRESCRIPTION DRUG MONITORING PROGRAM (PDMP). Effective July 1, 2020.

Licensee may be disciplined and required to pay a $(**XX**) civil penalty, by a 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 30 days of the effective date of the Order.

> **NOTE:** Required date means the date that the rule became effective (July 1, 2020), the date of initial licensure in Oregon, or the date the licensee obtains a DEA number, whichever comes latest.
>
> **NOTE:** Failure to be registered with the PDMP for one day to three months from the required date may result in a Letter of Concern.
>
> **NOTE:** Failure to be registered with the PDMP for three months to six months from the required date may result in a reprimand.
>
> **NOTE:** Failure to be registered with the PDMP for longer than six months from the required date may result in a reprimand and a $1000.00 civil penalty.

STANDARD PROTOCOLS FOR CONSENT ORDERS
RELATED TO DIAGNOSED SUBSTANCE USE DISORDER

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

Licensee shall voluntarily enter the State's Health Professionals' Services Program (HPSP) and abide by all of the terms and conditions established by the HPSP vendor, per Oregon law ORS 676.

Licensee shall contact and initiate procedures to enter HPSP within one (1) business day of the effective date of this Order. Business days are defined as days Monday through Friday excluding holidays. Licensee understands that failure to enroll in HPSP will result in notification to the Board.

Licensee shall not apply for relief from these conditions within five years of the effective date of the Order, and must do so in writing. Periods of time Licensee is not practicing dentistry as a dentist in Oregon, or dental hygiene as a dental hygienist in Oregon, shall not apply to reduction of the five-year requirement.

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

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

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

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

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

Licensee shall waive any privilege with respect to any physical, psychiatric, or psychological evaluation or treatment in favor of the Board for the purposes of determining

compliance with this Order, or the need to modify this Order, and shall execute any waiver or release upon request of the Board.

Licensee shall submit to a Board approved, random, supervised, urinalysis, hair, or blood testing program, at Licensee's expense, with the frequency of the testing to be determined by the Board, but initially at a minimum of 36 random tests per year. Licensee shall arrange for the results of all tests, both positive and negative, to be provided promptly to the Board.

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

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

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

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

IF APPROPRIATE –

Licensee, agree to not order, store, inventory, audit, access, draw, administer, dispense, waste, or have unilateral access to any Scheduled controlled drugs for any clinic setting.

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

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

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

STANDARD PROTOCOLS FOR CONSENT ORDERS
SPECIFICALLY RELATED TO SEXUAL VIOLATIONS

SEX RELATED VIOLATIONS

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

Licensee shall not apply for relief from these conditions within five years of the effective date of the Order, and must do so in writing. Periods of time Licensee is not practicing dentistry as a dentist in Oregon, shall not apply to reduction of the five-year requirement.

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

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

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

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

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

Licensee shall report all arrests or interaction with law enforcement within 72 hours.

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

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

IF APPROPRIATE –

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

STANDARD PROTOCOLS FOR CONSENT ORDERS
REQUIRING CLOSE SUPERVISION

CLOSE SUPERVISION

For a period of at least (XX) months, Licensee shall only practice dentistry in Oregon under the close supervision of a Board approved, Oregon licensed dentist (Supervisor), in order to demonstrate that clinical skills meet the acceptable level of patient care. Periods of time Licensee does not practice dentistry as a dentist in Oregon, shall not apply to reduction of the (six) month requirement

Licensee will submit the names of any other supervising dentists for Board approval. Licensee will immediately advise the Board of any change in supervising dentists.

Licensee shall only treat patients when another Board approved Supervisor is physically in the office and shall not be solely responsible for emergent care.

The Supervisor will review and co-sign Licensee's treatment plans, treatment notes, and prescription orders.

Licensee will maintain a log of procedures performed by Licensee. The log will include the patient's name, the date of treatment, and a brief description of the procedure. The Supervisor will review and co-sign the log. Prior to the 15th of each month, Licensee will submit the log of the previous month's treatments to the Board.

For a period of two weeks, or longer if deemed necessary by the Supervisor, the Supervisor will examine the appropriate stages of dental work performed by Licensee in order to determine clinical competence.

After two weeks, and for each month thereafter for a period of six months, the Supervisor will submit a written report to the Board describing Licensee's level of clinical competence. At the end of six months, the Supervisor, will submit a written report attesting to the level of Licensee's competency to practice dentistry in Oregon.

At the end of the restricted license period, the Board will re-evaluate the status of Licensee's dental license. At that time, the Board may extend the restricted license period, lift the license restrictions, or take other appropriate action.

STANDARD PROTOCOLS – DEFINITIONS

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

STANDARD PROTOCOLS – PARAGRAPHS

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

Licensee shall successfully complete the Board/OAGD Mentor Program at Licensee's expense. Licensee will remain in the Mentor Program until such time as the mentor advises the Board that Licensee achieved an acceptable level of skill in the listed areas of XXX and the Board advises Licensee in writing that he met the provisions of this Order. Participation in the Mentor Program requires that Licensee successfully complete continuing education and/or engage in a study club, as recommended by the Mentor and move to adopt the Mentor's recommendations on treatment. In the event Licensee's mentor agreement ends prematurely, the Board may require an alternative education program for Licensee.

CORRESPONDENCE

From: Paula Hendrix <Paula.Hendrix@oit.edu>
Sent: Monday, June 26, 2023 1:35 PM
To: PRISBY Stephen * OBD <stephen.prisby@obd.oregon.gov>
Cc: HAYNES Teresa * OBD <teresa.haynes@obd.oregon.gov>
Subject: CRDTS examiner

Hello

This is Paula Hendrix (DH license H2229). I would like to request an approval from the Board of Dentistry to work as a dental hygiene examiner for CRDTS. I am currently an examiner for WREB. I received an approval in October of 2016 from you for that. Please let me know if you need anything else.

Thank you

Paula

Celebrating 75 Years Of Applied Learning

Paula J Hendrix
She/Her/Hers
Professor
Academic Program Director

Oregon Institute of Technology-Salem campus
4000 Lancaster Dr. NE, Salem, OR 97305
paula.hendrix@oit.edu | 503.399.4697 | www.oit.edu

Paula J. Hendrix, M.Ed., E.P.D.H.

paula.hendrix@oit.edu

EDUCATION

Master of Education, May 2013
Concordia University, Portland, Oregon
Major: Curriculum and Instruction
Minor: Career and Technical Education

Bachelor of Science, June 1985
Oregon Health Sciences University, Portland, Oregon
Major: Dental Hygiene

LICENSE/CERTIFICATIONS

Licensure	Expanded Practice Dental Hygienist, State of Oregon Endorsements in Local Anesthesia and Nitrous Oxide Sedation
Certifications	Healthcare Provider CPR/BLS certification-expires January 2025 Vocational Education Certificate --State of Washington, September 1996

Professional Affiliations

American Dental Hygienists' Association, 1985-present
American Dental Education Association, 2013-present
Association for Career and Technical Education, 2012-present

PROFESSIONAL EXPERIENCE

Dental Hygiene Program Director-Salem campus, Professor
Oregon Institute of Technology-September 2021-present

Dental Hygiene Program Director-Salem campus, Associate Professor
Oregon Institute of Technology~~July 2019-present
Oregon Tech Dental Hygiene at Chemeketa Community College
4000 Lancaster Dr. NE, Salem, Oregon 97305

- Courses Taught:
  - Clinical Dental Hygiene

- Periodontology I and II
- Pain Management I and II: Lecture and Lab
- Dental Anatomy
- Practice Management
- Sophomore Pre-Clinical Instructor
- Junior Clinical Instructor (Lead Instructor for maternity leave)

SUMMARY OF RESPONSIBILITIES:

- Maintain partnership, communication, and positive relationship with Chemeketa Community College
- Adhere to all Commission on Dental Accreditation (CODA) guidelines and requirements
- Department Quality Assurance Manager/OSHA Officer
- Maintain student and faculty records for CODA compliance and participate in accreditation process
- Collect and analyze data, assist in writing self-study reports and exhibits. Host visit for accreditation team
- Provide annual training for faculty in OSHA, HAZ-MAT, HIPAA, FERPA
- Hire, develop, motivate, evaluate, and manage full time and part time faculty
- Assign and coordinate workload for Salem faculty
- Hire and supervise administrative staff: Sterilization Manager, Office Manager, and Clinic Interpreter
- Deliver and manage curriculum including course scheduling and faculty assignments
- Develop and revise course curriculum in collaboration with department leaders
- Ensure opportunity for faculty calibration and collaboration (lead weekly staff meetings)
- Perform program assessments to align with department and university learning outcomes
- Manage Salem site budget including clinical budget and instructional budget
- Select and supervise student workers
- Oversee program facilities and equipment
- Develop and maintain relevant industrial and community partnerships
- Collaborate with community health partners to coordinate student external rotation site experiences
- Coordinate and update Clinical Affiliation Agreements in collaboration with Oregon Institute of Technology (OIT) legal department
- Conduct student advising, coordinating with Chemeketa advising department as needed
- Market and promote dental health careers and dental education programs within the community
- Recruit a diverse population of students and participate in student selection process
- Effectively communicate with a diverse population of students, faculty, and community partners
- Arrange and lead Advisory Board meetings
- 50% teaching duties (as Academic Director) to include traditional and non-traditional students

Master of Science in Allied Health-Associate Professor

Oregon Institute of Technology, Spring Term 2020-present

- Course Taught: ALH535: Assessment, Planning, Implementation and Evaluation for Healthcare Leaders

Academic Coordinator (Associate Dean) of Health Sciences

Chemeketa Community College~~July 2017-present

4000 Lancaster Dr. NE, Salem, Oregon 97305

SUMMARY OF RESPONSIBILITIES:

My primary responsibility is to serve as a role model; uphold the college's teaching and learning values; foster innovation, partnership and professionalism among faculty, staff, and students. My time is spent in the following ways:

- Regularly meet and work with faculty from Dental Assisting, Health Information Management, Pharmacy Technology, Nursing, Human Services, and Anesthesia Technology to assist with:
  - Motivation and encouragement
  - Accreditation planning and preparation
  - Curriculum development
  - Calculating schedule and workload
  - Budgeting
  - Strategic planning
  - Student issues
  - Personnel issues
  - Communicating emerging issues and changes
  - Bi-weekly program meetings
- Coordinate and update affiliation agreements with health science facilities and industry partners
- Serve as HIPAA Privacy Officer for the college
- Assist Program Chairs in coordinating all Allied Health Advisory committee meetings
- Attend all Allied Health Advisory Committee meetings
- Serve as liaison to Health Occupations high school programs through College Credit Now
- Work closely with the Dean of Health Sciences in managing all health science programs
- Perform yearly evaluations for all part-time faculty

Dental Hygiene Clinical Board Examiner

Western Regional Examining Board (WREB)~~February 2017-present

23460 N. 19th Ave. Ste.210

Phoenix, Arizona 85027

- Participate in examiner training and calibration workshops
- Examiner for Clinical Dental Hygiene exam 2-3 times per year in various locations

around the USA

Dental Hygiene Program Director-Salem campus, Assistant Professor
Oregon Institute of Technology~~August 2013-June 2017
Oregon Tech Dental Hygiene at Chemeketa Community College
4000 Lancaster Dr. NE, Salem, Oregon 97305

- Courses Taught: Clinical Dental Hygiene (First Year Lead), Periodontology, Ethics, Local Anesthesia

Dental Hygiene Instructor
Oregon Institute of Technology~~August 2011-August 2013
Oregon Tech Dental Hygiene at Chemeketa Community College
4000 Lancaster Dr. NE, Salem, Oregon 97305

- Courses Taught: Clinical Dental Hygiene (First Year Lead), Periodontology, Local Anesthesia

Registered Dental Hygienist
Scott Nicholson, DMD-- July 1999-December 2011
715 NW Elm St., Albany, Oregon 97321

Dental Hygiene Instructor & Dental Assisting Instructor
Lake Washington Technical College (Community College) --1996-1999
Kirkland, Washington

- Courses Taught: Anesthesia and Pain Management (including nitrous oxide sedation), Clinical Dental Hygiene (First Year Lead), Periodontology, Oral Anatomy (to Dental Hygiene and Dental Assisting students)
- Developed teaching skills and educational methodologies
- Assisted in accreditation process for dental hygiene program

Registered Dental Hygienist-Clinical and Restorative Dental Hygienist
Patricia Pauley, DDS --December 1988-January 1997
11605 132nd Avenue NE, Bellevue, WA 98034

Registered Dental Hygienist
Dalton Cooley, DMD --July 1985-November1988
715 NW Elm St.
Albany, Oregon 97321

TECHNOLOGY SKILLS

Microsoft Office Suite
Canvas and Blackboard Learning Management system
Fuse and Eaglesoft Dental Management Software systems

CURRENT CONTINUING EDUCATION (This is not a complete list, but are directly related to courses taught)

- 3/2023 ADEA Annual Session and Exhibition (9 CE)
- 1/26/23 Investigating Oral Irrigation Solutions Use and Education Practices Taught in Dental Hygiene Programs, Efficacy of Face Shields and Their Effect on the Blood-Oxygen levels Of Dental Hygiene Students, Report of the Educator's Forum and International Symposium on Dental Hygiene 2022 (2 CE)
- 1/24/2023 If Saliva Were Red (1 CE)
- 9/27/2022 Aligning Dental Hygiene Diagnosis with the 2018 AAP Classification (1 CE)
- 9/12/2022 The 2018 AAP/EFP Classification of Periodontal and Peri-Implant Diseases (3 CE)
- 8/5/2022 Dental Records: Best Practices for Information Management and Retention (2 CE)
- 8/4/2022 Meeting Accreditation Standards (2 CE)
- 8/4/2022 An Overview of Dental Anatomy (1 CE)
- July 7, 14, 21 LEAP Conference: The Empirical Art and Design of Dental Education (7 CE)
- 6/20/2022 The Hygienists Ultimate Guide: Injectable and Topical Anesthetics (1 CE)
- 6/2022 ADEA Allied Dental Program Directors' Conference (11.5 CE)
- 4/27/2022 WREB Local Anesthesia (3 CE)
- 4/7/22-5/15/22 Oregon Dental Conference
    - Nitrous Oxide and Oral Sedation (4 CE)
    - Vaccine Recommendations: Science, Success, and Myths (3 CE)
    - Infection Control and OSHA During and After Covid 19 (3 CE)
    - Calibrate Your Risk Radar (3 CE)
    - Save Lives: Suicide Prevention (2 CE)
    - The Future of Diversity in Dentistry (Cultural Competency) (3 CE)
    - Medical Emergencies (4 CE)
- 8/4/22 Meeting Dental Hygiene Accreditation Standards (2 CE)
- 12/2021-Teaching Local Anesthesia (2 CE)
- 9/2021-Faculty Calibration
- 9/2021-Oregon Tech Excellence in Teaching Conference
- 9-10/2021-RISE-A Conference for Clinic Coordinators (7 CE)
- 9/2021-Creating Effective Assessments Self-Paced Workshop (OLC)
- 6/2021 Oregon Tech Fuse Calibration (2 CE)
- 6/2021-Oral DNA: Advancing Wellness Through Salivary Diagnostics (1 CE)

- 6/2021-Local Anesthesia: Administration of Local Anesthetics (2 CE WREB)
- 6/2021-Dental Hygiene: Periodontal Assessment (6 CE WREB)
- 4/2021 Oregon Dental Conference: (17 CE):
  - AAP Classification of Periodontal Disease
  - Cultural Competency in Dentistry
  - The Heart of Health
  - Infection Control
  - Blaze Your Brain: How to Turn Negative Thoughts Into Positivity
  - Local Anesthesia: New Techniques, The Latest Trends, and Troubleshooting
- 1/2021-Head and Neck Manifestations of COVID-19: A Case Based Review (1 CE)
- 12/2020 -Medical Emergencies (4 CE)
- 11/2020-Aligning the Dental Hygiene Diagnosis with the 2018 AAP Classification of Periodontal and Peri Implant Diseases (1 CE)
- 10/2020-Dental Public Health Educator's Workshop including Pain Control and Clinic Coordination, 7 CE
- 10/2020-Canvas InstructureCon Conference
- 10/2020-ADEA Virtual Conference (7 CE)
- 10/2020 ODHA Virtual Conference: (12 CE)
  - The 2020 COVID-19 Pandemic: Safer Through Science
  - The Art of Listening: A Dental Professional's Principles for Success
  - The Dental Hygienist's Role in Diagnosis & Treatment of Erosive Tooth Wear & Bruxism
  - The Toxic Truth About Sugar Oral Health Implications of E-Cigarettes & Vaping
  - Don't Get Caught with your Pants Down: New Dental Products Review
  - Lasers in the Hands of Dental Hygienists
- 9/2020-Solutions to Generational Friction, 1 CE
- 9/2020-Oregon Tech Excellence in Teaching Conference:
  - Lessons Learned from Spring 2020
  - Perspectives on Student Learning
  - Accessibility
  - Making the Move to Open Educational Resources
  - Rocking the Virtual Classroom: Building an Engaged Community of Student Learners
  - Student Panel: Perspectives on Student Learning
  - Quality Teaching for Online and Remote Learning Environments
- 6/2020-Interim Infection Prevention and CDC Guidance for Dental Settings, 1 CE
- 5/2020-Virtual Clinic Assessments, 1 CE
- 5/2020- Virtual Clinic Curriculum and Competency Assessments, 1 CE
- 5/2020-Preventing Inflammation, 1 CE
- 5/2020-A Multi Layered Strategy for Effectively Managing Aerosols, 1.5 CE
- 4/2020-Barista Drug Dosing 101, 1 CE
- 11/2019-Intercultural Dental Hygiene, 1.5 CE

- 11/2019, AAP Classification Demystified. 2 CE
- 11/2019-Creating an Environment of Safety and Infection Prevention in the Dental Setting, 2 CE
- 10/2019-Oregon Tech Canvas Faculty Training course
- 10/2019-Optimize Your Treatment Outcomes and Efficient Choices in Ultrasonic Instrumentation, 2 CE
- 10/2019-CAMBRA-Risk Assessment, 1 CE
- 9/2019-Clinical Teaching Methodologies/AAP Review, 1 CE
- 6/2019- Pharmacology of Local Anesthetics: Clinical Implications (3 CE)
- 6/2019-An Overview of Dental Anatomy (1 CE)
- 6/2019- Local Anesthesia in Pediatric Dentistry (2 CE)
- 6/2019- Advanced Instrumentation for the General Practice Dental Hygienist (2 CE)
- 6/2019- Presentation on Surgeon General Report on Oral Health with Tim Ricks (2 CE)
- 3/2019-Removal of Amalgam: Is it Beneficial, 2 CE
- 11/2018- A Clinician's Guide to Clinical Endodontics, 2 CE
- 11/2018- Basic Radiation Physics, 2 CE
- 10/2018- Bloodborne Pathogens Awareness: Cal/OSHA
- 8/2018- Sedation in the Dental Office: An Overview, 2 CE
- 8/2018- Professional Dental Terminology for the Dental Assistant and Hygienist, 2 CE
- 8/2018- The Management of Patients with Periodontal and Cardiovascular Diseases, 1 CE
- 8/2018- Intraoral Imaging: Basic Principles, Techniques and Error Correction, 2 CE
- 8/2018- Ethics in Dentistry: Part III-Ethical Decision-making, 2 CE
- 8/2018- Microsoft Excel Basics
- 6/2018-WREB Clinical Dental Hygiene Calibration workshop, Kirkland, WA, 6 CE
- 6/2018- FERPA for Higher Education
- 6/2018- Title IX for Higher Education
- 6/2018- Campus Security Obligations Under Federal Law
- 5/2018-WREB Clinical Dental Hygiene Calibration workshop, Albuquerque, NM, 6 CE
- 5/2018- HIPAA Privacy Essentials
- 4/2018-Oregon Dental Convention: 12 CE
    - Review of CDC Guidelines for Infection Control
    - Infection Control in Dentistry
    - Change the Game: Reduce Stress to Boost Morale and Teamwork
    - Building a Healthier You
- 2/2018-WREB Dental Hygiene training session, Phoenix, AZ, 14 CE

SPECIAL COMPETENCE AND ACTIVITIES

Presentations and Publications:

- Oregon Tech Excellence in Teaching Conference Poster Presentation: "*Enhanced Student Feedback in Clinical Teaching"* in collaboration with Jessica Luebbers and Jeannie Bopp
- Information Sessions (in person and virtually) for interested students (3-4 times/year)
- Curriculum Report to full department annually
- "Dental Specialties: Periodontics", presented to CCC Dental Assisting Students, 2018-2021
- Community College Baccalaureate Association- "*Bringing the University Experience to the Community College* ", Washington DC, March 2018
- Association of Community College Trustees- "*Bringing the University Experience to the Community College*", San Diego, October 2015. In collaboration with Chemeketa Community College
- Quarterly presentations with adjunct clinical instructors on teaching methodology and calibration

Leadership Development:

- Authentic Leadership 3 Day Workshop, The Leadership Circle (10/2018)
- Mastering Active Listening in the Workplace (8/2018)
- Employee Development Certification Leadership Program-year-long training through Chemeketa Community College (2017-18)
- Leadership Advantage: Communicating Bad News (5/2018)
- Leadership Advantage: Leading Effective Meetings (4/2018)
- Financial Manager Training (10/2017)
- Supervisory Success by Judith Clarke (8/2017)
- ADEA Leadership 3 Day Workshop and Program Directors Meeting, Baltimore, MD (May 2017)

Professional Activities:

- Western Regional Examining Board Clinical Dental Hygiene and Local Anesthesia Examiner (23 State Examining Board), 2017-present
- School Coordinator-Western Regional Examining Board Dental Hygiene Examinations, Oregon Institute of Technology at Chemeketa Community College, April 2014-2017, April 2019-present
- OIT Doctor of Physical Therapy Director Search Committee, Winter/Spring 2020
- Chemeketa Community College President Search Committee, 2018-19
- Oregon Health Authority Pilot Project 100 Advisory Board, 2016-present
- Oregon Community Foundation Peggy Peterson Scholarship Committee, 2018-present

- Oregon Tech at Chemeketa Dental Hygiene Advisory Board 2017-2019 (while employed with CCC)
- Steering Committee for Guided Pathways, Chemeketa Community College 2017-2019
- Member of Chemeketa Community College Dental Assisting Advisory Board 2014-2017, 2019-present
- Represent Oregon Institute of Technology Dental Hygiene program at Salem area College and Career Fairs each year, 2011-present
- Dental Hygiene Lead-Oregon Mission of Mercy, 2014, 2015

901 Warrenville Road,
Suite 180
Lisle, IL 60532
Phone: 630-686-9875
Fax: 630-686-9876
Web: AADSM.org

June 29, 2023

Jose Javier, DDS
President, Oregon Board of Dentistry
1500 SW 1st Avenue, Suite 770
Portland, OR 97201

SENT VIA EMAIL: Information@obd.oregon.gov

Dear Dr. Javier:

The American Academy of Dental Sleep Medicine (AADSM) reached out to you earlier this year to make you aware of the AADSM standards of practice for oral appliance therapy. These standards outline that trained dentists are the only clinicians with the knowledge and skills to safely and effectively provide oral appliance therapy for obstructive sleep apnea.

Since that time, we have become aware of the growth of two different business models that provide unsuspecting patients with an oral appliance, but without the appropriate inclusion of a trained dentist in the provision of care. We are writing to make you aware of these business models and our concerns about the quality and safety of providing oral appliance therapy by a non-dentist.

In one of these models, medical assistants, and physician assistants under the supervision of an otolaryngologist – who may or may not see the patient – are taking dental impressions, having a singular designated appliance fabricated, and hand the appliance to the patient. In another model, durable medical equipment suppliers are making an oral appliance available for a patient to purchase directly through an online store, either with an impression kit that the patient uses at home or without impressions but instead with instructions for the patient to mold the trays to their teeth at home, by themselves.

We'd like to make you aware of the quality and safety concerns with these situations:

- The selection of an oral appliance should be made by a trained dentist based on an in-person evaluation of the patient. Only dentists have the education and experience to evaluate the patient's dentition and oral tissues and structures to identify all possible contraindications and to determine which of the many available oral appliances is the most appropriate to provide effective treatment with good retention to the teeth and the lowest risk of discomfort or side effects. In addition, the choice of oral appliance should be made in

conjunction with the patient taking into consideration their sleep habits, ability to or comfort with advancing the appliance, as well as concerns about cost.

- Impressions should be taken by dentists or trained dental assistants. Whether taken digitally or with traditional dental materials, accurate impressions are essential to a properly fitted and effective oral appliance. The current literature does not show a clear difference in the impact of a digital vs traditional impression; however, an inexpert impression whether taken by an unfamiliar adjunct healthcare employee or by the patient themselves can miss important dental structures that are essential to the proper fit and function of the appliance.

- The patient should receive follow-up care for the lifetime of the appliance and for as long as the patient wishes to use oral appliance therapy. The direct-to-consumer model offers no follow up care and leaves the patient at risk for ineffective control of symptoms, harmful side effects, and the risk of abandoning needed treatment of a medical condition that can negatively impact health. In the ENT clinic model of care, we are aware of patients who have been referred to their general dentist for the correction of problems caused by the ENT-delivered appliance, rather than appropriately followed and treated by a qualified dentist, preferably the same dentist who evaluated the patient, selected, and delivered the appliance.

The goal of the AADSM is to provide patients with access to safe, high-quality care. Oral appliance therapy is a proven, effective treatment if provided by a licensed dentist who has had additional training in dental sleep medicine and stays current through continuing education. Only qualified dentists such as these know how to select appropriate appliances to ensure the most effective treatment, prevent potential side effects, and manage and resolve side effects that do occur.

Medicare’s coverage for obstructive sleep apnea (LCD33611) and most commercial payers require a qualified dentist to provide oral appliance therapy, based not only on the AADSM standards for practice but also on clinical guidelines from the American Academy of Sleep Medicine and other scientific guidelines that confirm this therapy as within the scope of dentistry.

Should issues or concerns about non-dentist provide oral appliance therapy come to your attention, we are happy to be a resource to you as you consider the appropriate role of dentists and other providers in the care of patients with obstructive sleep apnea.

Sincerely,
Mitchell Levine, DMD, MS

The Oregon Dental Association represents over 2,100 dentists practicing in all corners of the State and the Oregon Dental Hygiene Association membership including over 600 licensees, with a combined membership of over 2,700 licensees statewide. Our two organizations write to formally request that the Oregon Board of Dentistry consider changes to the mental health questions that are currently part of the licensing process.

Recognizing the need to reduce stigma around mental health, the Oregon Medical Board recently moved to an attestation model in line with the Dr. Lorna Breen Heroes' Foundation's recommendations.

Yet, the line of questioning used by the Oregon Board of Dentistry during licensing remains outdated and stigmatizing—even though, according to the American Dental Association, the suicide rate amongst dentists is even higher than that of physicians, "Male dentists hold the highest suicide rate at 8.02 percent. Female dentists hold the fourth highest suicide rate at 5.28 percent. Physicians (7.87 percent), pharmacists (7.19 percent) and nurses (6.56 percent) also hold suicide rates much higher than the national average".

Notably, this data was gathered before the COVID-19 pandemic. More recently, the 2021 Dentist Well-Being Survey Report by the American Dental Association revealed that the percentage of dentists diagnosed with anxiety more than tripled in 2021 compared with 2003. Yet, providers report that they are fearful to seek the help that they need.

In recognition that healthcare providers encounter mental health and substance use disorders, the Oregon Medical Board uses the below form and wording for initial licensure and renewal. the Oregon Dental Association and the Oregon Dental Hygiene Association respectfully urge the Oregon Board of Dentistry to adopt similar language to replace stigmatizing language currently being used. Thank you for your consideration.

Mark Miller, DMD
President, ODA

Tracy Lynne Brunkhorst
RDH, EPDH, FADHA
President ODHA

Category II

The Oregon Medical Board recognizes that licensees encounter health conditions, including those involving mental health and substance use disorders, just as their patients and fellow health care providers do. The Board expects its licensees to address their health concerns and ensure patient safety. Options include seeking medical care, self-limiting the licensee's practice, and anonymously self-referring to the Oregon Health Professionals' Service Program (www.hpspmonitoring.com).

The failure to adequately address a health condition, resulting in the inability to practice your profession with reasonable skill and safety, can result in the Board taking action against your Oregon Medical Board license.

☐ **I have read and understand the above advisory and agree to abide by the Board's expectation.**

The answer to the below question is exempt from public disclosure under state and federal law. The answer may be considered by the Board and may be disclosed in any contested case hearing or appeal of a licensing decision based upon it.

Do you currently engage in the excessive or habitual use of alcohol or drugs or are you dependent on the use of alcohol or drugs which impair your ability to practice your health care profession safely and competently? "Excessive" as used in this question includes, but is not limited to, the use of alcohol or drugs that leads to disturbances, fights, arrest, DUII, injury, accident, illness, loss of consciousness, .08% BAC or above on a required chemical substance screening test, or other adverse consequences. If you are currently enrolled in the Oregon Health Professionals' Services Program (HPSP), you may answer "no."

If "yes," provide a full description. Documentation from the relevant law enforcement agency, court, or other entity must be sent directly to the Board. Additionally, a statement from your treating provider regarding your ability to safely practice must be sent directly to the Board.

OMB Adopting Mental Health Attestation Model for Licensure and Renewal Applications

The Oregon Medical Board recognizes that licensees encounter personal health conditions, including mental health and substance use disorders, just as their patients and fellow health care providers do. According to a 2022 survey conducted by The Physicians Foundation, nearly 40% of providers were afraid (or knew a colleague who was afraid) to seek mental health care because of questions asked as part of medical licensure or credentialing applications.

The **Dr. Lorna Breen Heroes' Foundation** challenged all medical boards to audit licensure and renewal mental health questions, change invasive or stigmatizing language, and communicate these changes to licensees.

To better support licensees in seeking the care they need without anxiety or trepidation, on April 6, 2023, the Board voted to remove intrusive and stigmatizing language around mental health care and treatment from licensure applications and renewals. The advisory statement uses supportive language around mental health and holds licensees and applicants accountable for their own well-being. The model makes it clear that self-care is patient care.

The advisory statement and attestation were included in applications effective June 1, 2023:

- **Personal History Questions for Licensure Application**
- **Personal History Questions for Licensure Renewal**

While there is still work to be done, this is a significant step in removing barriers to support and protecting licensees' mental health and wellbeing.

Oregon Medical Board
Initial Application Personal History Questions

Revised 06/2023

Answer all questions in both Category I and Category II. Category I will help the Board determine if you meet the essential requirements for registration. Category II will help the board determine if you are qualified to practice safely and competently, with or without reasonable modification.

If you answer "yes" to any of the questions, you must submit a complete explanation of the event(s) or conditions(s), including dates, names, addresses, circumstances, and results. If you need more space than is provided here, you may use the Personal History Explanation Form.

NOTE: Answer all of the following questions completely and honestly. Omission or false, misleading, or deceptive information in applying for or procuring a license, registration, or reactivation in Oregon is a violation of the Oregon Medical Practice Act and is grounds for a fine and future disciplinary action by the Board, including denials, suspension, or revocation of licensure. Such acts are reported to the National Practitioner Data Bank and/or appropriate national professional credentialing organizations.

Category I

The answers to these questions may be subject to disclosure in response to a public records request under state law. The answers me be considered by the Board and may be disclosed in any contested case hearing or appeal of a licensing decision based upon them.

1. Do you hold, or have you ever held, any licenses to practice another health care profession?
2. Have you ever failed a licensing examination, or any portion of a licensing examination, for a medical license (USMLE, NBME, NBOME, FLEX, ECFMG) or for any other health professional license? If you ever failed a portion of a licensing examination, you must answer "yes," even if you later passed the examination.
3. Have you ever been asked to and/or permitted to withdraw an application for licensure, credentialing, or certification with any board, agency, or institution?
4. Has any state licensing board refused to issue, refused to renew, or denied you a license to practice?
5. Have you ever had any disciplinary or adverse action imposed against any professional license or certification, or were you ever denied a professional license or certification, or have you entered into any consent agreement, stipulated order, or settlement with any regulatory board or certification agency; or have you ever been notified of any complaints or investigations related to any license or certification?
6. Regardless of the outcome, have you been denied approval to prescribe controlled substances, or been subject to an inquiry, or charged with a violation of federal or state controlled substance laws, or been asked to surrender your DEA number?
7. Have you ever been arrested, convicted of, or pled guilty or "nolo contendere" (no contest) to ANY offense in any state in the United States or any foreign country, other than minor traffic violations? Matters in which you were pardoned and/or diverted, or the conviction was deferred, set aside, or expunged must be disclosed.
8. Have you ever been contacted by or asked to make a response to any governmental agency in any jurisdiction regarding any criminal or civil investigation of which you are the subject, whether or not a charge, claim, or filing with a court actually occurred?
9. Are there any current, proposed, impending, or threatened civil or criminal action against you, which includes, but is not limited to malpractice claims? This includes whether or not the claim, charge, or filing was actually made with a court.

10. Have you ever entered into any formal, informal, out-of-court, or confidential settlement to deter, prevent, or settle a claim, lawsuit, letter of intent to sue, and/or criminal action? This includes whether or not a claim, charge, or filing was actually made with a court.
11. Has any award, settlement, or payment of any kind ever been made by you or on your behalf to resolve a malpractice claim, even if it was not required to be reported to the National Practitioner Data Bank (NPDB); or have you ever been notified in any manner that any such claim is proposed, pending, or threatened, whether or not a claim, charge, or filing was actually made with a court?
12. Have you interrupted the practice of your health care profession for one year or more, or ceased the practice of your specialty?
13. During medical school or postgraduate training, were you ever subject to an action for any academic, clinical, or professional concerns, including actions such as warning, remediation, probation, restriction, suspension, termination, or request to voluntarily resign?
14. Regarding your medically related employment, have you ever had an employment agreement or privileges denied, reduced, restricted, suspended, revoked, or terminated; or have you ever been subject to disciplinary action including but not limited to probation; or have you been terminated from employment or subject to non-renewal of an employment agreement with or without cause; or have you been asked to voluntarily resign or voluntarily suspend your privileges; or have you been under investigation by a hospital, clinic, surgical center, or other medically related entity; or have you been notified that such action or request is pending or proposed?

Category II

The Oregon Medical Board recognizes that licensees encounter health conditions, including those involving mental health and substance use disorders, just as their patients and fellow health care providers do. The Board expects its licensees to address their health concerns and ensure patient safety. Options include seeking medical care, self-limiting the licensee's practice, and anonymously self-referring to the Oregon Health Professionals' Service Program (www.hpspmonitoring.com).

The failure to adequately address a health condition, resulting in the inability to practice your profession with reasonable skill and safety, can result in the Board taking action against your Oregon Medical Board license.

☐ **I have read and understand the above advisory and agree to abide by the Board's expectation.**

The answer to the below question is exempt from public disclosure under state and federal law. The answer may be considered by the Board and may be disclosed in any contested case hearing or appeal of a licensing decision based upon it.

Do you currently engage in the excessive or habitual use of alcohol or drugs or are you dependent on the use of alcohol or drugs which impair your ability to practice your health care profession safely and competently? "Excessive" as used in this question includes, but is not limited to, the use of alcohol or drugs that leads to disturbances, fights, arrest, DUII, injury, accident, illness, loss of consciousness, .08% BAC or above on a required chemical substance screening test, or other adverse consequences. If you are currently enrolled in the Oregon Health Professionals' Services Program (HPSP), you may answer "no."

If "yes," provide a full description. Documentation from the relevant law enforcement agency, court, or other entity must be sent directly to the Board. Additionally, a statement from your treating provider regarding your ability to safely practice must be sent directly to the Board.

Oregon Medical Board
Renewal Application Personal History Questions

Revised 06/2023

Answer all questions in both Category I and Category II. Category I will help the Board determine if you meet the essential requirements for registration. Category II will help the board determine if you are qualified to practice safely and competently, with or without reasonable modification.

If you answer "yes" to any of the questions, you must submit a complete explanation of the event(s) or conditions(s), including dates, names, addresses, circumstances, and results. If you need more space than is provided here, you may use the Personal History Explanation Form.

NOTE: Answer all of the following questions completely and honestly. Omission or false, misleading, or deceptive information in applying for or procuring a license, registration, or reactivation in Oregon is a violation of the Oregon Medical Practice Act and is grounds for a fine and future disciplinary action by the Board, including denials, suspension, or revocation of licensure. Such acts are reported to the National Practitioner Data Bank and/or appropriate national professional credentialing organizations.

Category I

The answers to these questions may be subject to disclosure in response to a public records request under state law. The answers me be considered by the Board and may be disclosed in any contested case hearing or appeal of a licensing decision based upon them.

1. Has any licensing board refused to license, refused to renew, denied you a license to practice, or asked you or permitted you to withdraw an application for licensure?
2. Have you ever had any inquiry, disciplinary action, remediation, corrective action, or adverse action imposed against any professional license or certification, or were you ever denied a professional license or certification, or have you entered into any con-sent agreement, stipulated order, or settlement with any regulatory board or certification agency; or have you ever been notified of any complaints or investigations related to any license or certification?
3. Regardless of the outcome, have you been denied approval to prescribe controlled substances, or been subject to an inquiry or charged with a violation of federal or state controlled substance laws, or been asked to surrender your DEA number?
4. Have you been arrested and/or convicted of, pled guilty or "nolo contendere" (no contest) to ANY offense in any state in the United States or any foreign country, other than minor traffic violations? Matters in which you were pardoned and/or diverted, or the conviction was deferred, set aside, or expunged must be disclosed, excluding expunged juvenile records. Serious traffic convictions, such as reckless driving, driving under the influence of alcohol and/or drugs, hit-and-run, evading a peace officer, driving while the license was suspended or revoked, or failure to appear, must be disclosed. This list is not all-inclusive.
5. Have you been contacted by or asked to make a response to any governmental agency in any jurisdiction regarding any criminal or civil matter of which you are the subject, whether or not a charge, claim or filing with a court actually occurred?
6. Are there any current, proposed, impending or threatened civil or criminal actions against you, which includes, but is not limited to malpractice claims? This includes whether or not a claim, charge or filing was actually made with a court.
7. Have you entered into any formal, informal, out-of-court, confidential settlement and/or agreement to deter, prevent, or settle a claim, lawsuit, letter of in-tent to sue, and/or criminal action? This includes whether or not a claim, charge or filing was actually made with a court.

8. Has any award, settlement, agreement or payment of any kind been made by you or on your behalf to resolve a malpractice claim, even if it was not required to be reported to the Federation of State Medical Boards (FSMB) or National Practitioner Data Bank (NPDB)? Have you been notified in any manner that any such claim is proposed, pending or threatened, whether or not a claim, charge or filing was actually made with a court?
9. Have you been subject to any academic, clinical, or professional action in a postgraduate training program during this time period, including actions such as warning, remediation, probation, restriction, suspension, termination, or request to voluntarily resign?
10. Regarding your medically related employment, have you had an employment agreement or privileges denied, reduced, restricted, suspended, revoked or terminated; or have you been subject to disciplinary action by a medically related entity including but not limited to probation; or have you been terminated from employment or subject to non-renewal of an employment agreement with or without cause; or have you been asked to voluntarily resign or voluntarily suspend your privileges; or have you been under investigation by a hospital, clinic, surgical center, or other medically related entity, or have you been notified that such action or request is pending or proposed?
11. Have you interrupted the practice of your health care profession for two years or more?
12. Have you ceased the practice of medicine in your specialty, or has the nature of your practice changed since your last license renewal?

Category II

The Oregon Medical Board recognizes that licensees encounter health conditions, including those involving mental health and substance use disorders, just as their patients and fellow health care providers do. The Board expects its licensees to address their health concerns and ensure patient safety. Options include seeking medical care, self-limiting the licensee's practice, and anonymously self-referring to the Oregon Health Professionals' Service Program (www.hpspmonitoring.com).

The failure to adequately address a health condition, resulting in the inability to practice your profession with reasonable skill and safety, can result in the Board taking action against your Oregon Medical Board license.

☐ **I have read and understand the above advisory and agree to abide by the Board's expectation.**

The answer to the below question is exempt from public disclosure under state and federal law. The answer may be considered by the Board and may be disclosed in any contested case hearing or appeal of a licensing decision based upon it.

Do you currently engage in the excessive or habitual use of alcohol or drugs or are you dependent on the use of alcohol or drugs which impair your ability to practice your health care profession safely and competently? "Excessive" as used in this question includes, but is not limited to, the use of alcohol or drugs that leads to disturbances, fights, arrest, DUII, injury, accident, illness, loss of consciousness, .08% BAC or above on a required chemical substance screening test, or other adverse consequences. If you are currently enrolled in the Oregon Health Professionals' Services Program (HPSP), you may answer "no."

If "yes," provide a full description. Documentation from the relevant law enforcement agency, court, or other entity must be sent directly to the Board. Additionally, a statement from your treating provider regarding your ability to safely practice must be sent directly to the Board.

License Renewal Application

Renewal Type

Once you have accessed your online renewal application, you will be able to complete the process entirely online. If you should need to stop in the middle of the process your information, up to the last completed page will be saved allowing you to return at a later date to complete the process. Late fees are not charged for 10 days after your license has expired, although you may not practice with an expired license for any reason.

- [x] Dental License (DXXXX)

Save And Next

Application Instructions

You have accessed the renewal application for dentists with an expiration date of March 31, 2023. Y ou are required to complete this application yourself; outside parties are prohibited from completing a renewal application on your behalf. The renewal application and OHWI survey must be completed, and your fees must be paid, before your license will be renewed. If you have any questions about the renewal application, please contact the OBD office at information@obd.oregon.gov or 971-673-3200

Save & Next

General Information

Upload current selfie type photo of your face .

Taken within within one year of application date.
We will NOT ACCEPT the photo if you are wearing a hat, sunglasses, or anything obstructing any portion of your face.

Choose File No file chosen

First Name: KEITH

Middle Name:

Last Name: TEST

Suffix:

Non-public Email:

Public Email:

License Number DXXXX

Mailing Address:

Street: PORTLAND

City:

Country: United States

State: Oregon

Zip: 97217

County:

Phone Number:

Residence Address:

Street:

City: PORTLAND

Country United States

State:

Zip: 97217

County:

Business Address:

Street:

City: PORTLAND

Country United States

State: Oregon

Zip: 97217

County:

Save & Next

Military Service Information

Oregon Dental, Dental Therapy & Dental Hygiene licensure fees are waived for licensees who are active duty military. For those individuals seeking waiver of fees, you must select yes stating that you are 'Active Duty Military'. Once you have selected yes , in lieu of payment, you must upload documentation from your commanding officer of your active duty military status. Please confirm with your commanding officer that you are allowed to take the waiver, as the military has changed their policy.

Yes No

Mandatory Renewal Response Questions

Question 1: Do you hold a current license to practice dentistry, dental therapy or dental hygiene in any other state or jurisdiction? If 'yes' enter information below. ○ Yes ◉ No

Question 2: Do you hold a license to practice any other health care profession (i.e., physician, nurse, chiropractic, massage therapy, denturist) in this or any other state or jurisdiction? If 'yes' enter information below. ○ Yes ◉ No

Question 2A: Since the date of your last dental, dental therapy or dental hygiene license application (initial or renewal), have you been the subject of any pending or final (formal, informal, or corrective) action involving any other health care profession license? If 'yes' enter information below. ○ Yes ◉ No

Question 3: Regardless of the outcome, since the date of your last license application (initial or renewal), have you been arrested for a misdemeanor or felony; or charged or convicted with a misdemeanor or felony? If 'yes' enter information below. ○ Yes ◉ No

Question 4: Are you aware of any physical or mental condition that would inhibit your ability to practice safely? If 'yes' enter information below. ○ Yes ◉ No

Question 5: Since your last license application (initial or renewal), were there any criminal or civil matters filed against you, including pending cases that involved alcohol, drugs, or mind altering substances, other than what is already known by the Board's Diversion Coordinator? If 'yes' enter information below. ○ Yes ◉ No

Question 6: Since the date of your last license application (initial or renewal), did you use or possess illegal drugs, Scheduled controlled drugs, or mind altering substances, in violation of any law, other than what is already known by the Board's Diversion Coordinator or the State's Health Professionals' Services Program? If 'yes' enter information below. ○ Yes ◉ No

Question 7: Since the last date of your last license application (initial or renewal), have you been evaluated for alcohol or drug abuse, or received treatment, counseling or education for your abuse of alcohol, drugs or mind altering substances, other than what is already known by the Board's Diversion Coordinator or the State's Health Professionals' Services Program? If 'yes' enter information below. ○ Yes ◉ No

Question 8: Since the date of your last license application (initial or renewal), has there been any written request to you, your malpractice insurance company, or risk retention group regarding an alleged injury that may have been caused by your professional negligence, or any written notification from you to your malpractice insurance company or risk retention group that a person has made a request from you for an alleged injury caused by your professional negligence? If 'yes' enter information below. ○ Yes ◉ No

Qualified Provider

Other than yourself, do you use a Qualified Provider to induce anesthesia/sedation (excluding local anesthesia) in your office? If Yes, enter who the provider(s) are. ○ Yes ◉ No

Continuing Education

1.I have completed, or will complete by 3/31/2023, the 40 hours of continuing education required for licensure period 4/1/2021 to 3/31/2023, including THREE (3) hours related to medical emergencies in the dental office. If 'no' enter information below. ◉ Yes ○ No

2.Since the date of my last license application (initial or renewal), I have maintained at all times a current and valid Health Care Provider BLS/CPR certification. If 'no' enter information below. ◉ Yes ○ No

Document Name	Document T ype	Date	Link	Action
BLS Certificate	BLS/CPR Certification	03/21/2023 12:00:00 AM	Document Details	

Document Name :

Document Type : BLS/CPR Certification

Document:

Drop file here to upload or click here to browse and select file(s) to upload.

Click here to complete Upload | Cancel

3.I have completed, or will complete by 3/31/2023, the TWO (2) hours of cultural competency continuing education required for licensure period 4/1//2021 to 3/31/2023. If 'no' enter information below. ◉ Yes ○ No

4.I have completed, or will complete by 3/31/2023, the TWO (2) hours of infection control required for licensure period 4/1/2021 to 3/31/2023. ◉ Yes ○ No

5.I have completed or will complete by 3/31/23, the one (1) hour pain management course through the Oregon Health Authority, Oregon Pain Management Commission (https://www.oregon.gov/oha/hpa/dsi-pmc/pages/module.aspx) for the licensure period 4/1/2021 to 3/31/2023 ◉ Yes ○ No

Workforce Survey

Save & Next

ANESTHESIA RENEWAL: Only Applicable to Current Permit Holders

Save & Next

Acknowledgement

Certification and Signature Digital Certification: Submission of the information on this application by electronic means and payment via credit card or ACH constitutes a valid digital signature. Furthermore, I certify that I am the person described in this application and the information I submitted by electronic means is true and correct. I understand that any falsification could result in board action, including, but not limited to, denial, suspension, or revocation of my license.

Signature : Keith Test

Date: 03/21/2023

Fee and Payment

Payment Method :	Credit / Debit Card
Dental Renewal Fee :	336
OHWI Workforce Survey Fee :	4
Service Fee :	3.5
Prescription Drug Monitoring Program Fee :	50
Total Fees :	393.5

Application For Initial License

Application Instructions

Dental Licensure by Examination

These instructions are designed to assist you in the application process for dental licensure in Oregon. Licensure by Examination is intended for those applicants who have passed their clinical examination within the immediate five years preceding their application . Please carefully review OAR 818-021-0010 prior to submitting your application. Failure to meet any of the requirements will result in your application being rejected. If you have questions or you are uncertain if you meet the requirements, please contact the OBD at 971-673-3200 or at information@obd.oregon.gov prior to submitting your application.

Fees: (All Fees are Mandatory):

1. Application Fee: $345.00
2. Biennial Licensure Fee: $340.00
3. Prescription Drug Monitoring Fee: $50.00

Items needed to be uploaded into the application:

-Current Photo taken within one year of application date.

-Proof of passage of National Board.

-Proof of passage of clinical examination.

-Current copy of BLS for Healthcare Providers or its equivalent.

-Proof of completion of a one hour pain management course taken through the Oregon Health Authority - Oregon Pain Management Commission.

ALL APPLICANTS Additional Requirements

Transcript (W ith Degree Posted) - Transcripts must be posted with dental degree from an ADA accredited dental program, and must be sent to the Board directly from the school or third-party agent for the school i.e., Parchment, National Student Clearinghouse etc. Transcripts may be sent electronically directly from the school or agent to information@obd.oregon.gov, or via U.S. mail to Oregon Board of Dentistry, 1500 SW 1st Avenue, Suite 770, Portland, OR 97201 Dentists who completed non-ADA accredited programs must also have successfully completed a predoctoral dental education program of not less than two years at a dental school accredited by the Commission on Dental Accreditation of the American Dental Association, and be proficient in the English language. (OAR 818-021-0010(1)(b).

Pain Management Requirement - In addition to the above requirements OAR 818-021-0010 requires that prior to licensure all dentists must complete a one-hour pain management course taken through the Oregon Health Authority - Pain Management Course link . You will upload a copy of course completion in the "Supplemental" tab in the online application.

Additional Requirements - REQUIRED FOR APPLICANTS WHO ARE CURRENTL Y LICENSE OR HAVE HELD LICENSURE IN ANOTHER STATE, COUNTRY OR JURISDICTION:

License V erification Requirement License verifications must be requested by the applicant and submitted directly from every state, country or jurisdiction in which the applicant is currently licensed or has held licensure following below is the link to request a Certificate of Standing Certification. (Note: Many states charge a fee for this service. Please contact the state and/or country directly prior to submitting your request to prevent delays in processing.)

Certificate of Licensure Form

DEA Registration Applicants who are or who have been licensed in another state must have this form completed and returned to the Board by the Drug Enforcement Administration.

DEA Registration Form

All Applicants - Optional - Anesthesia Permit Applications - Nitrous Oxide, Minimal Sedation, Moderate Sedation, General Anesthesia Permit Applications

If you would like to administer sedation/anesthesia in Oregon you must apply for a sedation permit, please click on the following link below and following the instructions on that application. Applying for an anesthesia/sedation permit is not completed through this online application process.

Anesthesia Permits

Please Note: Applicants are solely responsible for ensuring that they meet all requirements for their chosen application pathway. Per ORS 679.0120(8), fees paid are not refundable or transferrable. Failure to meet the requirements will result in the application being rejected, and the applicant will be required to submit (at minimum) a new application and application fee.

Dentists who have graduated from a dental program located outside the United States or Canada must also meet additional education requirements. Please review OAR 818-021-0010 for additional education requirements.

IMPORTANT INFORMATION

Affirmative Responses to Questions on the Background and Disciplinary T ab. If you answer "yes' to any of the questions, for any reason, you must submit additional supporting documentation for that question as indicated on the application. This documentation should include:

1. Written letter of explanation from you giving full details.
2. Certified copies of disciplinary action, police reports, court documents, and medical evaluations or any other pertinent information.

Application V alid 180 Days (OAR 818-021-0120):

1. If all information and documentation necessary for the Board to act on an application in not provided to the Board by the applicant within 180 days from the date the application is received by the Board, the Board shall reject the application as incomplete.
2. An applicant whose application has been rejected as incomplete must file a new application and must pay a new application fee.
3. An applicant who fails the examination or who does not take the examination during the 180-day period following the date the Board receives the application, must file a new application and must pay a new application fee.

Jurisprudence Examination and Live Scan Fingerprints

Once the OBD has received your application and fee, your Jurisprudence Examination will be emailed to you a link to take the examination. This examination is "open book" and must completed and uploaded into the Applicant Portal. The OBD will also email you the Request for Transmission for Live Scan Fingerprint form, which will give you the information to schedule your fingerprints at a Fieldprint location near you. Live Scan fingerprints can only be transmitted electronically.

PLEASE ANTICIPATE APPROXIMATELY 6 - 8 WEEKS FOR APPLICA TION PROCESSING. We are unable to honor requests for expedited applications. Once requested, documentation from other states or jurisdictions and background checks may take several weeks to arrive. If you would like to know the status of your application, please first review your application in your user portal to see which documents are missing.

You may also use this link to check the status of your application: https://www .oregon.gov/dentistry/Pages/status.aspx .

PLEASE DO NOT CALL OUR OFFICE T O INQUIRE ABOUT THE STATUS OF YOUR APPLICATION.

Save & Next

General Information

Upload current passport type photo.

Taken within one year of application date..

We will NOT ACCEPT the photo if you are wearing a hat, sunglasses, or anything obstructing any portion of your face.

Choose File No file chosen

First Name : Gordon

Middle Name :

Last Name : Test

Gender : Male

SSN # :

Birthdate :

Age :

Other Name Used : Yes N/A

Place of Birth :

Country : United States

State :

City :

Mailing Address :

Street :

State :

City : Portland

Country United States

OR

Zip : 97227

County: Multnomah

Residence Address :

Street :

City : Portland

Country United States

State : Oregon

Zip : 97227

County: Multnomah

Select if the Residence Address is your Mailing Address

Office Address :

Street :

State :

City : Vancouver

Country United States

WA

Zip : 98683

County: Out of State

Select if the Office Address is your Mailing Address

Non-public Email Address : @gmail.com

Home Telephone # :

Cell Telephone # :

Office Telephone # : (XXX) XXX-

XXXX

Save & Next Cancel

Education & Certifications

CM = Education 2

Undergraduate School or Schools

Add

University or College	City	State	Years Attended From	Years Attended T o	Degree Earned	Actions
Marquette University	Milwaukee	WI	08/2012	05/2016	Bachelors of Science in Biomedical Sciences	.

Dental/Dental Hygiene/Dental Therapy School/Program Attended

Add

University or College	City	State	Years Attended From	Years Attended T o	Degree Earned	Actions
Marquette University School of Dentistry	Milwaukee	WI	08/2015	05/2019	Doctor of Dental Surgery DDS	

Specialty T raining or Specialty Board Membership

Institution :

Address :

Street:

City :

Zip :

Country : United States

State : Alabama

Years Attended : From : MM/YYYY To : MM/YYYY

Degree Earned :

Save Cancel

Add

University or College	City	State	Years Attended From	Years Attended T o	Graduation Date	Degree Earned	Actions
No Record Found							

Background/Discipline

You must respond fully and truthfully to these questions. Failure to fully and truthfully respond to these questions may result in the denial of your application or another appropriate sanction as authorized by law . Fully and truthfully includes, but is not limited to, reporting DUII (Driving Under the Influence of Intoxicants) and MIP (Minor in Possession) violations, possession of a controlled substance, theft, shoplifting, domestic violence, or assault violations, or any other violation of the law , misdemeanor or felony , of any state or federal law , regardless of the state or territory in which it happened.

This information must be reported whether or not the arrest/citation was dismissed, dismissed through diversion, set aside, or judged not guilty , regardless of how long ago it happened.

A fillable box will be displayed for any affirmative answers provided below . Please use this box to provide a written statement explaining the incident that led you to answer affirmatively to that question. If you have copies of relevant medical, police or court records, you may upload them below . The OBD may request further documentation to be sent directly from relevant police/court departments depending on the nature of the incident.

1. Are you aware of any physical or mental conditions that would inhibit your ability to practice safely?* ○ Yes ◉ No

2. Have you ever been denied a license to practice dentistry or dental hygiene or denied the right to take an exam for such licensure?* ○ Yes ◉ No

3. Have you ever voluntarily surrendered a license to practice dentistry or dental hygiene?* ○ Yes ◉ No

4. Have you ever been the subject of any pending or final (formal, informal, or corrective) action regarding any dental or dental hygiene license you now hold or have ever held? (Include any disciplinary actions by the U.S. Military, U.S. Public Health Service, Drug Enforcement Administration, state licensing board or other entity.)* ○ Yes ◉ No

5. Has there been any investigation or disciplinary action taken against you by any dental or dental hygiene school or program?* ○ Yes ◉ No

6. a. Have you ever been cited, arrested, charged or convicted of any crime, offense, or violation of the law in any state, or country even if those charges were dismissed or set aside?* ○ Yes ◉ No

6. b. Are there any pending criminal actions against you that could result in your imprisonment in a state, local or federal institution (even if not imprisoned)?* ○ Yes ◉ No

7 Have you ever been convicted of any crime of any federal, state or local law relating to the possession, distribution, use or dispensing of mind altering or controlled substances?* ○ Yes ◉ No

8 Have you ever used or possessed illegal drugs, scheduled controlled drugs, or mind altering substances, that would have been a crime by state or federal law?* ○ Yes ◉ No

9 Have you ever been evaluated for alcohol or drug abuse; or received treatment, counseling, or education for abuse of alcohol, drugs or mind altering substances?* ○ Yes ◉ No

10. a. Do you currently hold, or have you ever held, a license in this or any other state or country to practice a health care profession other than dentistry or dental hygiene? If yes, list on License History Tab.* ○ Yes ◉ No

10. b. Has there been any disciplinary action, pending or final, regarding any health care professional license (other than dental or dental hygiene) by a licensing board?* ○ Yes ◉ No

License History

List all states/countries in which you are or have been licensed or in which application is pending. (Enter "None" if none).

☐ None

Add License

State	License Number	Issue Date	Expiration Date	License Status	License Type	Actions
WA		06/02/2020	11/26/2023	Active	Dental	

Have you practice as a dentist or dental hygienist in any jurisdiction?* ○ Yes ◉ No

List in reverse chronological order all positions you have held in which you practiced dentistry or dental hygiene as well as any residencies or other formal training not otherwise listed on this application.

Add

Name of Institution or Employer	City	State	Zip	From	To	Action
	Vancouver	WA	98683	07/06/2020	01/26/2023	
	Portland	OR	97239	07/01/2019	06/30/2020	

Dental Biennial Licensure

Name as you wish it to appear on your formal license

First Name :

Middle Name :

Last Name :

Suffix :

Save and Next

Supplemental Documents

Please upload all of the following documents, which are required to complete the application process. If you do not have all of these documents, you may upload them at a later date, but please note your application will not be approved until all of the documents below have been received.

1. Proof of passage National Board

2. Proof of passage of a general dental clinical examination.

3. Current copy of BLS for Healthcare Providers or its equivalent certification.

4. Proof of completing Pain Management Course thorough the Oregon Pain Management Commission. (https://www.oregon.gov/oha/HPA/dsi-pmc/Pages/module.aspx)

5. Signed Fieldprint Memo/Privacy Act Statement form. This form will be emailed to you upon submission of your application. Please sign/date the form once your fingerprints have been taken, and upload it to this section of your application.

Document Name	Document T ype	Date	Uploaded By	Uploaded For	Link	Action
Fieldprint Memo/Privacy Act	Other	01/31/2023 12:00:00 AM	(OL)		Document Details	
Transcripts	Other	01/30/2023 12:00:00 AM	(BO)		Document Details	
NBDE	National Board Scores	01/30/2023 12:00:00 AM	(BO)		Document Details	
DEA	Other	01/30/2023 12:00:00 AM	(BO)		Document Details	
ADEX	Clinical Examination	01/30/2023 12:00:00 AM	(BO)		Document Details	
Pain Management Certificate	BLS for Healthcare	01/23/2023 12:00:00 AM	(OL)		Document Details	
BLS	BLS for Healthcare	01/17/2023 12:00:00 AM	(OL)		Document Details	

Document Name :

Document Type : BLS for Healthcare

Document:

Drop file here to upload or click here to browse and select file(s) to upload.

Click here to complete Upload

Cancel

Deficiency

Supplemental Documents (Applicant)

Affidavit of Applicant

- [x] I hereby declare that I am the person described in this application for licensure.

- [x] I have carefully read the questions in the application and have answered them completely , without reservations of any kind, and I declare under the penalty of perjury that my answers and all statements made by me are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice dentistry/dental hygiene in the State of Oregon.

- [x] I hereby authorize all hospitals, institutions, or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Oregon Board of Dentistry any information, files or records requested by the Board in connection with the processing of this application. I further authorize the Board to release to the organizations, individuals and groups listed above any information, which is material to my application.

Signature : Gordon Test

Date: 02/01/2023

Fee and Payment

Payment Method : Check

Override : [x]

Payment Date :

Application Fee: Dental LBE : 345

Licensure Fee: Dental LBE : 340

Prescription Drug Monitoring Fee : 50

Total Fees : 735

Check # : -

Comment : .

Date created: August 7, 2023

APA calls for removal of mental health questions on applications to practice law

Mental Health (https://www.apa.org/topics/mental-health) Forensics, Law, and Public Safety (https://www.apa.org/topics/forensics-law-public-safety)

Managing Human Capital (https://www.apa.org/search?query=managing%staff)

Data show no connection between treatment history and competence

WASHINGTON — People seeking to be licensed as attorneys should not be required to reveal their mental health history, including whether they have ever had a mental health diagnosis, according to the American Psychological Association.

APA's governing Council of Representatives unanimously approved a policy at its meeting Aug. 2 pledging to work alongside the American Bar Association and state bar associations to remove questions regarding mental health diagnoses or treatment history from character and fitness questionnaires.

"[S]tatistical data reveal that there is no connection between bar application questions about mental health and attorney misconduct and that such questions have not been empirically shown to work as a successful screening tool for who can and cannot practice law in a competent manner," the resolution states.

Read the resolution

APA Resolution to Oppose Mental Health Screening Questions on Character and Fitness Examinations for Licensure to Practice Law (PDF, 57KB) (/about/policy/resolution-mental-health-screening-practice-law.pdf)

Thirty-seven states and the District of Columbia include one or more questions on their character and fitness questionnaire referencing the mental health status of applicants, which can include a statement that it is the applicant's responsibility to "check with your treating health care professional" regarding diagnoses, according to the American Bar Association.

The U.S. Department of Justice has stated that such questions tend "to screen out individuals with disabilities based on stereotypes and assumptions about their disabilities and are not necessary to assess the applicants' fitness to

practice law" and recommended removal of applicant questions about diagnoses.

APA called for law schools to support law students seeking appropriate mental health treatment and reduce the stigma associated with mental health.

Contact
Kim I. Mills
(202) 336-6048

750 First St. NE, Washington, DC 20002-4242
Telephone: (800) 374-2721; (202) 336-5500 | TDD/TTY: (202) 336-6123

OTHER ISSUES

From: Kowalski Sarah E <SARAH.E.KOWALSKI@oha.oregon.gov>
Sent: Wednesday, July 19, 2023 9:33 AM
Subject: DPP#100 - Advisory Committee Conclusion

Good Morning,

Attached, please find a memo from OHA regarding the conclusion of the Dental Pilot Project #100 Advisory Committee work. Secondly, please find a copy of the closing report from the project sponsor. Please note, this is one of two reports from the Northwest Portland Area Indian Health Board. The final report is due to OHA in November.

I want to thank you each for your time. We began this work in 2016 and we met a total of 16 times, each time for about two hours. Several of you have been with the committee from the very beginning and graciously attended site visits throughout the State of Oregon, assisting OHA with meeting our obligations and responsibilities.

We greatly appreciate all of your time, enthusiasm and subject-matter expertise.

Sincerely,
Sarah Kowalski

Sarah Kowalski, MS, RDH
Dental Pilot Projects: Oral Health Program Operations
Sarah Kowalski, MS, RDH *(she/her)*
Oral Health Operations & Policy Analyst
Dental Pilot Project Program
OREGON HEALTH AUTHORITY
Public Health Division
sarah.e.kowalski@dhsoha.state.or.us

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

July 18, 2023

Via Email Transmission

Sarah Kowalski, RDH, MS
Dental Pilot Project Program
Oregon Health Authority

RE: Oregon Dental Pilot Project #100 Discontinuation

Dear Ms. Kowalski:

We are writing to inform you of the discontinuation of Dental Pilot Project #100 (DPP #100), effective May 31, 2023. Please accept this letter to meet the project requirement of submitting a closing report within two months after the project's end date.

Reason for Discontinuation:

DPP #100 was approved in and began in 2016. The project's original end date, 5 years after initiation, was May 31, 2021. The project then requested and was granted two consecutive requests to extend its duration by one year each. These requests were submitted to allow project participants to continue to serve their communities until the option to work under authority of a state license was available. This option became available via the Oregon Board of Dentistry in September 2022 (following passage of authorizing legislation, HB 2528, in 2021). In fall and winter of 2022-2023, DPP #100 participants were able to go through the required processes and received Oregon state dental therapy licenses. By May of 2023, all participating clinics had exited DPP #100 and the project was no longer needed.

Summary of Dental Pilot Project #100:

Clinics: Three clinics participated in Pilot Project #100:

- Native American Rehabilitation Association (NARA)
- Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians (CTCLUSI)
- Ko-Kwel Wellness Center – a clinic of the Coquille Indian Tribe (Ko-Kwel)

Participants: The project included a total of six participants. Five of these participants completed the training phase: attendance and graduation from the Alaska Dental Therapy Education Program (ADTEP) at Ilisagvik College. One participant was a previous graduate of ADTEP, so did not participate in the training phase during DPP #100 participation; he was able to begin his DPP #100 participation in the utilization phase. Five of the project participants participated in the

employment/utilization phase, which included a 400+ hour direct-supervision preceptorship: two at NARA, two at CTCLUSI, and one at Ko-Kwel.

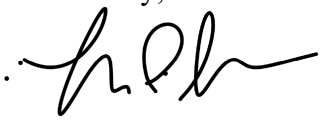
Four of the participants have applied for and received a dental therapy license from the Oregon Board of Dentistry.

DPP #100 adhered to a thorough evaluation and monitoring plan protocol. As part of this, quarterly detailed data reports of all completed procedures were sent to the Oregon Health Authority including chart reviews from an outside dental reviewer. Additionally, a lengthy quarterly narrative detailing specific clinic updates was provided as well.

The Northwest Portland Area Indian Health Board (NPAIHB) is proud to have sponsored this Dental Pilot Project #100. The strong record of safety and efficacy that DPP#100 dental therapists demonstrated led to passage of legislation authorizing this profession statewide in 2021, which we trust will lead to improved access to high quality dental care for more communities in Oregon for future generations.

We have appreciated this opportunity for Tribal communities to work with the Oregon Health Authority toward a shared goal of supporting optimal health in Oregon.

Sincerely,



Laura Platero, JD
Executive Director
Northwest Portland Area Indian Health Board

CENTER FOR PREVENTION AND HEALTH PROMOTION
Oral Health Program
Tina Kotek, Governor

Oregon Health Authority

800 NE Oregon St, Ste 825
Portland, Oregon 97232-2186
Office: 971-673-1563
Cell: 509-413-9318
www.healthoregon.org/dpp

July 14, 2023

TO: Advisory Committee Members
Dental Pilot Project #100

FROM: Sarah E. Kowalski, MS, RDH
Dental Pilot Project Program Coordinator

RE: Conclusion of Dental Pilot Project #100 and Advisory Committee

Dear Advisory Committee Member,

The Oregon Health Authority (OHA) would like to thank you for your service as an Advisory Committee member for Dental Pilot Project #100 "Oregon Tribes Dental Health Aide Therapist Pilot Project".

We want to thank you for the time, talent, and subject-matter expertise you have given to the Dental Pilot Project Program through your active participation on the Advisory Committee. Your ideas, input, and enthusiasm were most helpful and have assisted OHA in meeting its responsibilities of the Program.

The goal of the Dental Pilot Project Program is to offer a unique opportunity to address health disparities and create more equitable oral health care delivery systems by testing innovative ways to improve oral health practice, workforce, and access. Dental pilot projects are community driven and intentionally designed to increase access to dental care for communities of color and other populations which evidence-based studies have shown to have the highest dental disease rates and the least access to dental care.

In 2021, legislation was passed which resulted in the authorization of dental therapists in Oregon. Dental therapists are now a recognized licensed provider type and are overseen by the Oregon Board of Dentistry. Licensed dental therapists are required to provide 51% of their services to individuals who are part of historically underserved populations.[1]

On May 31, 2023, Dental Pilot Project #100 officially concluded. The project sponsor will be submitting a required final report of findings to OHA in late November 2023. The final report is based on the Evaluation & Monitoring Plan and any subsequent modifications approved by OHA. The Advisory Committee will not hold any further meetings. The final report will be disseminated to all committee members and posted online for review.

Again, thank you for your contributions, time, and effort while serving on this advisory committee.

[1] Oregon Administrative Rule 409-017-0121

Title: OBD Tribal Relationship & Cooperation Policy

Effective Date: February 25, 2022

Purpose:

The State of Oregon and the Oregon Board of Dentistry (OBD) share the goal to establish clear policies establishing the tribal consultation and requirements to further the government-to-government relationship between the OBD and the nine federally recognized Tribes of Oregon (Oregon Tribes) with the passage of HB 2528 (2021) and on any other matters that are important to the Tribes. This policy shall fulfill the requirements of ORS 182.164 & ORS 182.166.

Nine Federally Recognized Tribes of Oregon ("Oregon Tribes"):

- Burns Paiute Tribe
- Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians
- Confederated Tribes of Grande Ronde
- Confederated Tribes of Siletz Indians
- Confederated Tribes of the Umatilla Indian Reservation
- Confederated Tribes of Warms Springs
- Coquille Indian Tribe
- Cow Creek Band of Umpqua Tribe of Indians
- Klamath Tribes

Other Organizations
Urban Indian Health Programs (UIHP)
Northwest Portland Area Indian Health Board (NPAIHB)

This Policy:

- Identifies individuals within the OBD who are responsible for developing and implementing programs, rules, policies and draft legislation that affect Tribes.
- Establishes a process to identify the OBD programs, rules, policies and draft legislation that impact Tribes.
- Promotes communication between the OBD and the Tribes.
- Promotes positive government-to-government relations between the OBD and Tribes.
- Promotes positive relationships with any entity that serves tribal members including the Northwest Portland Area Indian Health Board and Urban Indian Health Programs
- Establishes a method for ensuring that OBD employees comply with ORS 182.162 to 182.168 and this policy.
- Streamlined for ease to understand and apply: the OBD is a small agency with 8 employees.
- This Policy is to meet compliance with ORS 182.164, but also should be utilized in working with any tribal group, entity or organization that supports tribal members and is impacted by the OBD's work.

Meaningful consultation between tribal leadership and agency leadership shall result in information exchange, transparency, mutual understanding, and informed decision-making on

behalf of the Oregon Tribes and the State. One key goal of this policy is to prevent avoidable surprises between the OBD and Oregon Tribes.

Other key goals of this policy include, but are not limited to: helping to eliminate health and human service disparities of Indians; ensuring that access to critical health and human services is maximized; advancing and enhancing the social, physical, behavioral and oral health of Indians; making accommodations in State programs when possible to account for the unique nature of Indian health programs; collaborating on the development and improvement of programs, rules, policies and draft legislation; and ensuring that the Oregon Tribes are consulted to ensure meaningful and timely tribal input as required under Federal and State law when health and human service policies have an impact on Indians and the Oregon Tribes. To achieve this goal, and to the extent practicable and permitted by law, it is essential that the Oregon Tribes and the OBD engage in open, continuous and meaningful consultation and collaboration.

This policy applies to the OBD (Board Members and staff) and shall serve as a guide for the Oregon Tribes to participate in OBD legislative, rule and policy development to the greatest extent allowable under law. The relationship between the OBD and the Oregon Tribes is important and should be on a foundation of trust and mutual respect. It is important for the OBD to work closely with Oregon Tribes on issues related to Dental Therapy and any other matter that is important to the Oregon Tribes.

Policy #834-413-019 OBD Tribal Relationship & Cooperation
Policy Effective Date: February 25, 2022

Applicability: All Board Members, full and part time employees, temporary employees and volunteers

References:
(1) Purpose
This tribal relations policy is adopted pursuant to ORS 182.162 – 182.168, which requires state agencies to develop and implement tribal relations policies.
(2) General Policies and Principles
It is OBD's policy to promote the principle stated in Executive Order No.96-30 that "[a]s sovereigns the tribes and the State of Oregon must work together to develop mutual respect for the sovereign interests of both parties." OBD interacts with tribes in differing roles: in its role as legal advisor to and representative of other state agencies; and in its role as independent administrator of certain OBD programs. In all of its roles, it is OBD's policy to promote positive government to government relations with the federally recognized tribes in Oregon ("tribes") by
(a) Facilitating communication and understanding and appropriate dispute resolution among OBD, other state agencies and those tribes;
(b) Striving to prevent unnecessary conflict with tribes;
(c) Interacting with tribes in a spirit of mutual respect;
(d) Involving tribal representatives in the development and implementation of programs, rules, policies and draft legislation that affect them; and
(e) Seeking to understand the varying tribal perspectives.
(3) The OBD's Native American Affairs Coordinator is the OBD's Executive Director
(a) The state is best served through a coordinated approach to tribal issues. The OBD's Executive Director has been designated as the OBD's Native American Affairs Coordinator, who serves as the OBD's key contact with tribal representatives.
(b) Individuals at the OBD who are working on a significant matter involving or affecting a tribe

shall notify the Native American Affairs Coordinator.
(4) Dissemination of Tribal Relations Policy
(a) Upon adoption, this policy shall be disseminated to members of the OBD, and shall be incorporated into the OBD Policy Manual. In addition, this policy and information regarding ORS 182.162 – 168 shall be included in new Board Member and employee orientation.
(b) The Executive Director will be responsible for submitting the OBD's annual report in December to the Governor and the Commission on Indian Service per ORS 182.166 detailing its work with the Tribes for the prior year and this Policy.
(5) Training
(a) Appropriate OBD representatives will attend annual training provided by the Department of Administrative Services pursuant to ORS 182.166(1).
(b) The OBD's assigned attorney who may come into contact with tribes will be encouraged to consider taking advantage of outside CLE opportunities on Indian law and culture.
(7) Identification of OBD Programs Affecting Tribes
The Executive Director will compile a list of OBD programs, rules, policies and draft legislation that affect tribes, as well as the OBD individuals responsible for implementing them with feedback from the affected Tribes or tribal members.
(8) Guidelines for OBD Programs
The OBD will invite tribal participation on Dental Therapy issues and other areas of interest that the Tribes bring forth to the OBD.

OBD Commitment to Tribal Consultation

The OBD was established by the Oregon State Legislature in 1887 and is accountable to the people of Oregon, acknowledges this unique relationship, the statutory and regulatory framework for states to consult with Tribes, and recognizes the right of Indian tribes to self-determination and self-governance. The special government-to-government relationship between the Tribes and federal and state governments will be respected in all dealings with the Tribes and OBD. Relationship of State Agencies with Indian Tribes, ORS 182.162 to 182.168.

In order to fully effectuate this policy, OBD will:

- Ensure inclusion of the Tribes prior to the development of policies and program activities that impact Tribes, utilizing the OBD's formal notice that provides descriptive content and a timeline of all public meetings;
- Create opportunities for Tribes to raise issues with the OBD and for the OBD to seek consultation with Tribes;
- Establish communication channels with Tribes to increase knowledge and understanding of OBD programs;
- Support tribal self-determination;
- Include on every regular Board Meeting Agenda an opportunity for the Tribes to directly communicate with the OBD.

Tribal Consultation Principles:

Consultation is an enhanced form of communication that emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation includes collaboration and often results in an iterative process between parties. Meaningful consultation is integral to a

deliberative process that results in effective collaboration and informed decision-making, with the ultimate goal of reaching consensus on issues and better outcomes.

To establish and maintain a positive government-to-government relationship, meaningful communication and consultation must occur on a regular and as needed basis so that Tribes have an opportunity to provide meaningful, and timely input on issues that may have an impact on Tribes. This government-to-government relationship applies between the Tribes and the State.

Consultation with the Tribes is important in the context of health programs because the Tribes serve many roles in their communities:

- Tribes and tribal governments are sovereign nations with inherent authority over their internal affairs; have a government-to-government relationship with the federal government, state governments, and other sovereigns; and have the responsibility to ensure the health and well-being of their tribal citizens, among various other governmental responsibilities.
- Tribal governments operate businesses, are employers, and are health care providers, through administration of clinics and other health programs, which includes public health

Policy Action

It is the intent of OBD to meaningfully consult with Tribes on any rule changes, policy, programs, rules and draft legislation that will impact the Tribes before any action is taken.

Such rule changes or policies include those that:

- Have Indian or Tribal implications; or
- Have implications on the Indian Health Service, tribal health programs or urban Indian health program, or
- Have a direct effect on one or more Tribes, or
- Have a direct effect on the relationship between the state and Tribes, or
- Have a direct effect on the distribution of power and responsibilities between the state and Tribes; or
- Are a federally or statutorily mandated proposal or change in which OBD has flexibility in implementation.

Tribal Consultation Process:

An effective consultation between the OBD and the Tribes requires trust between all parties which is an indispensable element in establishing a good consultative relationship.
Any Issue includes, but is not limited to:

- Policy, programs, rules and draft legislation development impacting the Tribes;
- Program activities that impacting Tribes;
- Data collection and reporting activities impacting Tribes;
- Rulemaking impacting Tribes; or
- Any other OBD action impacting Tribes or that has implications on the NPAIHB, tribal health programs or IHS.

Upon identification of any Issue meeting any of the above criteria the OBD will initiate consultation regarding the issue.

To initiate and conduct consultation, the following serves as a guideline to be utilized by the OBD and the Tribes:

- Identify the Issue: complexity, implications, time constraints, deadlines and issue(s).
- Identify how the Issue impacts the Tribes.
- Identify affected/potentially affected Tribes.

Determining Consultation Mechanism: The most useful and appropriate consultation mechanisms can be determined by OBD and Tribes after considering the Issue and Tribes affected/potentially affected. Consultation mechanisms include but are not limited to one or more of the following:

- Email
- Teleconferences
- Virtual Meetings
- Face-to-Face Meetings at regular Board or Committee Meetings
- Other regular or special consultation sessions needed.

Communication Methods: The determination of the Issue and the level of consultation mechanism to be used by OBD shall be communicated to affected/potentially affected Tribes using all appropriate methods and with as much advance notice as practicable or as required under this policy.

These methods include but are not limited to the following:

- Official Notification: Upon the determination of the consultation mechanism, proper notice of the Issue and the consultation mechanism utilized shall be communicated to affected/potentially affected Tribes using all appropriate methods including mailing and broadcast e-mail. Such notice shall be provided to:
    - Tribal Chair or Chief and their designated representative(s)
    - Any other entity that the Tribes identify that should be included

- The OBD will regularly update its mailing/email list to ensure notice is being provided to designated leadership. Each Tribe is responsible for providing this information to OBD's Executive Director to regularly update the list.

Rulemaking: The OBD will include the Tribes in all legislative, rulemaking and policy making processes that have tribal implications. The Tribes will have a regular and open invitation to attend any OBD Committee meeting or public rulemaking hearing to provide additional input on rule concepts and language.

Creation of Committees/Work Group(s): Round tables and work groups may be used for discussions, problem resolution, and preparation for communication and consultation related to an Issue but do not replace formal tribal consultation. Round tables and work groups will provide the opportunity for technical assistance from the OBD to Indian health programs and the Tribes to address challenges or barriers and work collaboratively on development of solutions to bring to the meetings.

Implementation Process and Responsibilities: The process should be reviewed and evaluated for effectiveness as requested.

Tribal Consultation Evaluation: The OBD is responsible for evaluating its performance under this Tribal Consultation Policy. To effectively evaluate the results of the consultation process and the ability of the OBD to incorporate tribal recommendations, the OBD may assess its performance on an annual basis in the Executive Director's performance review or as needed.

Meeting Records and Additional Reporting: The OBD is responsible for making and keeping records of all public meetings and its tribal consultation activity. All such records shall be made readily available to the Tribes.

Definitions:

Indian or American Indian/Alaska Native (AI/AN1Indian and/or American Indian/Alaska Native (AI/AN) means any individual defined at 25 USC 1603(13),1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12. This means the individual:

Is a member of a Federally recognized Indian Tribe;
Resides in an urban center and meets one or more of the four criteria:
Is a member of a Tribe, band, or other organized group of Indians, including those Tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;
Is an Eskimo or Aleut or other Alaska Native;
Is considered by the Secretary of the Interior to be an Indian for any purpose; or
Is determined to be an Indian under regulations issued by the Secretary;
Is considered by the Secretary of the Interior to be an Indian for any purpose; or
Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.
Tribe. Tribe means any Federally recognized Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians. Oregon's nine Federally Recognized Tribes include:

- Burns Paiute Tribe
- Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians
- Confederated Tribes of Grande Ronde
- Confederated Tribes of Siletz Indians
- Confederated Tribes of the Umatilla Indian Reservation
- Confederated Tribes of Warms Springs
- Coquille Indian Tribe
- Cow Creek Band of Umpqua Tribe of Indians
- Klamath Tribes

Disclaimer:

OBD respects the sovereignty of each of Oregon's Tribes. In executing this policy, no party waives any rights, including treaty rights; immunities, including sovereign immunities; or jurisdictions. This policy does not diminish any rights or protections afforded other Indian persons or entities under state or federal law. Through this policy, the parties strengthen their collective ability to successfully resolve issues of mutual concern. While the relationship described by this policy provides increased ability to solve problems, it likely will not result in a resolution of all issues. Therefore, inherent in their relationship is the right of each of the parties to elevate an issue of importance to any decision-making authority of another party, including, where appropriate, the Governor’s Office.

House Bill 3173

Sponsored by Representative SANCHEZ; Representatives BOWMAN, CHAICHI, GOMBERG, HARTMAN, MARSH, NELSON, NOSSE, PHAM K, Senators GELSER BLOUIN, GORSEK, STEINER, TAYLOR

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Establishes Task Force on Tribal Consultation and specifies task force membership. Requires task force to identify and clarify requirements of state agencies to engage in tribal consultation. Requires task force to report findings and recommendations on tribal consultation to interim committee of Legislative Assembly related to government by September 15, 2024.

Sunsets December 31, 2024.

Takes effect on 91st day following adjournment sine die.

A BILL FOR AN ACT

Relating to tribal consultation; and prescribing an effective date.

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

SECTION 1. (1) The Task Force on Tribal Consultation is established.

(2) The task force consists of 15 members appointed as follows:

(a) The President of the Senate shall appoint one member from among members of the Senate.

(b) The Speaker of the House of Representatives shall appoint one member from among members of the House of Representatives.

(c) The President of the Senate and the Speaker of the House of Representatives shall jointly appoint one member who is a member of the Commission on Indian Services.

(d) The Governor shall appoint:

(A) One member who is a representative of the office of the Governor;

(B) One member from each of the nine federally recognized Indian tribes in this state; and

(C) Two members, each of whom is a representative of a state agency that is required to engage in tribal consultation.

(3) The task force shall identify and clarify the requirements of state agencies to engage in tribal consultation.

(4) A majority of the voting members of the task force constitutes a quorum for the transaction of business.

(5) Official action by the task force requires the approval of a majority of the voting members of the task force.

(6) The task force shall elect one of its members to serve as chairperson.

(7) If there is a vacancy for any cause, the appointing authority shall make an appointment to become immediately effective.

(8) The task force shall meet at times and places specified by the call of the chairperson or of a majority of the voting members of the task force.

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

(9) The task force may adopt rules necessary for the operation of the task force.

(10) The task force shall submit a report in the manner provided by ORS 192.245, and may include recommendations for legislation, to an interim committee of the Legislative Assembly related to government no later than September 15, 2024.

(11) The office of the Governor shall provide staff support to the task force.

(12) Members of the Legislative Assembly appointed to the task force are nonvoting members of the task force and may act in an advisory capacity only.

(13) Members of the task force who are not members of the Legislative Assembly are not entitled to compensation or reimbursement for expenses and serve as volunteers on the task force.

(14) All agencies of state government, as defined in ORS 174.111, are directed to assist the task force in the performance of the duties of the task force and, to the extent permitted by laws relating to confidentiality, to furnish information and advice the members of the task force consider necessary to perform their duties.

SECTION 2. Section 1 of this 2023 Act is repealed on December 31, 2024.

SECTION 3. This 2023 Act takes effect on the 91st day after the date on which the 2023 regular session of the Eighty-second Legislative Assembly adjourns sine die.

NEWSLETTERS & ARTICLES OF INTEREST

The CRDTS Report

Over 50 Years of Testing Excellence

Central Regional Dental Testing Service, Inc. Spring 2023

President's Message

Sam Jacoby, DDS
President

EXPRESS YOURSELF

For those of us who enjoy watching sports of almost any variety, football, basketball, track, baseball, it doesn't matter, there is something we see at nearly every contest. It is the vision of some participant who has just completed an amazing feat of athleticism, who in an expression of self-approval beats on his chest like Tarzan, thrusts his arms with fingers pointed skyward and bellows a primal howl that would wake the dead. This could happen at any point in the game when the outcome is still uncertain……Is that really necessary? I didn't used to think so, but I have changed my mind lately. If someone wants to beat on their chest because they have devoted countless hours of hard work and preparation to accomplish something, then praise the Lord for the opportunity and ability to do it, they have every right.

I feel that way now because for the better part of two years I have been working with a group of people at CRDTS who deserve to beat on their chest some. CRDTS dental hygiene has increased exam sites by over 25% the previous year. That doesn't just happen by accident. It is the result of great public relations, exam content, exam administration, cooperation and coordination with Central Office staff, outstanding leadership from their professional staff and committees, and a high level of performance from their examiners. CRDTS dental has streamlined the administration of their exam, revamped all the manuals, and with excellent professional staff leadership and ad hoc committee work, has developed and instituted a psychometrically valid and pertinent diagnosis and treatment planning written exam to supplement the clinical exams. All of the independent test sites, developed through the vision and commitment of the Executive and Steering Committees, have hosted multiple dental exams to supplement our school-based exams. CRDTS dental and dental hygiene have been working together with our partners in Europe, SIMtoCARE, to develop virtual haptic technology that augments our examinations and remediation. The CRDTS CARE Program has been developed and is available for dental boards to obtain reliable and verifiable remediation results when needed for licensees. Our organization is making progress and growing, and with all this increased activity, our amazing Central Office staff manages to continue to build schedules, arrange meetings, organize exam supplies, handle finances, and crunch exam data with accuracy and efficiency. We are also fortunate to have an Executive Director who has worked extremely hard to gain an understanding of our organization and profession so that she can communicate effectively in any situation. As a result of that process, she has developed a tenacious loyalty to CRDTS.

There is no question that what I have just described is the definition of great teamwork by an outstanding team. CRDTS has an excellent group of examiners to draw from when leadership asks for help to achieve goals, so the response is usually quick and effective. Even so, sometimes it feels like the hard work, long hours, and extra effort result in ever so small gains. So as individual members of a great team, if you have a small victory in whatever you are doing for CRDTS, and it helps your psyche to beat on your chest and scream like a banshee, I say go for it! All your efforts are appreciated!

Sam Jacoby, DDS
CRDTS President

Volume 19, Issue 1

Sheli Cobler, Executive Director

CRDTS AND THE STATE DENTAL BOARDS

One thing I've come to understand better in my role as Executive Director for CRDTS is the importance of the state dental boards and each state dental board member, not only monitoring dental professionals in their state, but in understanding the content, criteria, and scoring for each of the dental licensure examinations. By working with dental testing agencies to ensure the most valid, reliable, and fair initial licensure examinations are administered, the state dental boards take the first step to ensure graduates are competent to enter the world and provide safe service to the public. It is because of the important work of each and every state dental and dental hygiene board or commission member that the United States has the highest quality of dental and oral health care available.

As a national examining agency with more than 50 years of testing excellence, CRDTS' goal is to continue our work with the state dental boards to help you meet your mission. That is why we value the collaboration we have with each of our CRDTS state board Members and why we carefully monitor the rules and regulations of all state dental and dental hygiene boards, including those that are not currently members – to ensure our exams are meeting laws and regulations nationally.

CRDTS leadership has gone to great lengths the past couple of years to renew relationships with each state dental board and provide updates regarding the importance of our organization and the development of our exams. That work will continue on a regular basis going forward. We are anxious to visit each and every state dental/dental hygiene board and collaborate with you on the great work we are doing and learn how we can better serve you, with the same goal to protect the safety and welfare of the public in dental care. We encourage you to contact us if there is ever a time you would like to hear from us on any of the great initiatives we are working on.

As one of just a few testing agencies in the business, we especially appreciate the great work of the dental boards that are going the extra mile to ensure that each of the initial licensure examinations meets the requirements of their state laws and board rules. For example, one state dental board recently did a thorough review and side by side comparison of each licensure exam and recognized discrepancies in the examinations administered by each testing agency. In January 2023, that state's dental board members voted that the other agency examinations do not meet the standards set out in their state statues and that CRDTS is the only acceptable dental and dental hygiene examination in that state for any clinical exam initiated after November 1, 2022. While the review of each agency exam requires a great deal of work, we appreciate that state boards are not shying away from it and are diligently completing the responsibility they have been charged with. It is through this work that CRDTS continues to provide the gold standard in dental and dental hygiene licensure examinations.

Without a regular and thorough review of the examinations, it would be difficult to ensure each exam meets the standards set forth by the states. It is for that reason that CRDTS involves the state dental boards in the development and enhancement of our examinations on a regular basis. Who better to have input and decision-making authority on what is best for a dental or dental hygiene examination than state board members? Each CRDTS Member State enjoys a seat on our governing board, our dental exam review committee, and our dental hygiene review committee. Thus, if rules or regulations change that impact our examinations, CRDTS is immediately able to factor that information in our regular review of each examination. Furthermore, state board members are welcomed and encouraged to examine for our agency, so you have firsthand knowledge of how the exams are administered.

Without competing agencies to keep each other accountable, the state dental boards run the risk of losing control of the quality of the examination, the costs associated with the exams, and the efficiency in how the exams are administered. A monopoly in any business is a detriment to the public and that is why CRDTS works so hard to continue the more than 50 years of excellence we are known for.

Since the day I walked through the doors of my office at CRDTS, I could tell that relationship building was the cornerstone of this organization. Our current President Elect, Dr. Otto Dohm, has stated many times that "CRDTS is all about the people." That is a statement that I think everyone associated with CRDTS understands. CRDTS is not just a business. It is an organization made up of genuine, thought provoking, sincere professionals who have the best interest of the public and upcoming dental professionals at heart. It's not about making money. It's about the people!

If your state dental board is not currently a member of CRDTS I encourage you to ask why that is. CRDTS is the only dental and dental hygiene testing agency that regularly collaborates with each and every one of our members to ensure the best quality exam and the most efficient and professional way of administering every single exam.

continued on page 3

CRDTS and the State Dental Boards Continued...

Thank you to all CRDTS Members! Your participation in the development and continued enhancement of the initial dental and dental hygiene licensure examinations is crucial to the quality of minimal competency assessments for newly graduating dental professionals as they enter the workforce. Your voice matters to us!!

If your state is not already a member and you would like more information about becoming a member of CRDTS, please contact me at richael@crdts.org or 785.273.0380.

Sheli Cobler
CRDTS Executive Director

Otto Dohm, DDS
President Elect

THE PHOENIX/ AKA CRDTS

The Phoenix is a mythological creature that is said to perish only to reinvent itself and rise from the ashes.

I am excited to tell you that the Phoenix is not mythical but is in fact embodied in CRDTS today. The CRDTS organization has retooled, reimagined and reinvigorated itself and is now rising from the ashes!

CRDTS, unlike the Phoenix, is not seeing this resurgence via some supernatural power. No, this re-emergence is the fruit of the labors of a dedicated and professional group of people that have devoted themselves to retooling and reimagining the organization after 50 years. I stated previously that for me, CRDTS is "all about the people" and I stand by that statement. The effort expended by individuals for the good of this organization has been and continues to be remarkable. The effort has been relentless. CRDTS has conducted itself with professionalism and integrity that should make all members proud.

The development and execution of a fluid strategic plan is now showing concrete results. The dental/dental hygiene tests are significantly increased as of last year and there are reasons to expect continued growth. The development and rollout of the CARE program provides a much needed remediation service to dental boards and practitioners throughout the country. This program is an amalgamation of the highest tech available in dentistry with industry leaders in continuing education. It will quickly become the national standard for remediation.

CRDTS today represents the highest iteration of Dental/ Dental Hygiene testing in the country and the CARE program is unrivaled.

We are growing, we have the products to meet the needs of the profession, but we must continue to rise from the ashes. The work has been started but we have more to do. Where do we go?

We must continue to modify and improve upon our exams to ensure they are the gold standard. The quest to have every state board accept CRDTS results as meeting the requirements for licensure will remove more impediments to CRDTS providing testing at various schools. The rollout of the CARE program and marketing to state boards should increase activity at the Topeka testing site as the years progress.

The rise is not complete. We must continue to push forward, encourage and support each other. We must be imaginative, creative and rigorous in our effort. We can't compromise our principles or our integrity but we can move forward. I would urge all to recommit to the endeavor. It is a quest worthy of the effort. I am humbled to be a part of this group.

Otto Dohm, DDS
President Elect

Andrew Johnston, RDH
Vice President

MID-YEAR CHECK-IN

I cannot believe it is already almost halfway through 2023! Looking back at our New Year's Resolutions, how are we all doing? I made a resolution to be more positive, to keep a more open mind when presented with difficult situations, and to think longer before I spoke. Depending on who you talk to, I am either doing amazing or failing spectacularly! Another resolution was to spend more time dedicated to CRDTS, taking the role seriously and among other responsibilities, trying to improve upon the amazing Annual Meeting we had in 2022.

It will be a tall order to do better than last year's Annual Meeting, but we will surely try. This year, the meeting will be held in Kansas City on August 25th-26th. The feedback we received from the last meeting was overwhelmingly positive and our plan is to bring you some more dynamic speakers to help you with your CE needs, in a location that is near all of the action. The hotel is located in the heart of a shopping district and just a short ride away from endless downtown possibilities. We have also restructured the schedule for Saturday's events so that everyone is able to attend all of the events and we are excited to bring back Casino Night after the President's Dinner!

As a member of the Executive Committee, I am excited by the goals we are setting for ourselves - to do better for our candidates, our state board members, and for you. I am pleased by the achievements CRDTS has made this past year with commitments from schools for additional exams, improved relationships with program directors and deans of dental schools, and candidates utilizing our independent exam options. Our professional and administrative staff is among the best I have seen in any organization, which bodes well for our future growth and success.

Looking forward to seeing you all soon,

Andrew Johnston, RDH
Vice President

CRDTS DENTAL HYGIENE CCAP PROGRAM COMING JANUARY 2024!

The CRDTS Dental Hygiene team is excited to announce the official release of the Clinical Calibration and Assessment Program (CCAP) Program. This program has been occurring in a trial form for the last two years. It has been presented to approximately 15 dental hygiene programs that have stated the CRDTS CCAP Program is beneficial for the calibration of all their faculty – new and experienced, and well worth the time to help their programs become even better.

Available to all dental hygiene programs across the nation and U.S. territories, the CCAP program will assist dental hygiene programs and their clinical faculty with some of the accreditation requirements for the Commission on Dental Accreditation (CODA). The Program can be given in conjunction with a dental hygiene exam or independently and a nominal fee will be charged.

With over 50 years of expertise in calibrating examiners, CRDTS can work with your program to help ensure your faculty is adequately calibrated to each other. We can also help you review your current calibration plan and discuss methods that will help with improving and/or maintaining calibration.

Some of the benefits include:

- ▶ Documentation for CODA accreditation
- ▶ CE credit available
- ▶ Methodology discussions
- ▶ Hand Skills calibration
- ▶ Clinical assessment that includes your current grading criteria for clinic

Watch your email for more details and if you are not on our email list currently but would like information, please send a note to info@crdts.org and we will make sure you get added to the list.

An email with instructions for registration and travel has been sent out and may also be found at www.crdts.org/AnnualMeeting.

THURSDAY, AUGUST 24

7:30 AM - 6:00 PM	Committee Meetings

FRIDAY, AUGUST 25

7:30 AM - 3:30 PM	Committee Meetings
4:00 PM - 4:45 PM	State Board Meet & Greet
5:00 PM - 6:00 PM	Happy Hour (Cash Bar)
6:00 PM - 7:00 PM	President's Dinner - Past Presidents Recognized Retiree Recognition
7:00 PM - 9:30 PM	Casino Night

SATURDAY, AUGUST 26

7:30 AM - 9:00 AM	Continental Breakfast
8:00 PM - 9:45 AM	Business Meeting
10:00 AM - 11:00 AM	CE Speaker
11:10 AM - 12:40 PM	CE Speaker
12:45 PM - 1:45 PM	Luncheon
2:00 PM - 3:00 PM	Dental Exam Changes 2024
2:00 PM - 3:00 PM	Dental Hygiene Changes 2024
3:15 PM - 5:00 PM	Dental Educator's Meeting
3:15 PM - 5:00 PM	Dental Hygiene Educator's Meeting

Mark Edwards, DDS, Director of Dental Examinations

Rod Hill, DDS, ERC Committee Chair

FROM THE OFFICES OF THE DENTAL EXAM REVIEW COMMITTEE CHAIR AND THE DIRECTOR OF DENTAL EXAMINATIONS

Here's hoping that 2023 is off to a safe and strong start for all. The CRDTS Dental ERC has been busy continuing to modify simulated patient examination typodonts as well as simulated patient content, criteria, and policy. Following careful psychometric review and analysis of simulated patient examination scoring and candidate performance statistics from 2019-2022, Dr. Brett Foley of Alpine Testing Solutions has supported a modification to the retake policy for all procedures within the CRDTS simulated patient exams. Beginning in the 2023-2024 Dental testing year (Class of 2024), candidates will be able to bank all procedures passed, and only retake those procedures with less than a 75% score.

CRDTS continues to embrace and explore new avenues and the impact of technology in dental and dental hygiene licensure assessment, education, and remediation. CRDTS continues to work in a collaborative relationship with SIM-toCARE to develop and refine virtual haptic technology to be used in education and remediation at our independent testing site in Topeka, KS. CRDTS has also entered into a partnership agreement with Acadental relative to utilizing Teo virtual reality technology as a remediation tool for distance learning via 3-D evaluation and critique of licensee work.

CRDTS dental leadership on February 17-19 attended the American Student Dental Association (ASDA) meeting in Seattle, Washington, and also attended the American Dental Education Association (ADEA) meeting in Portland, OR on March 11-14. These events provided excellent opportunities to share the CRDTS vision and mission with both students and educators as we continue to spread the word on services that CRDTS can offer in dental examination for initial licensure as well as in remediation/re-training and re-education.

Again, the dental leadership team is open to your thoughts and ideas on how we can most effectively serve the parties whom we represent. From State Dental boards in their mission to protect the welfare of the public, to dental candidates and dental schools, CRDTS continues to develop and implement fair, valid and reliable scoring criteria and examination policy.

Mark Edwards, DDS
Director of Dental Examinations

Rod Hill, DDS
ERC Committee Chair

CHANGE AND INSPIRATION

2023 is nearly 6 months in or halfway over whichever way you want to look at it! What a successful and eventful year it has been so far! At the end of this year, CRDTS Dental Hygiene will have completed dental hygiene exams for around 104 schools at more than 90 sites. This means that we will have had an opportunity to provide a fair, valid, and reliable dental hygiene examination to more than 1500 candidates in our member states. (These numbers are estimates and projections for 2024 are even higher!)

A BIG change is the increased number of total examinations that CRDTS is able to provide for not only Dental Hygiene but also Restorative Auxiliary, Written Anesthesia, and Clinical Anesthesia Examinations. Our CRDTS Dental Hygiene Leadership Team is also collaborating with our Dental Leadership to refine our Dental Therapy Examination. This was the first Dental Therapy Examination ever given in the United States and that was in Minnesota! Now DT is an even bigger national change as seven states have already voted to accept Dental Therapy Candidates for licensure. Several more states are either considering it or have already voted on accepting mid-level providers for the benefit of the public we serve and to help with the shortage of dental professionals that we are currently facing. It is an exciting time to be in the dental and dental hygiene testing field and we know that more changes are on the horizon.

Another BIG change is the increase in exam sites that are only hosting the CRDTS simulated (manikin) examination. With the Dental Boards of Georgia, New Mexico, and Wyoming moving to a permanent acceptance of the simulated examination (instead of the emergency actions that were taken during COVID) we are seeing a decrease in the number of patient-based examinations. Some candidates are more comfortable using a live patient for testing and we are able to accommodate them with creative planning and scheduling by some of the talented members of the CRDTS Dental Hygiene Team.

Research says that change is good for our brains and lives – so look out to the Dental World as you hear and have an opportunity to learn more about what we have been working so hard on! You will soon be able to acquire more knowledge about the CRDTS Clinical Calibration and Assessment Program which is growing and helping dental hygiene programs meet some of the criteria for CODA Accreditation. You can also check out our website to see information about the CRDTS CARE Program that is already assisting State Boards with remediation. It is also a current and efficient method for professionals that want to develop skills they are interested in or need more one-on-one guidance to become clinically competent and more self-confident in their skills and abilities. One thing we know for sure is that to succeed as a dental professional in this day and age you have to develop a love for lifelong learning and we all like to advance our skills to be the best that we can be.

The World of Artificial Intelligence is another Big Big world change and CRDTS is already advanced far into the ability to use virtual training, the Sim-to-Care digital technology, TEO software and virtual reality, and MORE. I never really wanted to attempt an endo procedure, prep a crown or bridge, or try placing an implant; but I had opportunities to do all of that at our Educational Facility in Topeka, KS. What an unbelievable opportunity for learning and collaborating with our future dental and dental hygiene professionals and current colleagues.

It takes some time to process, along with serious contemplation, to grasp how much CRDTS is growing and expanding to meet the needs of our dental and dental hygiene programs in our member states plus the State Boards. We at CRDTS are leaders in keeping up with all the changes, challenges, and advances in our beloved profession. We are deeply involved in all the changes and what we are doing as a Testing Organization. We are constantly inspired by the talented, intelligent, and dedicated individuals on our CRDTS team who are forward-thinking and making all this and more happen. We constantly look back and appreciate all the work that was done before us to get us to this point. Everyone is appreciated and valued, including our Executive Director, Sheli Cobler, and all those important, mostly behind-the-scenes, team members who work out of the Central Office and support all of us so that together we can make all this happen.

We are all excited about the CHANGES and advances CRDTS is achieving! There is an old saying, “Hold On Tight” and also one that says, ”Don’t blink so you won’t miss anything” – these sayings appropriately apply to what CRDTS is experiencing now and in our future as we continue to provide excellence in dental hygiene and dental testing.

Your Dental Hygiene Team,

Cindy Gaskill, RDH, MAE
Janine Sasse-Englert, RDH, MS, DHEd
Trelawny Saldana, RDH

CRDTS CARE PROGRAM

CRDTS is excited to announce the introduction of our new program for remediation and reeducation. The CRDTS Calibrate, Administrate, Remediate, and Educate (CARE) Program is all about Professionals helping Professionals to ensure the best in Dental Health Care across the nation.

WHO: State Dental and Dental Hygiene Boards and Commissions, individual licensees, educators, and students.

We are proud to be working directly with the following organizations: SIMtoCARE, Spear, Acadental, CEZoom, EBAS and Alpine Testing

WHAT: To assist State Dental Boards and individual licensees in meeting the standards of the dental profession to protect the health, safety, and welfare of the public.

The program is customized to licensee deficiencies, outlines a detailed program structure, creates potential partnership with leaders in the profession, utilizes progressive technology and is equipped with an ample supply of educators.

WHERE: On-site at the CRDTS state of the art Topeka, KS Education Facility; and/or, remote/virtual learning from the comfort of home or office.

WHEN: As per State Board order or at convenience as mutually agreeable and scheduled.

WHY: To comply with State Board orders, refresh or improve hand skills, brush up on ethics, re-enter the workplace after a long-term absence, and meet standards of the profession.

HOW: CRDTS will work directly with respective State Dental/Dental Hygiene Boards or Commissions to develop a plan for a licensee ordered to undergo a remediation program, training, or education; and/or, CRDTS will work directly with individual licensees who are not under discipline or order by a state board to establish a plan based on need and request.

We were pleased to have so many State Dental Board and Commission Executive Directors and even some board members participate in our Zoom presentations regarding the CARE Program the first week of June. If you were not able to participate and would like more information, please contact Richael Cobler, Executive Director at richael@crdts.org.

From: Dental Assisting National Board <communications@danb.org>
Sent: Wednesday, June 7, 2023 2:32 PM
To: Stephen Prisby <stephen.prisby@state.or.us>
Subject: DANB Report: State Updates for Dental Assistants

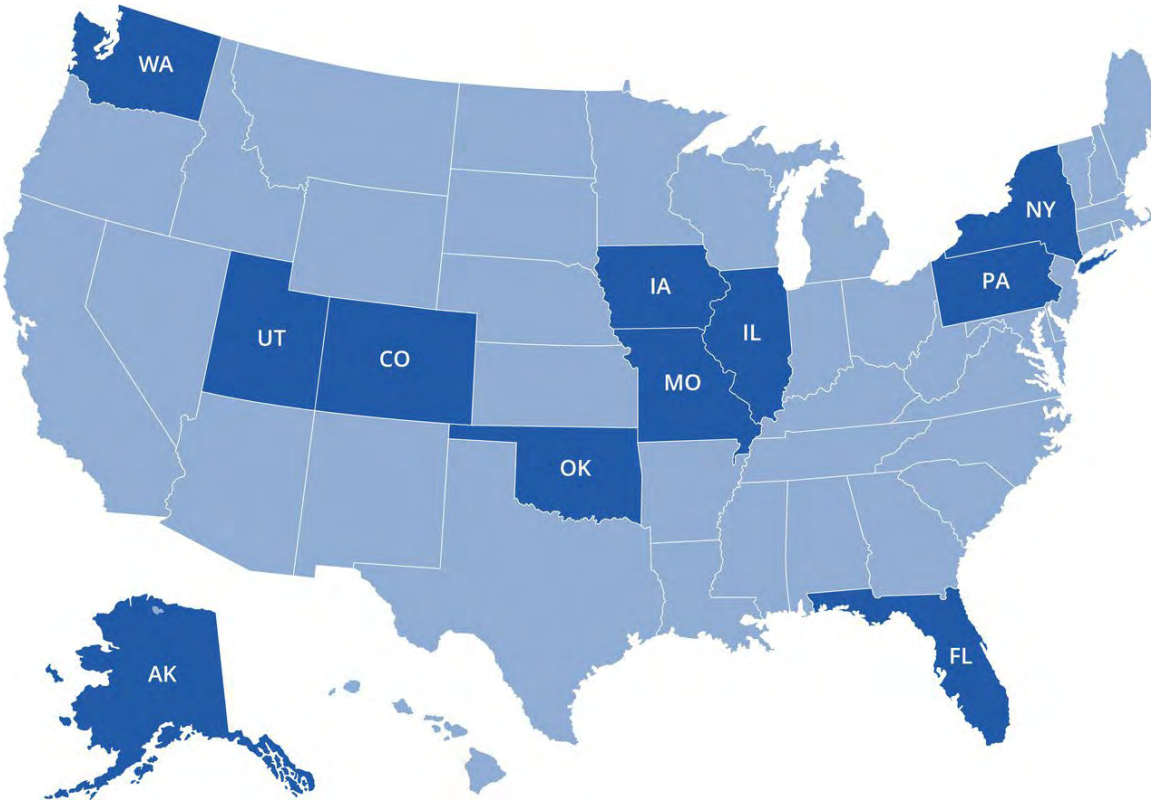
DANB
Dental Assisting
National Board

Dear Stephen,

Throughout the year, the Dental Assisting National Board (DANB) monitors for new dental assisting bills and regulations. The latest report includes highlights of state legislative and regulatory changes from Sept. 2022 through May 2023.

See the report

The report includes updates from 11 states: Alaska, Colorado, Florida, Illinois, Iowa, Missouri, New York, Oklahoma, Pennsylvania, Utah, and Washington. States are defining and expanding dental assistants' roles in providing care to areas that are underserved or affected by workforce shortages; states are also seeking to refine training and scope for expanded functions performed by dental assistants.



View all state requirements

Look up the dental assisting information for any state, including radiography requirements, dental assisting levels and related requirements, and downloadable charts with allowable and prohibited duties.

See all requirements

We hope you find this information valuable. If you have any questions or comments, please contact Director of Government Relations Katherine Landsberg at klandsberg@danb.org.

Sincerely,
DANB

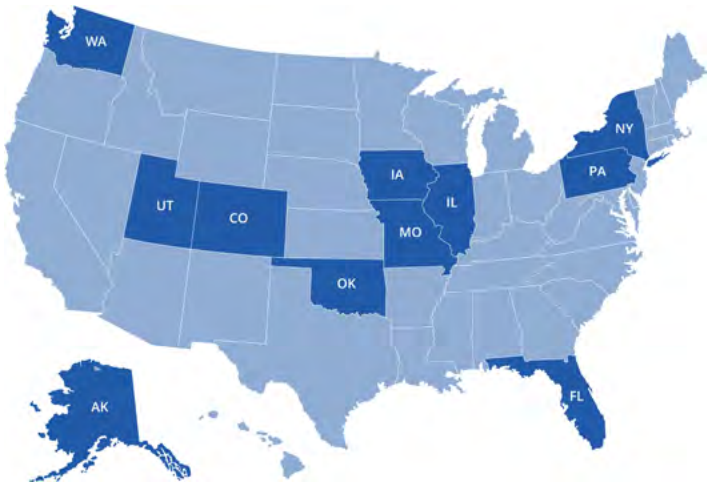
STATE OF THE STATES

September 2022-May 2023

DANB's compilation of state dental assisting requirements — on its website and in its state publications — is one of the most comprehensive resources available on this topic. The updates below highlight recent state legislative and regulatory changes that may be of interest to stakeholders of DANB and the DALE Foundation.

Alaska

Effective Oct. 5, 2022, SB173 allows a dental hygienist holding an advanced practice permit to delegate to a dental assistant the exposure and development of radiographs and application of topical preventive agents and pit and fissure sealants.



Colorado

A new dental therapist law went into effect Jan. 1, 2023, specifying that an articulated plan between a dentist and dental therapist must include policies for supervising dental assistants. Additionally, effective Nov. 3, 2022, a new board policy specifies that prescription-strength whitening systems available only to dentists require direct supervision when used by dental assistants.

Florida

In June 2019, the Florida Board of Dentistry adopted a rule providing for the delegation of remediable restorative functions to dental assistants who have received required training. On May 18, 2023, the Board amended the rule to add a requirement that, in order to enroll in a restorative functions training program, a dental assistant must have a delegating dentist, and the delegating dentist must supervise and evaluate a portion of clinical requirements for dental assistants receiving restorative functions training. The amended rule further specifies the following:

- the delegating dentist must attend an online interactive training on the laws and rules of remediable restorative functions and a calibration session for clinical requirements and procedures
- the 25 hours of training dedicated to live patients must be divided between instruction from the delegating dentist consisting of 12 hours and from the course provider institution consisting of 13 hours
- the previous live-patient requirement for training in fitting and contouring but not permanently cementing stainless steel crowns is replaced with a lab, case-based clinical scenario

The amendment provides for a rule review in five years.

Illinois

As part of an effort to address workforce shortages of dental hygienists in urban and rural underserved areas, a new law took effect Jan. 1, 2023, to increase access to dental care by now allowing dental assistants to perform coronal scaling above the gum line on children up to 17 years old (prior age limit was 12 years) who qualify under one of the following provisions: on Medicaid, uninsured, or whose family household income is not higher than 300% (previously was 200%) of the federal poverty level. The legislation also increased the training required from 16 hours to 32 hours for dental assistants to provide this limited service.

Iowa

New rules went into effect Dec. 21, 2022, that eliminate the formal application process for dental assistant trainee status and allow dental assistants to train on the job for purposes of registration for 12 months from the date of

the start of employment; update requirements for registration as a dental assistant and for qualification in dental radiography; and amend the definition of "personal supervision" to allow more flexibility in the training of dental assistant trainees as delegated by a licensed dentist. Additionally, rules related to expanded functions training were updated effective Jan. 18, 2023, and some requirements for dental assistant registration by verification were relaxed April 12, 2023.

Missouri

A rule clarifying EFDA functions went into effect Sept. 30, 2022, adding "sizing and cementing prefabricated crowns" to the EFDA permit in fixed prosthodontics and making minor amendments to clarify language for EFDA functions. Additionally, an emergency rule issued in January 2023 and effective through July 10 initiated a pilot program in dental telehealth. This pilot is a collaboration between the board and the Office of Dental Health within the Missouri Department of Health and Senior Services designed to examine new methods of extending dental care to residents in assisted living facilities, intermediate-care facilities, residential-care facilities, skilled nursing facilities, and home-bound special-needs patients. Under this rule, the Missouri Dental Board is authorized to issue temporary waivers to dentists to allow for the supervision of dental assistants, certified dental assistants, and EFDAs using telehealth technology. The Missouri Dental Board is to provide a final report on the pilot project by Dec. 31, 2025.

New York

Effective Aug. 17, 2022, A07754 adds "placing and removing temporary restorations" to the list of functions Registered Dental Assistants can perform. Also in 2022, in response to questions received from licensees, the New York State Board for Dentistry determined that an RDA may not perform bleaching procedures because such procedures irreversibly alter tooth enamel. The Board also determined that an RDA may not apply fluoride varnish because the function is listed in the scope of practice for dental hygienists, and that RDAs may not perform those functions that are considered the practice of dental hygiene.

Oklahoma

Signed by the governor May 5, 2023, Senate Bill 754 adds two new expanded duty permits that a dental assistant may apply for: (1) phlebotomy and venipuncture and (2) elder care and public health.

This brings the number of expanded duty permits available to dental assistants in Oklahoma to seven. While it is still unclear what will be required of applicants for the phlebotomy and venipuncture permit, the bill specifies that a minimum of two years of dental assisting practice is necessary to receive the elder care and public health permit. The elder care permit will allow dental assistants to aid hygienists, under the general supervision of a licensed dentist, in providing treatment to patients in adult and long-term healthcare facilities.

Pennsylvania

SB 1173, effective Nov. 3, 2022, allows licensees and certificate holders to earn three hours of CE for volunteer practice at a clinic or health center or charity dental event. The law applies to EFDAs, who are state certified and must renew their certificate periodically, as well as to dentists and dental hygienists.

Utah

Effective March 27, 2023, new rules prohibit the following three tasks from being performed by a dental assistant: starting, or administering medication through, an IV line; converting a denture into a fixed implant prosthesis; and adjusting a permanent or final prosthetic, removable or fixed, that is to be worn by a patient.

Washington

Signed by the governor May 15, 2023, HB 1678 recognizes licensure for dental therapists statewide and allows for licensed dental therapists to supervise dental assistants and EFDAs. The new law becomes effective Jan. 1, 2024.

SmileDirectClub to release customers from NDAs in settlement

The Seattle Times June 23, 2023

By
Erin Griffith
The New York Times

SmileDirectClub, which provides orthodontic services through the mail, has agreed to release customers who asked for refunds from nondisclosure agreements, as part of a settlement with the District of Columbia's attorney general.

The settlement, announced Thursday, allows 17,000 customers to talk publicly about their experiences with SmileDirectClub's teeth aligners, said the attorney general, Brian L. Schwalb. The company previously asked customers who wanted refunds to agree not to discuss their experiences and delete negative social media posts about the company.

In 2020, The New York Times reported that SmileDirectClub tied confidentiality agreements to some refunds. The District of Columbia attorney general's office sued the company in 2022, accusing it of blocking customers who were injured by its services from filing complaints with regulators or law enforcement.

"SmileDirectClub promised a simple, safe and affordable way to straighten teeth and touted five-star reviews — but behind the scenes, the company

silenced dissatisfied consumers and buried complaints about injuries caused by its products," Schwalb said in a statement.

SmileDirectClub, which also agreed to pay $500,000, said in the settlement that it had not violated the law or engaged in unfair or deceptive practices.

Susan Greenspon Rammelt, SmileDirectClub's chief legal officer, said in a statement that claims that the company sought to stop negative consumer feedback were a "misinformation campaign." She said that the company did not ask customers to sign a nondisclosure agreement if they asked for a refund within 30 days of receiving their aligners and that the agreements were negotiable.

The company said that its release form was modeled on one used by the orthodontics industry and that it already had plans to "tailor the nondisclosure provision more narrowly."

SmileDirectClub's services, which are cheaper than traditional orthodontics because they often do not involve in-person visits, have drawn criticism from dentist and orthodontist groups. The company has sued some of those critics and accused California's dental board of conspiring to stifle competition.

SmileDirectClub went public in 2019, raising $1.29 billion at a valuation of nearly $9 billion. It has not turned a profit as a public company. Its stock has fallen below $1 a share, valuing it at $166 million.

Cover Story

Evidence-based clinical practice guideline on restorative treatments for caries lesions

A report from the American Dental Association

Supplemental material is available online.

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ABSTRACT

Background. An expert panel convened by the American Dental Association (ADA) Council on Scientific Affairs together with the ADA Science and Research Institute's program for Clinical and Translational Research conducted a systematic review and developed recommendations for the treatment of moderate and advanced cavitated caries lesions in patients with vital, non-endodontically treated primary and permanent teeth.

Types of Studies Reviewed. The authors searched for systematic reviews comparing carious tissue removal (CTR) approaches in Ovid MEDLINE, Embase, Cochrane Database of Systematic Reviews, and Trip Medical Database. The authors also conducted a systematic search for randomized controlled trials comparing direct restorative materials in Ovid MEDLINE, Embase, Cochrane Central Register of Controlled Trials, ClinicalTrials.gov, and the World Health Organization International Clinical Trials Registry Platform. The authors used the Grading of Recommendations Assessment, Development, and Evaluation approach to assess the certainty of the evidence and formulate recommendations.

Results. The panel formulated 16 recommendations and good practice statements: 4 on CTR approaches specific to lesion depth and 12 on direct restorative materials specific to tooth location and surfaces involved. The panel conditionally recommended for the use of conservative CTR approaches, especially for advanced lesions. Although the panel conditionally recommended for the use of all direct restorative materials, they prioritized some materials over the use of others for certain clinical scenarios.

Practical Implications. The evidence suggests that more conservative CTR approaches may decrease the risk of adverse effects. All included direct restorative materials may be effective in treating moderate and advanced caries lesions on vital, nonendodontically treated primary and permanent teeth.

Key Words. Evidence-based dentistry; clinical practice guideline; direct restorative materials; caries; general dentistry; pediatric dentistry; American Dental Association.

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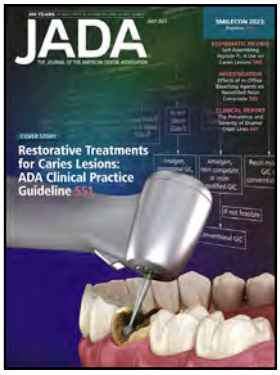

Restorative dentistry is integral to managing caries.[1] The decisions involved in restoring teeth are complex and based on the balance of several factors such as prognosis, caries risk and activity assessment, and clinical or radiographic signs of cavitation.[2,3] When indicated, various carious tissue removal (CTR) approaches (that is, the extent of carious tissue removed) and direct restorative materials are available to restore moderate and advanced (Table 1) caries lesions on vital, nonendodontically treated primary and permanent teeth.

Clinicians select a CTR approach and restorative material on the basis of their clinical experience, influenced by factors such as the goal of restoring form, function, and esthetics and reducing the likelihood of outcomes such as pulp exposure, restoration failure, and secondary caries. Commercially available restorative materials in the United States include amalgam, compomer, conventional glass ionomer cement (GIC), preformed crowns, resin composite (RC), and resin-modified GIC (RMGIC).

Although there is evidence of the success of restorative treatment after different CTR approaches and restorative materials for vital, nonendodontically treated primary and permanent teeth, there is a need for an evidence-based clinical practice guideline (CPG) to assist clinicians in making restorative choices with their patients. The American Dental Association (ADA) Council on Scientific Affairs convened a panel of general, pediatric, and public health dentists specializing in cariology, operative dentistry, and dental materials to develop this guideline on restorative treatments for caries lesions. The ADA Science and Research Institute program for Clinical and Translational Research (formerly known as the Center for Evidence-Based Dentistry) provided methodological support, led stakeholder engagement, and drafted the article. The ADA funded this guideline, but the ADA was not involved in formulating the clinical questions or recommendations.

SCOPE, PURPOSE, AND TARGET AUDIENCE

This guideline is a part of the ADA's CPG series on caries management[4] and its purpose is helping clinicians choose the most appropriate CTR approaches and direct restorative materials for treating moderate and advanced caries lesions on vital, nonendodontically treated primary and permanent teeth requiring restorations (Table 1). These recommendations apply when the decision to treat a caries lesion with a direct restoration has been made and do not inform when to treat a caries lesion using nonrestorative or restorative approaches. Furthermore, the following are not within the scope of this guideline: indirect materials (for example, inlays and onlays), the use of liners or silver diamine fluoride, the means to remove carious tissue (for example, rotary and hand instruments and chemicals), pulp therapy, or choosing between repairing or replacing a restoration. The target audience for this guideline includes dental practitioners and their support teams, dental students, and patients. Policy makers also may benefit from these recommendations.

ABBREVIATION KEY

ADA: American Dental Association.
AE: Adverse effect.
ART: Atraumatic restorative treatment.
CoE: Certainty of the evidence.
CPG: Clinical practice guideline.
CTR: Carious tissue removal.
GIC: Glass ionomer cement.
GRADE: Grading of Recommendations Assessment, Development and Evaluation.
HT: Hall technique.
NIH: National Institutes of Health.
NIDCR: National Institute of Dental and Craniofacial Research.
PMC: Preformed metal crown.
PVP: Patients' values and preferences.
RC: Resin composite.
RCT: Randomized control trials.
RMGIC: Resin-modified glass ionomer cement.
SR: Systematic review.

METHODS

We followed the Appraisal of Guidelines for Research and Evaluation Reporting Checklist II[5] and Guidelines International Network-McMaster Guideline Development Checklist.[6]

The panel and methodologists met in person in August 2019 to review conflicts of interest of all panel members and determine the guideline's scope, purpose, target audience, and clinical questions. Meetings occurred virtually to review the evidence from the associated systematic review (SR) led by ADA Science and Research Institute methodologists[7] (November 2021, January 2022) and to formulate clinical recommendations (June and July 2022). Methodologists (L.P., S.P.) facilitated the formulation of recommendations using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) Evidence-to-Decision framework.[8-11] After reviewing the evidence, the panel members formulated clinical recommendations via discussion until they achieved consensus. When agreement was elusive, the panel voted on the decision. As per GRADE guidance, the strength of recommendations can be strong or conditional, and each has implications for clinicians, patients, and policy makers (Table 2).[12] Methodologists conducted stakeholder and public engagement throughout the development of this guideline. Additional details regarding the methodology can be found in the Appendix Methods, available online at the end of the article.[7]

RESULTS

How to use the recommendations

The panel developed these recommendations and good practice statements to assist clinicians (in collaboration with their patients) and policy makers in the restorative decision-making process. Clinicians should use clinical judgment to determine when the recommended course of action may not be appropriate, warranting deviation from these recommendations.

Table 1. Definitions of carious tissue removal approaches and clinical presentation of caries lesion.

CARIOUS TISSUE REMOVAL APPROACHES (THAT IS, THE EXTENT OF CARIOUS TISSUE REMOVED)	
Nonselective Caries Removal	Carious tissue is removed until hard dentin is reached. Also known as complete caries removal.
Selective Caries Removal	Carious tissue is removed until soft or firm dentin is reached. Also known as partial or incomplete caries removal.
Stepwise Caries Removal	Carious tissue is first removed until soft dentin is reached and then a temporary restoration is placed. Months later, the restoration and carious tissue are removed until firm dentin is reached and a permanent restoration is then placed. Also known as 2-step caries removal.
No Carious Tissue Removal	No carious tissue is removed prior to the placement of a definitive restoration.
CLINICAL PRESENTATION OF CARIES LESIONS	
Moderate Caries Lesion	International Caries Detection and Assessment System codes 3 and 4
Advanced Caries Lesion	International Caries Detection and Assessment System codes 5 and 6

Evidence to decisions

Question 1

In patients with vital primary teeth requiring restorative treatment without pulp therapy and regardless of direct restorative material and means to remove carious tissue (that is, mechanical or chemomechanical), should we recommend nonselective, stepwise (advanced caries lesions only), selective, or no CTR (that is, sealing lesions with a preformed crown) to treat moderate and advanced caries lesions (Table 3, Figure 1)?

Desirable and undesirable effects

One SR[13] (12 randomized controlled trials [RCTs])[14-25] identified data on caries progression, clinical failure, patient discomfort during treatment, patient satisfaction, postoperative pain and discomfort, pulp exposure, pulp necrosis, time needed to perform the restoration, and tooth loss (Appendix Results, eTable 1, eTable 2, eFigure 1, eFigure 2, available online at the end of this article).

Six RCTs[14-19] informed recommendations for CTR approaches to treat moderate caries lesions. Moderate to very low certainty evidence suggests that nonselective and selective CTR may be less effective when compared with no CTR across most outcomes (eTable 3, eTable 4, eFigure 3, eFigure 4, available online at the end of this article). Evidence also suggests that neither nonselective nor selective CTR may be more effective than the other (very low certainty; eTable 5, eFigure 5, eFigure 6, available online at the end of this article).

Six RCTs[20-25] informed recommendations for CTR approaches to treat advanced caries lesions. Moderate to very low certainty evidence suggests that selective CTR may be more effective when compared with nonselective, stepwise, and no CTR across all outcomes (eTable 6, eTable 7, eTable 8, eFigure 7, eFigure 8, eFigure 9, eFigure 10, available online at the end of this article). In addition, nonselective CTR may be less effective across all outcomes compared with stepwise (low certainty; eTable 9, available online at the end of this article).

We found no SRs meeting our selection criteria that reported undesirable effects.

Values and preferences

The panel judged that there was possibly important uncertainty or variability in patients' values and preferences (PVPs) among all CTR approaches. This judgment was based on indirect evidence from studies conducted outside of the United States among people with permanent teeth, along with panel discussion regarding the additional appointments required for stepwise and, in some instances, no CTR. Additional details are in the Appendix, available online at the end of this article.

Resources required

One potential difference in cost is that stepwise and, in some instances, no CTR requires multiple visits, increasing the procedure's cost and treatment time. Preformed crowns are often placed after

Table 2. Definitions of the certainty of the evidence and strength of recommendations and implications for stakeholders.*

DEFINITION OF CERTAINTY OF THE EVIDENCE	
Category	**Definition**
High	Very confident that the true effect lies close to that of the estimate of the effect.
Moderate	Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.
Low	Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect.
Very Low	Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect.

DEFINITION OF STRONG AND CONDITIONAL RECOMMENDATIONS AND IMPLICATIONS FOR STAKEHOLDERS		
Implications	**Strong Recommendations**	**Conditional Recommendations**
For Patients	Most patients in this situation would want the recommended course of action and only a small proportion would not. Formal decision aids are not likely to be needed to help individuals make decisions consistent with their values and preferences.	Most patients in this situation would want the suggested course of action, but many would not.
For Clinicians	Most patients should receive the intervention. Adherence to this recommendation according to the guideline could be used as a quality criterion or performance indicator.	Recognize that different choices will be appropriate for individual patients and that you must help each patient arrive at a management decision consistent with his or her values and preferences. Decision aids may be useful in helping patients making decisions consistent with their values and preferences.
For Policy Makers	The recommendation can be adapted as policy in most situations.	Policy making will require substantial debate and involvement of various stakeholders.

* Source: Andrews and colleagues.[8,9] Reproduced with permission of the publisher from Balshem and colleagues.[12]

no CTR, which presents a higher cost to the patient than other direct restorations. Thus, the panel judged nonselective and selective CTR as the least costly, stepwise CTR as having intermediate costs, and no CTR as the most costly.

Acceptability

Although the panel concluded that key stakeholders probably find all CTR approaches acceptable, variation in acceptability of nonselective and selective CTR may exist owing to some clinicians having concerns about leaving carious tissues behind and other clinicians being in favor of more conservative and biological removal approaches (that is, selective).[26,27] In addition, the panel determined that on the basis of reviewed studies, no CTR is generally acceptable in cases in which a preformed metal crown (PMC) is indicated and emphasized that stepwise CTR may not be as acceptable owing to the need for a second appointment required to place a final restoration. For additional details, see the Appendix, available online at the end of this article.

Feasibility

We found no evidence regarding the feasibility of all CTR approaches. Although the panel noted that all CTR approaches are generally feasible, they judged stepwise as slightly less feasible owing to the need for a second appointment to remove more demineralized tissue and place the final restoration.

Question 2

In patients with vital permanent teeth requiring restorative treatment, without pulp therapy and regardless of direct restorative material and means to remove carious tissue (that is, mechanical or chemomechanical), should we recommend nonselective, stepwise (advanced lesions only), selective, or no CTR to treat moderate and advanced caries lesions (Table 3, Figure 2)?

Desirable and undesirable effects

One SR[13] (6 RCTs)[21,26-30] identified data on failure, patient discomfort during treatment, pulp exposure, pulp necrosis, pulpal complications due to infection, and tooth loss (Appendix Results, available online at the end of this article).

Table 3. Summary of clinical recommendations and good practice statements for carious tissue removal and direct restorative materials for caries lesions on vital, nonendodontically treated primary and permanent teeth.

CLINICAL SCENARIO	CLINICAL QUESTIONS	RECOMMENDATIONS AND GOOD PRACTICE STATEMENTS
Carious Tissue Removal Approaches in Primary Teeth	In patients with vital **primary** teeth requiring restorative treatment, regardless of direct restorative material* and means to remove carious tissue,† and without pulp therapy, which caries removal approach‡ should we recommend to treat **moderate**§ **caries lesions**?	To treat **moderate**§ **caries lesions** on vital **primary** teeth requiring a restoration, the guideline panel suggests the use of selective carious tissue removal,¶ nonselective carious tissue removal,# or no carious tissue removal (that is, sealing lesions with a preformed crown) (conditional recommendation, very low certainty).**,††,‡‡
	In patients with vital **primary** teeth requiring restorative treatment, regardless of direct restorative material* and means to remove carious tissue,† and without pulp therapy, which caries removal approach‡ should we recommend to treat **advanced**§§ **caries lesions**?	To treat **advanced**§§ **caries lesions** on vital **primary** teeth requiring a restoration, the guideline panel suggests prioritizing the use of selective carious tissue removal¶ or no carious tissue removal (that is, sealing with a preformed crown) over nonselective carious tissue removal# or stepwise carious tissue removal¶¶ (conditional recommendation, very low certainty).††,‡‡,##
Carious Tissue Removal Approaches in Permanent Teeth	In patients with vital **permanent** teeth requiring restorative treatment, regardless of direct restorative material* and means to remove carious tissue,† and without pulp therapy, which caries removal approach‡ should we recommend to treat **moderate**§ **caries lesions**?	To treat **moderate**§ **caries lesions** on vital **permanent** teeth requiring a restoration, the guideline panel suggests prioritizing the use of selective carious tissue removal¶ over nonselective carious tissue removal# (conditional recommendation, very low certainty).##
	In patients with vital **permanent** teeth requiring restorative treatment, regardless of direct restorative material* and means to remove carious tissue,† and without pulp therapy, which caries removal approach‡ should we recommend to treat **advanced**§§ **caries lesions**?	To treat **advanced**§§ **caries lesions** on vital **permanent** teeth requiring a restoration, the guideline panel suggests prioritizing the use of selective carious tissue removal¶ over stepwise carious tissue removal¶¶ or nonselective carious tissue removal# (conditional recommendation, very low certainty).##
Direct Restorative Materials for Primary Teeth	In vital **primary** teeth requiring restorative treatment, regardless of carious tissue removal approach‡ and without pulp therapy, which direct restorative material should we recommend to restore moderate§ and advanced§§ caries lesions on **anterior** teeth?	For moderate§ and advanced§§ caries lesions on vital **anterior primary** teeth requiring a **Class III** (approximal) restoration, the guideline panel suggests the use of either nanocomposite or hybrid resin composite (RC) (conditional recommendation, very low certainty).**,***
		For moderate§ and advanced§§ caries lesions on vital **anterior primary** teeth requiring a **Class V** (cervical third of facial or lingual) restoration, the guideline panel suggests the use of either conventional GIC, hybrid RC, or resin-modified GIC (conditional recommendation, very low certainty).**,***,†††,‡‡‡
	In vital **primary** teeth requiring restorative treatment, regardless of carious tissue removal approach‡ and without pulp therapy, which direct restorative material should we recommend to restore moderate§ and advanced§§ caries lesions on **posterior** teeth?	For moderate§ and advanced§§ caries lesions on vital **posterior primary** teeth requiring a **Class I** (pit and fissure) restoration, the guideline panel suggests prioritizing the use of resin-modified GIC, RCs, conventional GIC, or preformed crowns over compomer or dental amalgam (conditional recommendation, very low certainty).‡‡,##,†††,‡‡‡,§§§,¶¶¶
		For moderate§ and advanced§§ caries lesions on vital **posterior primary** teeth requiring a **Class II** (approximal) restoration, the guideline panel suggests prioritizing the use of resin-modified GIC, RCs, or preformed crowns over compomer, conventional GIC, or dental amalgam (conditional recommendation, very low certainty).‡‡,##,‡‡‡,§§§,¶¶¶,###
		For moderate§ and advanced§§ caries lesions on vital **posterior primary** teeth requiring a **Class V** (cervical third of facial or lingual) restoration, the guideline panel suggests the use of either conventional GIC, hybrid RC, or resin-modified GIC (conditional recommendation, very low certainty).**,***,†††,‡‡‡
	No corresponding clinical question	Good practice statement: The US Food and Drug Administration recommends not using dental amalgam in "children, especially those younger than six years of age; people with pre-existing neurological disease; people with impaired kidney function; [and] people with known heightened sensitivity (allergy) to mercury or other components (silver, copper, tin)" wherever possible.****

* Direct restorative materials are limited to the use of dental amalgam, compomer, conventional glass ionomer cement (GIC), preformed crowns, resin composites (RC) (that is, hybrid RC, macrofilled RC, and nanocomposite), and resin-modified GIC. † Means to remove carious tissue is defined as mechanical or chemomechanical. ‡ Carious tissue removal approach is defined as the extent of carious tissue removed. § Moderate caries lesion is defined as International Caries Detection and Assessment System codes 3 and 4. ¶ Selective carious tissue removal is defined as carious tissue being removed until soft or firm dentin is reached. Also known as partial or incomplete caries removal. # Nonselective carious tissue removal is defined as carious tissue being removed until hard dentin is reached. Also known as complete caries removal. ** The guideline panel assigned no prioritization among the recommended interventions. †† Clinicians may perform no carious tissue removal for lesions in which a preformed metal crown is indicated. Clinicians should consider the number of involved surfaces, caries risk and activity, moisture control, patient behavior, patient or caregiver preferences, and anticipated time to exfoliation when deciding whether to place a preformed metal crown using the Hall technique. ‡‡ Preformed crowns include the use of stainless steel or esthetic crowns. §§ Advanced caries lesion is defined as International Caries Detection and Assessment System codes 5 and 6. ¶¶ Stepwise carious tissue removal is defined as carious tissue being first removed until soft dentin is reached and then a temporary restoration is placed. Months later, the restoration and carious tissue are removed until firm dentin is reached and a permanent restoration is then placed. Also known as 2-step caries removal. ## The prioritization of interventions in this recommendation is a ranking determined by the panel owing to their effectiveness, patients' values and preferences, resources required, acceptability, and feasibility. *** RC and resin-modified GIC materials may be used as a conventional or strip crown restoration. ††† Conventional and resin-modified GIC may be preferable when tooth isolation cannot be achieved, in patients with special health care needs or in patients lacking predictable access to care. ‡‡‡ Conventional GIC may be preferable when light-curing is not feasible. §§§ RCs refer to hybrid RC, macrofilled RC, and nanocomposite. ¶¶¶ Clinicians should reserve preformed crowns for lesions where indicated. Clinicians should consider the extent of the lesion, caries risk and activity, moisture control, patient behavior, patient or caregiver preferences, and anticipated time to exfoliation when deciding whether to perform a single or multisurface direct restoration or place a preformed crown. ### Resin-modified GIC may be preferable when tooth isolation cannot be achieved, in patients with special health care needs or in patients lacking predictable access to care. **** US Food and Drug Administration.[53] †††† The guideline panel assigned no ranking among the prioritized interventions.

Table 3. Continued

CLINICAL SCENARIO	CLINICAL QUESTIONS	RECOMMENDATIONS AND GOOD PRACTICE STATEMENTS
Direct Restorative Materials for Permanent Teeth	In vital **permanent** teeth requiring restorative treatment, regardless of carious tissue removal approach[‡] and without pulp therapy, which direct restorative material should we recommend to restore moderate[§] and advanced[§§] caries lesions on **anterior** teeth?	For moderate[§] and advanced[§§] caries lesions on vital **anterior permanent** teeth requiring a **Class I** (lingual pit and fissure) restoration, the guideline panel suggests the use of either conventional GIC, hybrid RC, or resin-modified GIC (conditional recommendation, very low certainty).[**,†††,‡‡‡]
		For moderate[§] and advanced[§] caries lesions on vital **anterior permanent** teeth requiring a **Class III** (approximal) restoration, the guideline panel suggests the use of either nanocomposite or hybrid RC (conditional recommendation, very low certainty).[**]
		For moderate[§] and advanced[§§] caries lesions on vital **anterior permanent** teeth requiring a **Class V** (cervical third of facial or lingual) restoration, the guideline panel suggests the use of either conventional GIC, hybrid RC, or resin-modified GIC (conditional recommendation, very low certainty).[**,†††,‡‡‡]
	In vital **permanent** teeth requiring restorative treatment, regardless of carious tissue removal approach[‡] and without pulp therapy, which direct restorative material should we recommend to restore moderate[§] and advanced[§§] caries lesions on **posterior** teeth?	For moderate[§] and advanced[§§] caries lesions on vital **posterior permanent** teeth requiring a **Class I** (pit and fissure) restoration, the guideline panel suggests prioritizing the use of conventional GIC, dental amalgam, RC, or resin-modified GIC over compomer (conditional recommendation, very low certainty).[##,†††,‡‡‡,§§§,††††]
		For moderate[§] and advanced[§§] caries lesions on vital **posterior permanent** teeth requiring a **Class II** (approximal) restoration, the guideline panel suggests prioritizing the use of dental amalgam, RC, or resin-modified GIC over conventional GIC (conditional recommendation, very low certainty).[##,‡‡‡,§§§,###,††††]
		For moderate[§] and advanced[§§] caries lesions on vital **posterior permanent** teeth requiring a **Class V** (cervical third of facial or lingual) restoration, the guideline panel suggests the use of either conventional GIC, hybrid RC, or resin-modified GIC (conditional recommendation, very low certainty).[**,†††,‡‡‡]
	No corresponding clinical question	Good practice statement: The Food and Drug Administration recommends not using dental amalgam in "children, especially those younger than six years of age; people with pre-existing neurological disease; people with impaired kidney function; [and] people with known heightened sensitivity (allergy) to mercury or other components (silver, copper, tin)" wherever possible.[****]
	In vital **permanent** teeth requiring restorative treatment, regardless of carious tissue removal approach[‡] and without pulp therapy, which direct restorative material should we recommend to restore moderate[§] and advanced[§§] root caries lesions on **anterior and posterior** teeth?	For moderate[§] and advanced[§§] **root caries lesions** on vital **anterior and posterior permanent** teeth requiring a restoration, the guideline panel suggests the use of either resin-modified GIC or conventional GIC (conditional recommendation, low certainty).[**,‡‡‡]

Six RCTs[21,28-32] informed recommendations for CTR approaches to treat advanced caries lesions. Moderate to very low certainty evidence suggests that nonselective CTR may be less effective than stepwise across most outcomes (eTable 10, eFigure 11, eFigure12, available online at the end of this article), and neither nonselective nor selective CTR may be more effective than the other (eTable 11, eFigure 13, eFigure 14, available online at the end of this article). Very low certainty evidence suggests that neither stepwise nor selective CTR may be more effective than the other (eTable 12, eFigure 15, eFigure 16, eFigure 17, available online at the end of this article).

We found no studies meeting our selection criteria for CTR approaches to treat moderate caries lesions on vital permanent teeth. The panel decided to inform this clinical question using the same body of evidence summarized for advanced caries lesions on permanent teeth, rating down the certainty of the evidence (CoE) 1 level owing to serious issues of indirectness (very low).

We identified no SRs meeting our selection criteria that reported undesirable effects.

The panel used the same body of evidence on PVP, resources required, acceptability, and feasibility described for Question 1 to inform recommendations for permanent teeth.

See Appendix Results, available online at the end of this article, for a narrative summary of outcomes and comparisons for CTR approaches in primary and permanent teeth that did not allow for the calculation of treatment effect estimates and 95% CIs.

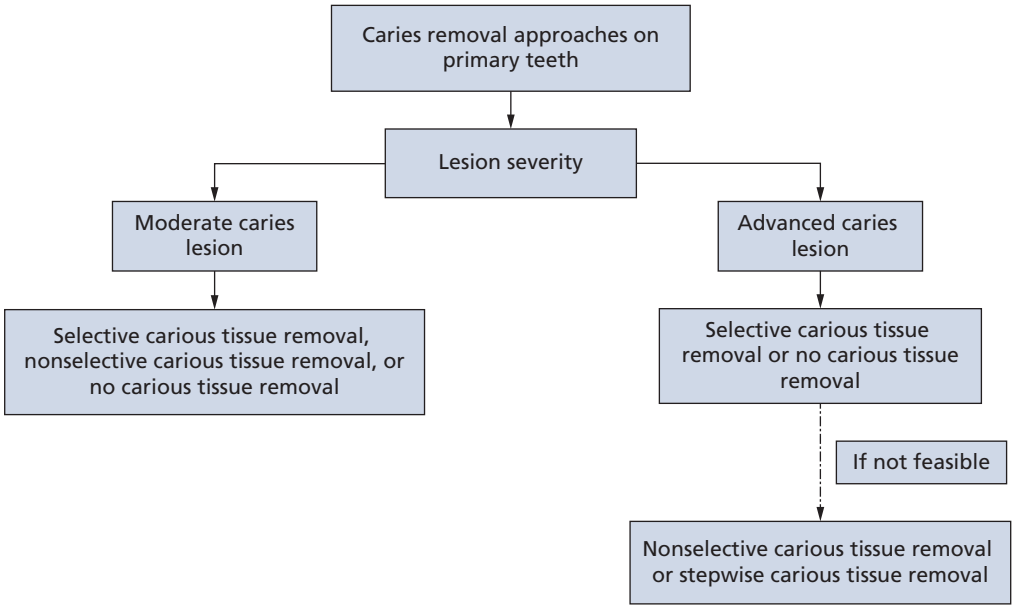

Figure 1. Clinical pathway of carious tissue removal approaches for the treatment of vital, nonendodontically treated, primary teeth. Caries removal approach is defined as the extent of carious tissue removed. Moderate caries lesion is defined as International Caries Detection and Assessment System codes 3 and 4. Advanced caries lesion is defined as International Caries Detection and Assessment System codes 5 and 6. Selective carious tissue removal is defined as carious tissue being removed until soft or firm dentin is reached, which also is known as partial or incomplete caries removal. Nonselective carious tissue removal is defined as carious tissue being removed until hard dentin is reached, which also is known as complete caries removal. No carious tissue removal is defined as sealing a caries lesion with a preformed crown. Clinicians may perform no carious tissue removal for lesions in which a preformed crown is indicated. Clinicians should consider the number of involved surfaces, caries risk and activity, moisture control, patient behavior, patient or caregiver preferences, and anticipated time to exfoliation when deciding whether to place a preformed crown. The prioritization of caries removal approaches in this recommendation is a ranking determined by the panel on the basis of their effectiveness, patients' values and preferences, resources required, acceptability, and feasibility. Stepwise carious tissue removal is defined as carious tissue being first removed until soft dentin is reached, followed by placement of a temporary restoration. Months later, the restoration and carious tissue are removed until firm dentin is reached and a permanent restoration is then placed. This is also known as 2-step caries removal.

Question 3

In patients with vital primary teeth requiring restorative treatment, regardless of CTR approach and without pulp therapy, should we recommend amalgam, conventional GIC, compomers, preformed esthetic crowns, PMCs, RMGIC, or RC to restore moderate and advanced caries lesions on anterior and posterior teeth (Table 3, Figure 3)?

Desirable and undesirable effects

Sixteen RCTs[16,33-47] informed the desirable effects, providing data on oral health–related quality of life, patient satisfaction, postoperative pain and discomfort, restoration failure, restoration fracture, restoration loss, secondary caries, unacceptable anatomic form, unacceptable color match, and unacceptable marginal adaptation.

We did not find direct evidence on direct restorative materials for Class III and Class V restorations on primary teeth. Therefore, the panel informed these recommendations using indirect evidence from 4 RCTs[33-36] on permanent teeth, rating down the CoE 1 level owing to serious issues of indirectness (very low certainty). For Class III restorations on permanent teeth, the evidence suggests that nanocomposite may be less effective for some outcomes and shows little to no difference in others compared with hybrid RC (eTable 13, available online at the end of this article). For Class V restorations on permanent teeth, very low certainty evidence suggests that when compared with hybrid RC and conventional GIC, RMGIC may be more effective for some outcomes and less effective for others (eTable 14, eTable 15, available online at the end of this article). In addition, conventional GIC may be more effective than hybrid RC (eTable 16, available online at the end of this article).

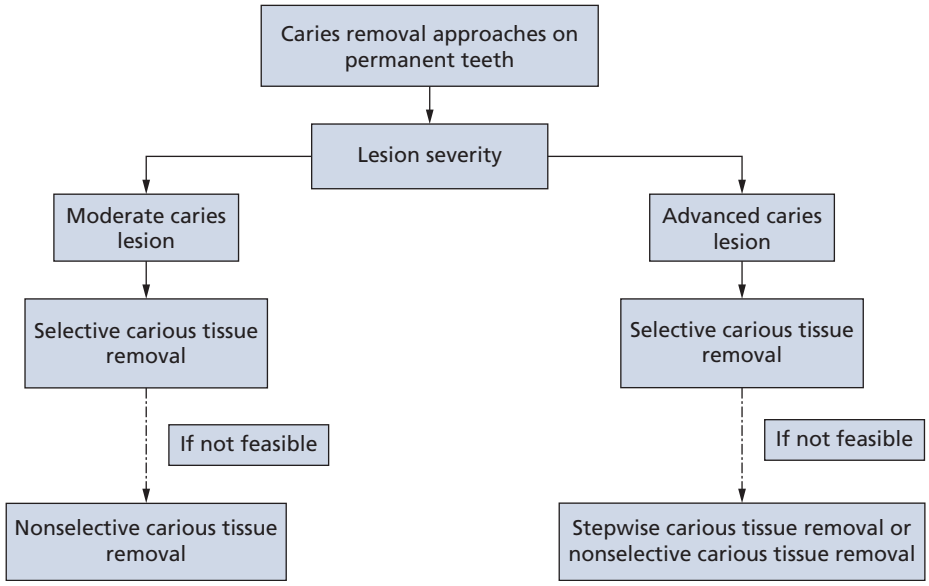

Figure 2. Clinical pathway of carious tissue removal approaches for the treatment of vital, nonendodontically treated, permanent teeth. Caries removal approach is defined as the extent of carious tissue removed. Moderate caries lesion is defined as International Caries Detection and Assessment System codes 3 and 4. Advanced caries lesion is defined as International Caries Detection and Assessment System codes 5 and 6. Selective carious tissue removal is defined as carious tissue being removed until soft or firm dentin is reached, which also is known as partial or incomplete caries removal. The prioritization of caries removal approaches in this recommendation is a ranking determined by the panel on the basis of their effectiveness, patients' values and preferences, resources required, acceptability, and feasibility. Nonselective carious tissue removal is defined as carious tissue being removed until hard dentin is reached, which also is known as complete caries removal. Stepwise carious tissue removal is defined as carious tissue being first removed until soft dentin is reached, followed by placement of a temporary restoration. Months later, the restoration and carious tissue are removed until firm dentin is reached and a permanent restoration is then placed. This is also known as 2-step caries removal.

Ten RCTs[16,37-44,47] informed recommendations for Class II restorations. Moderate to very low certainty evidence suggests that when compared with conventional GIC, amalgam, hybrid RC, macrofilled RC, nanocomposite, and RMGIC were more effective across most outcomes (eTable 17, eTable 18, eTable 19, eTable 20, eTable 21, available online at the end of this article). Neither hybrid RC nor RMGIC may be more effective than the other (very low certainty; eTable 22, available online at the end of this article). Low certainty evidence suggests that there may be little to no difference between compomer and conventional GIC (eTable 23, available online at the end of this article). PMCs placed with the Hall technique (HT) are probably more effective when compared with conventional GIC placed with atraumatic restorative treatment (ART) (moderate certainty; eTable 24, available online at the end of this article).

We did not find direct evidence on amalgam, hybrid RC, nanocomposite, PMCs, and RMGIC to restore Class I restorations on primary teeth. Therefore, the panel informed these recommendations using indirect evidence, prioritizing data on Class I and Class II restorations combined (that is, data from primary studies in which authors grouped and analyzed both posterior Class I and Class II restorations together) over Class II restorations alone. The panel acknowledged the risk of experiencing restoration failure was higher with involvement of more tooth surfaces and therefore assumed that direct materials proving effective in Class II restorations also may be effective in Class I posterior restorations (that is, a conservative risk of failure). We rated down the CoE 1 and 2 levels for Class I and Class II restorations combined and Class II restorations alone, respectively, owing to serious issues of indirectness (very low certainty).

Seven RCTs[15,37,39-41,45,46] informed recommendations for Class I restorations. Low to very low certainty evidence suggests that for Class I restorations, compomers may be less effective than conventional GIC (eTable 25, available online at the end of this article), whereas neither macrofilled RC nor conventional GIC may be more effective than the other (eTable 26, available online at the end of this article). For Class I and Class II restorations combined, indirect evidence

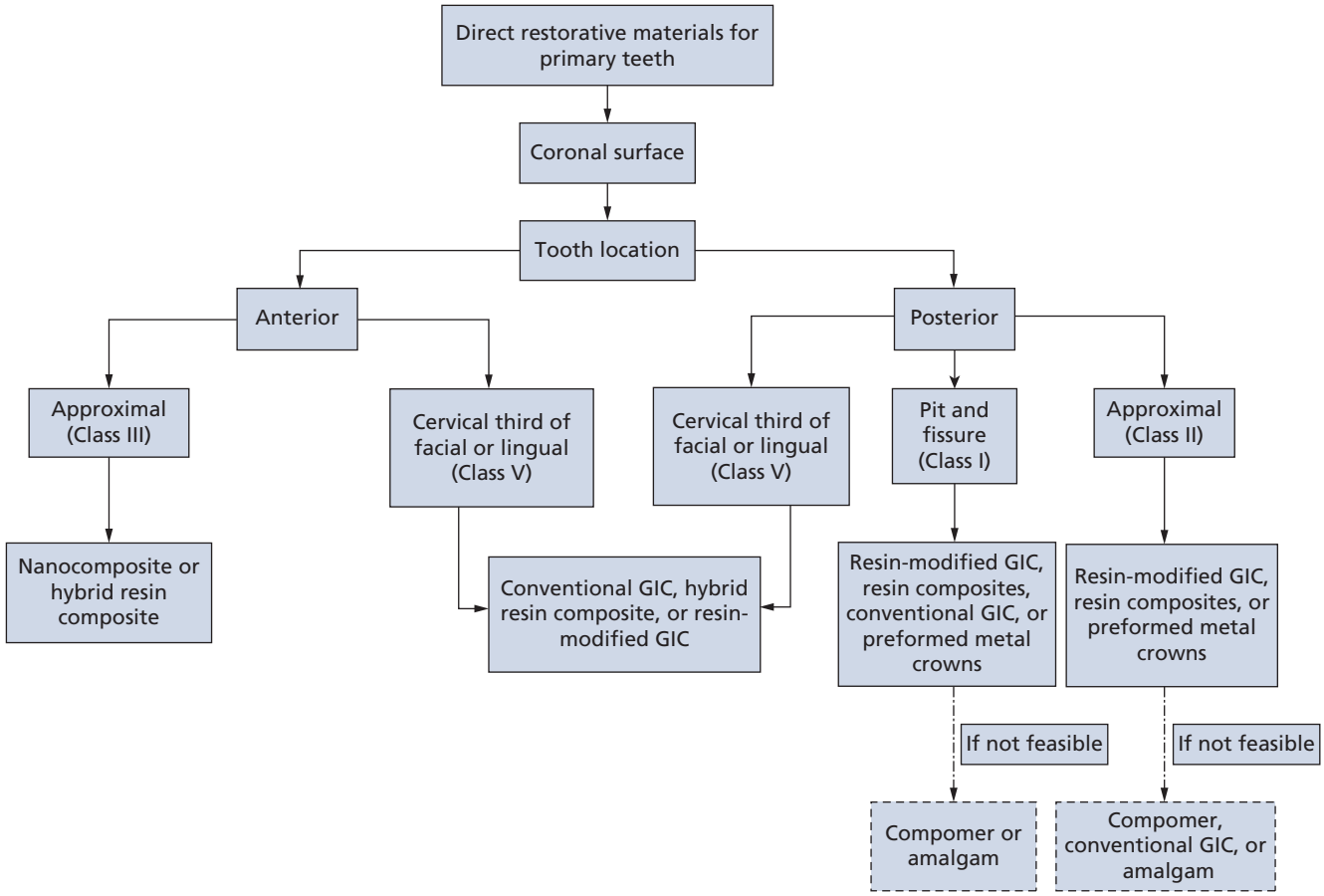

Figure 3. Clinical pathway of direct materials to restore vital, nonendodontically treated, primary teeth. The guideline panel assigned no prioritization among the recommended interventions. Conventional glass ionomer cement (GIC) may be preferable when light curing is not feasible. Conventional and resin-modified GIC may be preferable when tooth isolation cannot be achieved, in patients with special healthcare needs, or in patients lacking predictable access to care. Resin composites refer to hybrid resin composite, macrofilled resin composite, and nanocomposite. Preformed crowns include the use of stainless steel or esthetic crowns. Clinicians should reserve preformed crowns for lesions where indicated. Clinicians should consider the extent of the lesion, caries risk and activity, moisture control, patient behavior, patient or caregiver preferences, and anticipated time to exfoliation when deciding whether to perform a single-surface or multisurface direct restoration or place a preformed crown. The prioritization of interventions in this recommendation is a ranking determined by the panel based on their effectiveness, patients' values and preferences, resources required, acceptability, and feasibility. The US Food and Drug Administration recommends not using amalgam in "children, especially those younger than six years of age; people with pre-existing neurological disease; people with impaired kidney function; [and] people with known heightened sensitivity (allergy) to mercury or other components (silver, copper, tin)"[49] wherever possible. Resin-modified GIC may be preferable when tooth isolation cannot be achieved, in patients with special health care needs, or in patients lacking predictable access to care. Resin composite and resin-modified GIC materials may be used as a conventional or strip crown restoration.

suggests that when compared with amalgam and conventional GIC, RMGIC may be more effective for some outcomes and less effective for others (very low certainty) (eTable 27, eTable 28, available online at the end of this article). Indirect evidence on the use of hybrid RC (eTable 18, available online at the end of this article), nanocomposite (eTable 20, available online at the end of this article), and PMCs (HT) (eTable 24, available online at the end of this article) for Class II restorations summarized above also informed this recommendation.

We did not find direct evidence on the effect of preformed esthetic crowns for primary teeth; therefore, the panel informed these recommendations using indirect evidence from Class II, Class III, and Class V restorations as described above. In addition, we found no evidence of the effects of any direct restorative material for Class I anterior restorations.

One SR[48] informed the undesirable effects of amalgam and RCs to restore caries lesions, indicating there may be little to no difference in risk of experiencing adverse effects (AEs) (that is, anaphylaxis, neurobehavioral assessment, kidney function, psychosocial function, and physical development) among the materials. In addition to the conclusion of the SR by Worthington and colleagues,[48] a paucity of evidence on compomer, conventional GIC, PMCs, and RMGIC led to

Table 4. US national average cost to the patient for direct restorative materials.*

MATERIAL†	SURFACES INVOLVED, NO.	MEAN COST, $
Anterior Restorations		
Esthetic	1	114.01
Esthetic	2	137.71
Esthetic	3	157.73
Esthetic	≥ 4	186.51
Esthetic strip crown	Not applicable	233.63
Prefabricated esthetic crown (porcelain or ceramic)	Not applicable	190.42
Posterior Restorations		
Amalgam	1	97.78
Esthetic	1	125.07
Amalgam	2	120.40
Esthetic	2	158.74
Amalgam	3	140.70
Esthetic	3	184.78
Amalgam	≥ 4	163.56
Esthetic	≥ 4	211.50
Preformed metal crown	Not applicable	190.41
Prefabricated esthetic crown (porcelain or ceramic)	Not applicable	190.42

* Source: American Dental Association Health Policy Institute, Analysis of the IBM MarketScan Dental Database, unpublished data, 2019. † All tooth-colored restorations are coded as resin composite in the data set. Esthetic represents the resin composite treatment code and is representative of resin composites, glass ionomer cement, resin-modified glass ionomer cement, and compomer restorations.

uncertainty in the magnitude of harms for all direct restorative materials (Appendix, available online at the end of this article).

Patients' values and preferences

The panel determined there was important uncertainty or variability in PVPs regarding amalgam but probably no important uncertainty or variability regarding all other materials (Appendix, available online at the end of this article).

Resources required

On average, the cost to patients for amalgam restorations is approximately 75% of the price of esthetic restorations for the same number of surfaces (American Dental Association Health Policy Institute, Analysis of the IBM MarketScan Dental Database, unpublished data, 2019). The panel determined this difference was significant for decision making. For PMCs, the panel judged that the cost of a PMC was not significantly higher than that of amalgam or esthetic for 2-surface restorations. For single-surface restorations, however, the panel believed the cost of a PMC was substantially more than that of amalgam and esthetic restorations (Table 4).

Acceptability

Although amalgam has been recognized for its superiority in durability,[49] longevity, and affordability,[50,51] the panel highlighted that all direct restorative materials present acceptable levels of effectiveness. However, potential AEs for patients and the reported environmental harms of mercury have raised concerns, questioning the acceptability of amalgam. Although there is insufficient evidence[48,52,53] to support the hypothesis that amalgam increases the risk of AEs compared with any other restorative materials, national[54,55] and international stakeholders[56-58] have questioned the use of amalgam in general and in vulnerable populations specifically.

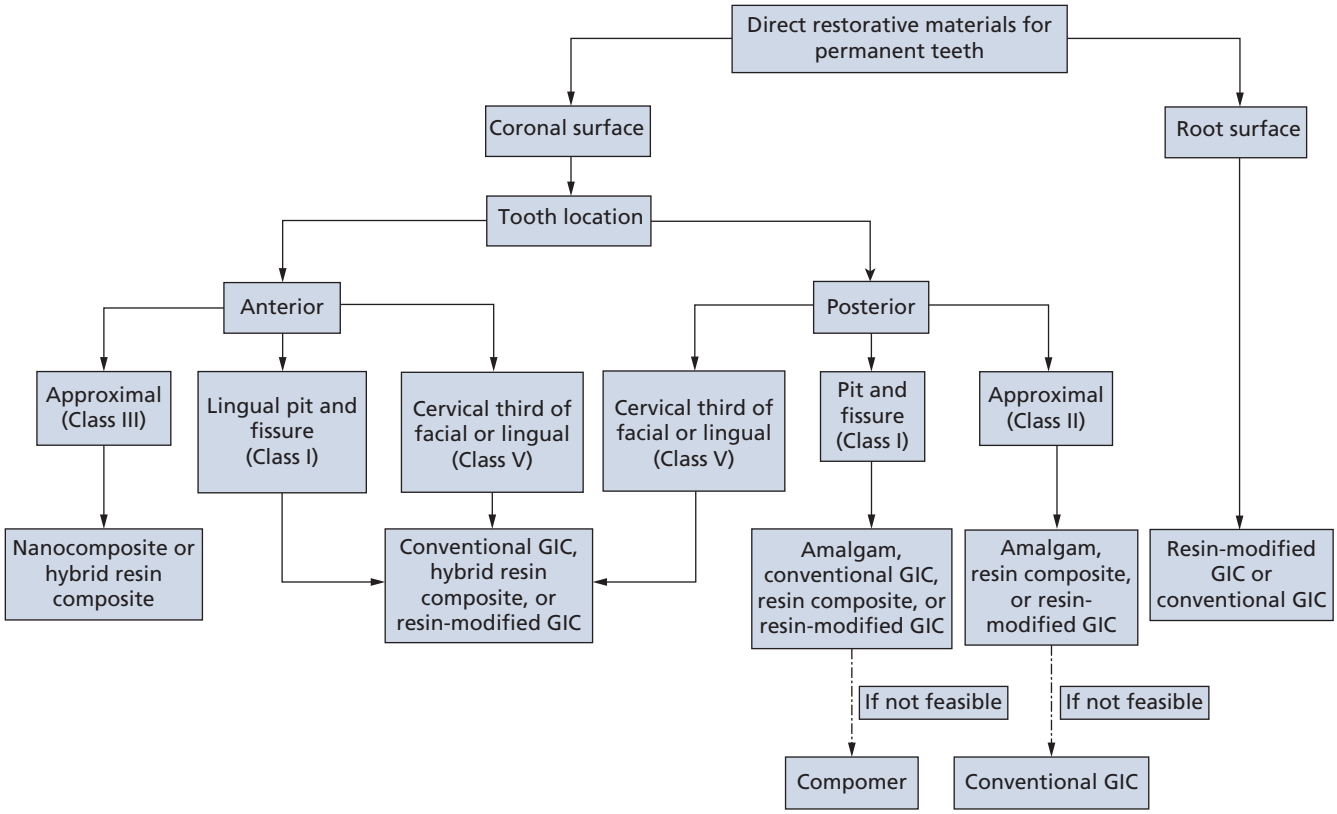

Figure 4. Clinical pathway of direct materials to restore vital, nonendodontically treated, permanent teeth. The guideline panel assigned no prioritization among the recommended interventions. Conventional glass ionomer cement (GIC) may be preferable when light curing is not feasible. Conventional and resin-modified GIC may be preferable when tooth isolation cannot be achieved, in patients with special healthcare needs, or in patients lacking predictable access to care. The US Food and Drug Administration recommends not using amalgam in "children, especially those younger than six years of age; people with pre-existing neurological disease; people with impaired kidney function; [and] people with known heightened sensitivity (allergy) to mercury or other components (silver, copper, tin)"[50] wherever possible. Resin composites refer to hybrid resin composite, macrofilled resin composite, and nanocomposite. The guideline panel assigned no ranking among the prioritized interventions. The prioritization of interventions in this recommendation is a ranking determined by the panel on the basis of their effectiveness, patients' values and preferences, resources required, acceptability, and feasibility. Resin-modified GIC may be preferable when tooth isolation cannot be achieved, in patients with special healthcare needs, or in patients lacking predictable access to care.

Feasibility

We found no evidence regarding the feasibility of any direct material to restore moderate and advanced caries lesions on primary teeth. The panel highlighted that most of these interventions already are widely used among clinicians in the United States, except for compomers.

Question 4

In patients with vital, permanent teeth requiring restorative treatment, regardless of CTR approach and without pulp therapy, should we recommend amalgam, conventional GIC, compomers, PMCs, RMGIC, or RC to restore moderate and advanced caries lesions on anterior and posterior teeth (Table 3, Figure 4)?

Desirable effects

Twenty-one RCTs[34-36,59-76] informed the desirable effects, providing data on tooth fracture (crown), patient satisfaction, postoperative pain and discomfort, restoration failure, restoration fracture, restoration loss, secondary caries, time needed to perform the restoration, unacceptable color match, and unacceptable marginal adaptation.

The panel used the same body of evidence summarized in Question 3 (eTable 13, eTable 14, eTable 15, eTable 16, available online at the end of this article) to inform recommendations for Class III and Class V restorations. In addition, we did not find direct evidence regarding the effect of direct materials for Class I anterior restorations on permanent teeth. The panel informed this

recommendation using indirect evidence from 3 RCTs[34-36] on Class V restorations on permanent teeth, as summarized in Question 3. We rated down the CoE 1 level owing to serious issues of indirectness (very low).

We did not find direct evidence regarding the effects of amalgam, macrofilled RC, and nanocomposite to restore Class I restorations alone and Class II restorations alone on permanent teeth. The panel informed these recommendations using indirect evidence from 8 RCTs[59-66] on Class I and Class II restorations combined. We rated down the CoE 1 level owing to serious issues of indirectness (very low).

Twelve RCTs[59-63,67-73] informed recommendations for Class I posterior restorations. Low certainty evidence suggests that RMGIC may be more effective than conventional GIC, and conventional GIC may be more effective than compomer across all outcomes for Class I posterior restorations (eTable 29, eTable 30, available online at the end of this article). Although conventional GIC may be less effective than hybrid RC (low certainty; eTable 31, available online at the end of this article), neither nanocomposite nor hybrid RC may be more effective than the other (low certainty; eTable 32, available online at the end of this article). Indirect evidence from Class I and Class II restorations combined showed that amalgam and macrofilled RC may be more effective than hybrid RC across most outcomes (low to very low certainty; eTable 33, eTable 34, available online at the end of this article).

Twelve RCTs[59-66,68,69,74,75] informed recommendations for Class II restorations. Low certainty evidence suggests that both hybrid RC and RMGIC may be more effective than conventional GIC across all outcomes for Class II restorations (eTable 35, eTable 36, available online at the end of this article). However, hybrid RC placed with rotary instruments may be more effective than conventional GIC placed with ART (moderate to very low certainty; eTable 37, available online at the end of this article). Indirect evidence from Class I and Class II restorations combined showed nanocomposite may be more effective than hybrid RC (eTable 38, available online at the end of this article). Indirect evidence from Class I and Class II restorations combined for amalgam (eTable 33, available online at the end of this article) and macrofilled RC (eTable 34, available online at the end of this article) summarized above also informed this recommendation.

One study[76] informed recommendations for restorations in root caries lesions. Low certainty evidence suggests that GIC may be more effective than RMGIC (eTable 39, available online at the end of this article).

The panel used the same evidence on undesirable effects, PVP, resources required, acceptability, and feasibility described for Question 3 to inform recommendations for permanent teeth.

The associated SR[7] includes a narrative summary of outcomes across comparisons for direct restorative materials in primary and permanent teeth that did not allow for the calculating treatment effect estimates and 95% CIs.

DISCUSSION

Summary of main findings

In most clinical scenarios, evidence did not show important differences between CTR approaches and direct restorative materials[7] to suggest whether 1 treatment option is superior to another. One key finding for advanced lesions was that more conservative CTR approaches were associated with fewer clinical failures. The panel identified important concerns relating to PVPs, acceptability, and feasibility, leading to prioritization of interventions within specific recommendations. For example, environmental concerns beyond the confines of dentistry influenced the acceptability factor for direct restorative materials.[57,58] It is important to emphasize that prioritizing an intervention does not equate to a recommendation against another. Very low certainty evidence resulted in conditional recommendations only. Clinicians should implement shared decision making with patients or caretakers when implementing these recommendations.

Implications for practice

Two important recommendations of this guideline highlight the prioritization of more conservative CTR to treat advanced caries lesions on primary and permanent teeth over nonconservative CTR. A paradigm shift in the last 20 years to preserve healthy tooth structure has changed how clinicians should treat advanced lesions. Although the panel acknowledges decisions regarding CTR approaches may be based on early clinical education,[77] learned behaviors, and preferences, they

suggest placing a greater emphasis on the evidence of increased risk of experiencing outcomes such as pulp exposure when all carious tissues are removed. The panel urges clinicians to use more conservative CTR approaches that align with restorative dentistry's 2 main aims: preserving healthy tooth structure[27] and protecting the pulp-dentin complex.[2]

Comparison with other guidelines

To our knowledge, this is the first CPG on CTR approaches and direct restorative materials for primary and permanent teeth informed by an SR and using the GRADE framework to assess the CoE and develop clinical recommendations. This guideline is consistent with earlier guidance and consensus documents developed by the American Academy of Pediatric Dentistry[3] and the International Caries Consensus Collaboration[2] suggesting more conservative approaches to treat moderate and advanced lesions. Regarding recommendations for direct restorative materials, the American Academy of Pediatric Dentistry also provides similar guidance to restore primary and permanent teeth in children and adolescents. Although the International Caries Consensus Collaboration did not provide recommendations for specific materials, they acknowledged that factors such as tooth location, lesion depth, and caries risk are necessary to inform the appropriate choice of direct restorative material. Guidance from other associations has not been formally assessed or endorsed by the ADA.

Implications for research

The lack of evidence on CTR approaches to treat moderate lesions on permanent teeth resulted in the panel using indirect evidence from advanced lesions to inform these recommendations. Given that moderate lesions may have a lower risk of experiencing pulpal complications regardless of CTR approaches, it is difficult to make assumptions about the true effect of CTR approaches using data from advanced lesions. Trials comparing CTR approaches in moderate lesions in permanent teeth would help address this research gap. In addition, the results regarding HT in primary teeth were challenging to consider in the context of this guideline (that is, comparing the success of the HT with conventionally placed direct restorations likely is influenced by the high success rate of PMCs and not CTR approaches). Future RCTs comparing the effectiveness of PMCs placed with the HT to preformed crowns placed conventionally is needed to evaluate the effect of CTR approaches and inform decision making.

The panel urges researchers in the field of direct restorative materials to include the evaluation of AE outcomes in their clinical studies. None of the studies in the associated SR[7] reported on AEs. There was also a lack of studies identified on preformed crowns for anterior and posterior primary teeth, which resulted in the use of limited indirect evidence to inform recommendations, warranting the conduct of new studies on this intervention. The low event rate for outcomes related to clinical failure contributed to the panel's inability to detect important differences among direct restorative materials, if a difference exists. Follow-ups over 36 months will allow more time for material longevity assessment and long-term outcomes such as secondary caries to be meaningfully evaluated. Another complication is the continual advancements in restorative materials, as materials used in trials may be obsolete when results are published. Overall, a more detailed reporting of lesion and treatment characteristics and reasons for restoration failure may enhance applicability for decision making.

CONCLUSIONS

To restore moderate and advanced caries lesions on vital, nonendodontically treated primary and permanent teeth, the panel suggests the use of more conservative, single-visit CTR approaches and various direct restorative materials. The panel acknowledges the importance of considering additional factors, such as patient and caregiver preferences and treatment costs, when developing a treatment plan. ■

SUPPLEMENTAL DATA

Supplemental data related to this article can be found at: https://doi.org/10.1016/j.adaj.2023.04.011.

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APPENDIX

METHODS

Panel configuration and conflicts of interest

In 2019, the American Dental Association (ADA) Council on Scientific Affairs convened and approved a multidisciplinary panel comprising general, pediatric, and public health dentists. Panel members completed intellectual and financial conflicts of interest disclosure forms reviewed by methodologists and the legal department at the ADA. All intellectual and financial conflicts of interest were disclosed at the beginning of the first panel meeting to define the scope, purpose, target audience, and clinical questions and at the last panel meeting to formulate recommendations. If panel members had conflicts of interest related to specific recommendations, methodologists asked them to refrain from discussing and formulating them.

Retrieving the evidence

The results of 2 systematic reviews (SRs) informed these clinical recommendations: 1 developed by the Cochrane Oral Health Group to inform recommendations regarding carious tissue removal (CTR) approaches (that is, the extent of carious tissue removed)[e1] and another led by methodologists at the ADA Science and Research Institute (ADASRI) program for Clinical and Translational Research to inform recommendations regarding direct restorative materials.[e2]

Methodologists led an SR to inform recommendations regarding CTR approaches to treat moderate and advanced caries lesions on primary and permanent teeth. We included SRs or overviews of SRs of randomized or quasi-randomized controlled trials (RCTs), including patients of any age with at least 1 caries lesion requiring a restoration on primary or permanent teeth published from 2017 through 2022. We included reviews that conducted searches in at least 2 electronic, bibliographic databases with the reporting of at least 1 search strategy and methods that are reproducible; included at least 2 interventions included in the clinical questions formulated by the panel; reported on predefined outcomes included as part of the clinical questions formulated by the panel; and provided details on study selection and data extraction. We excluded reviews that did not use the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach (or another validated tool) to assess the certainty of the evidence, did not report the extent of carious tissue removed, have been superseded by a subsequent update of the same SR or meta-analysis, only assessed the effectiveness of head-to-head comparisons of different means to remove caries (that is, mechanical or chemomechanical), and included primary studies in which a restoration was placed in an endodontically treated tooth.

This search strategy for desirable effects contained concepts for caries and caries removal. In collaboration with methodologists and the panel, an informationist (K.K.O.) built the search strategy in Ovid MEDLINE using a combination of subject headings and key words. All searches were completed in March 2022 in Ovid MEDLINE from 1946 through March 2022, Embase from 1947 through March 2022, Cochrane Database of Systematic Reviews, and Trip Medical Database. The SIGN systematic reviews filter was modified to include guideline language and applied to the MEDLINE and Embase searches.[e3] Database-supplied limits were used to limit to All Secondary Evidence in Trip and items published in the past 5 years in all databases. No language limits were applied. Complete search strategies for all 4 databases are provided below.

MEDLINE. Database: Ovid MEDLINE. Search conducted in this database on March 11, 2022.

#1 exp Dental Caries/

#2 (caries or carious).tw.

#3 ((tooth or teeth or dentin$ or dental) adj5 (decay$ or lesion$ or cavit$)).tw.

#4 #1 or #2 or #3

#5 exp Dental Cavity Preparation/

#6 “carious tissue removal”.tw.

#7 “complete caries removal”.tw.

#8 ((caries or carious or cavit$) adj5 (stepwise or excavation or excavator$)).tw.

#9 ((caries or carious or cavit$) adj5 (selective or partial or incomplete or remov$)).tw.

#10 ((caries or carious or cavit$) adj5 (nonselective or non-selective)).tw.

#11 ((caries or carious or cavit$) adj5 ('minimally invasive' or 'minimal invasion' or 'minimum invasion')).tw.

#12 (dentin$ adj3 remov$).tw.

#13 "hall technique".tw.

#14 #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 or #13

#15 #4 and #14

#16 Meta-Analysis as Topic/

#17 meta analy$.tw.

#18 metaanaly$.tw.

#19 Meta-Analysis/

#20 (systematic adj (review$1 or overview$1)).tw.

#21 exp "Review Literature as Topic"/

#22 review.pt.

#23 #16 or #17 or #18 or #19 or #20 or #21 or #22

#24 cochrane.ab.

#25 embase.ab.

#26 (psychlit or psyclit).ab.

#27 (psychinfo or psycinfo).ab.

#28 (cinahl or cinhal).ab.

#29 science citation index.ab.

#30 bids.ab.

#31 cancerlit.ab.

#32 #24 or #25 or #26 or #27 or #28 or #29 or #30 or #31

#33 reference list$.ab.

#34 bibliograph$.ab.

#35 hand-search$.ab.

#36 relevant journals.ab.

#37 manual search$.ab.

#38 #33 or #34 or #35 or #36 or #37

#39 exp guideline/

#40 (guideline or guidelines).ab,kw,ot,ti.

#41 ('consensus statement' or 'consensus statements').ab,kw,ot,ti.

#42 ('consensus recommendation' or 'consensus recommendations').ab,kw,ot,ti.

#43 #39 or #40 or #41 or #42

#44 selection criteria.ab.

#45 data extraction.ab.

#46 #44 or #45

#47 "Review"/

#48 #46 and #47

#49 Comment/

#50 Letter/

#51 Editorial/

#52 exp Animals/

#53 exp Humans/

#54 52 and 53

#55 #52 not #54

#56 #49 or #50 or #51 or #55

#57 #23 or #32 or #38 or #43 or #48

#58 #57 not #56

#59 #15 and #58

#60 limit #59 to last 5 years

Embase. Database: Embase via embase.com. Search conducted in this database on March 11, 2022.

#1 'dental caries'/exp

#2 caries:ti,ab,kw OR carious:ti,ab,kw

#3 ((tooth OR teeth OR dentin* OR dental) NEAR/5 (decay* OR lesion* OR cavit*)):ti,ab,kw

#4 #1 OR #2 OR #3

#5 'carious tissue removal':ti,ab,kw

#6 'complete caries removal':ti,ab,kw

#7 ((caries OR carious OR cavit*) NEAR/5 (stepwise OR excavation OR excavator*)):ti,ab,kw

#8 ((caries OR carious OR cavit*) NEAR/5 (selective OR partial OR incomplete OR remov*)):ti,ab,kw

#9 ((caries OR carious OR cavit*) NEAR/5 (nonselective OR 'non selective')):ti,ab,kw

#10 ((caries OR carious OR cavit*) NEAR/5 ('minimally invasive' OR 'minimal invasion' OR 'minimum invasion')):ti,ab,kw

#11 (dentin* NEAR/3 remov*):ti,ab,kw

#12 'hall technique':ti,ab,kw

#13 #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12

#14 #4 AND #13

#15 'meta analysis'/exp OR 'review'/exp OR 'review':it OR 'systematic review'/exp OR 'systematic review':it

#16 (meta NEXT/1 analy*) OR metaanalys*

#17 systematic* NEAR/5 (review* OR overview*)

#18 #15 OR #16 OR #17

#19 (practice NEAR/4 guideline*):ti,ab,kw

#20 (clinical NEAR/4 guideline*):ti,ab,kw

#21 'practice guideline'/exp

#22 'consensus statement':ti,ab,kw OR 'consensus statements':ti,ab,kw

#23 'consensus recommendation':ti,ab,kw OR 'consensus recommendations':ti,ab,kw

#24 #19 OR #20 OR #21 OR #22 OR #23

#25 'cancerlit':ab

#26 'cochrane':ab

#27 'embase':ab

#28 'psychlit':ab OR 'psyclit':ab

#29 'psychinfo':ab OR 'psycinfo':ab

#30 'cinahl':ab OR 'cinhal':ab

#31 'science citation index':ab

#32 'bids':ab

#33 #25 OR #26 OR #27 OR #28 OR #29 OR #30 OR #31 OR #32

#34 'reference lists':ab

#35 'bibliograph*':ab

#36'hand-search*':ab

#37 'manual search*':ab

#38 'relevant journals':ab

#39 #34 OR #35 OR #36 OR #37 OR #38

#40 'letter':it

#41 'editorial':it

#42 'animal'/exp

#43 'human'/exp

#44 #42 NOT (#42 AND #43)

#45 #40 OR #41 OR #44

#46 #18 OR #24 OR #33 OR #39

#47 #46 NOT #45

#48 #14 AND #47

#49 #48 AND [11-03-2017]/sd NOT [02-04-2022]/sd

Cochrane Library. Database: Cochrane Database of Systematic Reviews via Wiley. Search conducted in this database on March 11, 2022.

#1 MeSH descriptor: [Dental Caries] explode all trees

#2 ((caries or carious)):ti,ab,kw

#3 (((tooth or teeth or dentin* or dental) NEAR/5 (decay* or lesion* or cavit*))):ti,ab,kw

#4 #1 or #2 or #3

#5 MeSH descriptor: [Dental Cavity Preparation] explode all trees

#6 ('carious tissue removal'):ti,ab,kw

#7 ('complete caries removal'):ti,ab,kw

#8 (((caries OR carious OR cavit*) NEAR/5 (stepwise OR excavation OR excavator*))):ti,ab,kw

#9 (((caries OR carious OR cavit*) NEAR/5 (selective OR partial OR incomplete OR remov*))):ti,ab,kw

#10 (((caries OR carious OR cavit*) NEAR/5 (nonselective OR 'non selective'))):ti,ab,kw

#11 (((caries OR carious OR cavit*) NEAR/5 ('minimally invasive' OR 'minimal invasion' OR 'minimum invasion'))):ti,ab,kw

#12 ((dentin* NEAR/3 remov*)):ti,ab,kw

#13 ('hall technique'):ti,ab,kw

#14 #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 or #13

#15 #4 and #14 with Cochrane Library publication date Between Mar 2017 and Apr 2022

Grey literature. Database: https://www.tripdatabase.com. Search conducted in this database on March 11, 2022.

(dental caries OR carious lesion*) AND (caries removal OR hall technique)

Dates for search: January 2017 through March 2022.

Limits: All secondary evidence; Since 2017.

Two reviewers (L.P., S.P.) independently screened the titles, abstracts, and full texts of eligible references, and another reviewer (O.U.) served as an arbiter when consensus was elusive. We prioritized the selection of 1 SR to inform clinical recommendations using this criteria: SRs assessing all interventions of interest using network meta-analysis, if possible; including data on both primary and permanent dentition; using GRADE to assess the certainty of the evidence; reporting data specific to lesion depth; only including RCTs rather than both RCTs and other study designs; and SRs "[superseding a] subsequent SR or meta-analysis."[e4] Once 1 SR was identified, the same reviewers assessed the excluded studies table to confirm references were not excluded that would fit within the scope of our guideline. One methodologist (O.U.) critically appraised all SRs used to inform the development of this guideline using A MeaSurement Tool to Assess systematic Reviews 2.[e5]

In addition, methodologists led the development of an SR to inform recommendations regarding direct restorative materials to restore caries lesions on vital, nonendodontically treated primary and permanent teeth. Detailed information specific to the methodology used to conduct this review is published elsewhere.[e2] In brief, a search strategy containing caries and restorative materials concepts was developed and run in collaboration with an informationist (K.K.O.). Eligibility criteria included RCTs or quasi-RCTs, including children or adults requiring de novo or replacement restorations on vital teeth; head-to-head comparisons of the interventions of interest; and reporting on the predefined outcomes of interest. Pairs of reviewers (L.P., S.P., A.C.-L., and 3 authors of the related SR[e2]) independently screened titles, abstracts, and full texts of eligible references. When disagreements occurred, a third reviewer (L.P., S.P.) determined the final eligibility. Four reviewers (L.P., S.P., and 2 authors of the associated SR) independently and in duplicate extracted data from primary studies. We resolved all conflicts via group discussion.

In the absence of data on the undesirable effects of CTR approaches and direct restorative materials, 1 methodologist (O.U.) conducted a supplemental search for SRs and health technology assessments (HTAs) in MEDLINE via PubMed and the TRIP database using key words related to the population and interventions of interest. Another reviewer (L.P.) conducted quality control and independently audited the eligibility of each reference. We applied the same selection criteria described above. However, we relaxed the study design criteria to include SRs or HTAs summarizing observational studies in the absence of references summarizing data from RCTs.

Evidence synthesis and measures of association

We used a fixed-effects and a random-effects model to pool data for the direct restorative materials and CTR approaches SRs, respectively. We calculated risk differences and 95% CIs for dichotomous outcomes and mean differences and 95% CIs for continuous outcomes.

Certainty of the evidence

We used the GRADE approach to assess the certainty of the evidence.[e6] The certainty of the evidence indicates the panel's confidence in the treatment effects used to support the recommendations.

Moving from evidence to decisions

The panel defined and ranked outcomes a priori. Outcomes could either be critical, important, or not important for decision making.

For CTR approaches for primary teeth, the panel ranked pulp vitality, pulpal exposure, pulpal complications due to infection, the need to treat endodontically, caries progression, tooth loss, tooth extraction, postoperative pain and discomfort, and secondary caries as critical outcomes and adverse effects (AEs) (that is, anaphylaxis, neurobehavioral assessment, kidney function, psychosocial function, and physical development), tooth fracture, cost and cost-effectiveness, patients discomfort during treatment, restoration failure, injury to adjacent tissue or tooth, time needed to perform restoration, and patient satisfaction as important outcomes.

For CTR approaches for permanent teeth, the panel ranked tooth loss, pulp vitality, pulpal exposure, pulpal complications due to infection, the need to treat endodontically, tooth extraction, caries progression, postoperative pain and discomfort, secondary caries, longevity of restoration, and tooth fracture as critical and restoration failure, cost and cost-effectiveness, injury to adjacent tissue or tooth, patient discomfort during treatment, AEs, patient satisfaction, and time needed to perform restoration as important.

For direct restorative materials for primary teeth, the panel ranked pulpal complications due to infection, pulp vitality, caries progression, pulpal exposure, oral health–related quality of life, AEs, the need to treat endodontically, tooth loss, secondary caries, postoperative pain and discomfort, restoration fracture, tooth fracture, longevity of the restoration, and restoration failure as critical outcomes and unacceptable marginal adaptation, restoration loss, time needed to perform the restoration, patient satisfaction, patient discomfort during treatment, marginal discoloration or staining, unacceptable anatomic form, and unacceptable color match as important outcomes.

For direct restorative materials for permanent teeth, the panel ranked pulpal complications due to infection, AEs, pulp vitality, pulpal exposure, the need to treat endodontically, longevity of the

restoration, postoperative pain and discomfort, caries progression, secondary caries, unacceptable marginal adaptation, restoration failure, tooth retention, tooth fracture, patient satisfaction, oral health–related quality of life, and restoration fracture as critical outcomes and unacceptable anatomic form, restoration loss, patient discomfort during treatment, marginal discoloration or staining, unacceptable color match, and time needed to perform the restoration as important outcomes.

Methodologists (L.P., S.P.) facilitated recommendation formulation using the GRADE Evidence-to-Decision (EtD) framework.[e7] This framework includes 9 factors for panels to move from evidence to clinical recommendations: problem prioritization, magnitude of desirable effects, magnitude of undesirable effects, certainty of the evidence, balance of desirable and undesirable effects, patients' values and preferences, resources required, acceptability, and feasibility. We conducted nonsystematic searches to find evidence of patients' values and preferences, acceptability, and feasibility. If multiple study types were available on the same topic, we prioritized the use of SRs and RCTs over nonrandomized and observational studies when applicable.

Methodologists adapted GRADE's EtD approach to choose from multiple interventions[e8] to compare and judge interventions across all EtD criteria and mirrored this approach after 2 clinical practice guidelines: 1 developed by the American Society of Hematology[e9] and another developed by ADASRI, University of Pittsburgh, and University of Pennsylvania (A. Carrasco-Labra, written communication, August 2021). We used a star-based system ranging from 1 through 3 stars to rank all interventions considered in the factor. In this system, 1 star is the lowest score and considered the least, or one of the least, effective interventions, and 3 stars is the highest score and considered the most, or one of the most, effective interventions.

Overall, the more stars an intervention receives, the more favorable it is judged across each criterion. These judgments are relative terms used when comparing the interventions against one another and do not imply that a material's overall effectiveness is of superior, intermediate, or inferior value. Once the panel discussed the evidence and made judgments for each factor, the panel determined the direction and strength of each recommendation.

Stakeholder and public engagement

We conducted stakeholder engagement twice during the guideline development process. We first requested internal and external stakeholders to provide feedback on the scope, purpose, clinical questions, and target audience and then on the clinical recommendations. We also invited the general public to review and provide feedback on the recommendations on the ADASRI program for Clinical and Translational Research website.[e10] We reviewed and considered all relevant feedback in the final draft of the recommendation statements and remarks.

Updating process

ADASRI program for Clinical and Translational Research will update the guideline recommendations every 5 years or when new evidence is available and could change the direction and strength of recommendations.

RESULTS

Characteristics of included studies and methodological quality assessment

We identified 372 citations from the literature search to inform recommendations for CTR approaches. After removing 84 duplicates, we screened 288 titles and abstracts and 32 full-texts of SRs. Four[e1,e11-e13] SRs met our selection criteria, and, ultimately, 1[e1] was included, which assessed the effectiveness of interventions to treat caries lesions on vital, nonendodontically treated primary and permanent teeth (eFigure 1, eTable 1, eTable 2). Although the authors included nonrestorative and restorative strategies in this SR, only studies related to nonselective, stepwise, selective, and no CTR (that is, sealing a caries lesion with a preformed metal crown [PMC]) were of interest.

We identified 3 SRs[e14-e16] and 1 HTA[e17] to inform the undesirable effects of direct restorative materials. There was overlap in the primary studies included in these reviews reporting on the outcomes of interest to the panel. Therefore, we prioritized using data from an SR by Worthington and colleagues,[e14] as the study authors used the GRADE approach, allowing for continuity in the way the certainty of the evidence was assessed across our evidence base.

Both SRs[e1,e14] were judged to be of high methodological quality (eFigure 17). In addition, because both included SRs[e1,e14] were published in 2021, methodologists decided not to update them. However, 2 reviewers (L.P., S.P.) reextracted data from the included primary studies of the SR by Schwendicke and colleagues[e1] to guarantee that the panel was presented with all critical and important outcomes for decision making.

Desirable and undesirable effects related to CTR approaches for moderate and advanced caries lesions on primary teeth

For the comparison of nonselective vs selective CTR to treat moderate caries lesions on primary teeth,[e18] there were 0 events in both arms of the study for the outcomes of loss of restoration at 12-month follow-up (very low certainty).

For the comparison of nonselective vs selective CTR to treat advanced caries lesions on primary teeth,[e19,e20] there were 0 events in both arms of the studies for the outcomes of restoration loss, postoperative pain and discomfort, and pulpal complications due to infection at 6-month follow-up (very low certainty).

Values and preferences related to CTR approaches for moderate and advanced caries lesions on primary and permanent teeth

We found no studies conducted in the United States reporting on the relative importance of various clinical outcomes that patients place when undergoing CTR (for example, pulp exposure, need for endodontic treatment, secondary caries, restorative complications) in primary or permanent teeth.

We identified 1 mixed-methods study conducted in Germany,[e21] which gathered data on patient preferences toward selective and nonselective CTR. Results from 150 patients aged 18 through 85 years showed that most participants (82.7%) preferred nonselective over selective CTR. When factoring in other variables, participants who were more emotionally stable and had university degrees were more likely to prefer selective CTR than participants who were less emotionally stable and without a university degree. In addition, a risk acceptance assessment showed that patients were more likely to accept a higher cost, the need for root canal treatment, and impaired esthetics than the outcomes of nerve damage, restoration failure, and secondary caries. The panel considered there is possible important uncertainty or variability in patients' values and preferences (PVP) for selective and nonselective CTR. Regarding stepwise and no CTR, the panel discussed that patients or caregivers may prefer not to return for a second appointment that is necessary for stepwise CTR and sometimes no CTR. On the basis of this information, the panel determined that there was possibly important uncertainty or variability in PVPs for all CTR approaches.

Acceptability related to CTR approaches for moderate and advanced caries lesions on primary and permanent teeth

From the clinician's perspective, research evidence suggests varying degrees of acceptability of nonselective, stepwise, selective, and no CTR. Two studies[e22,e23] surveyed clinicians to determine their beliefs, attitudes, and practices when treating advanced caries lesions restoratively. Most respondents stated that they would remove all carious tissue regardless of the risk of pulp exposure and that no carious tissue should be left behind to ensure the success of a restoration. Because nonselective CTR has been the reference standard over the past decades,[e24] Oen and colleagues[e22] highlighted that clinicians may emphasize their colleagues' approval and perspectives over the evidence showing the increased effectiveness of conservative CTR approaches when determining treatment.

In addition, Nascimento and colleagues[e25] evaluated the teaching practices of CTR approaches among cariology department faculty members from 43 dental schools in the United States. Study authors found slight variability in how dental schools defined principles related to caries removal and how lesion depth affects treatment planning. Most respondents (26 of 40 dental schools) agreed that infected dentin should always be removed to prevent the progression of caries under the restoration and disagreed that affected dentin should always be removed to avoid the progression of caries under the restoration (35 of 40 dental schools). Twenty-seven respondents agreed and 8 disagreed that caries removal should be minimally invasive regardless of lesion depth and only infected dentin should be removed.

Lastly, an RCT conducted in Germany assessed children's pain perception and acceptability among parents and dentists of conventional restorative treatment, Hall technique (HT), and nonrestorative caries treatment.[e26] Results suggested that more than one-half of the parents were very satisfied with their child's treatment, and almost all parents stated that they would choose the same treatment option again. In addition, clinicians noted that most HT and conventional restorative treatments were easy to perform or handle and took long to complete. However, there were differences between the provided and preferred treatment for each caries lesion. Seventy-two percent of clinicians would have performed conventional restorative treatment, whereas only 30.7% of treatments provided during the study were conventional restorative treatment. Furthermore, 17% preferred conventional restorative treatment with a PMC, and HT would not have been used as an option for treatment. However, it is important to note that "the HT was introduced to the clinic and taught to the clinicians as part of this trial, so they were unfamiliar with it…following this trial, the HT [is now] routinely performed…indicating an increased level of acceptance and use of [this technique]."[e26]

The panel discussed that although some key stakeholders may place more preference on 1 CTR approach over another, overall, key stakeholders may find all CTR approaches acceptable.

Desirable and undesirable effects related to direct restorative materials for moderate and advanced caries lesions on primary and permanent teeth

Of the 8 RCTs included in the review by Worthington and colleagues, 3[e27-e29] reported data on undesirable effects. Bernado and colleagues[e27] and Soncini and colleagues[e29] reported on outcomes related to toxicity (that is, immune, neuorologic, neuoropsychological, psychological, and renal function and physical development), whereas Kemaloglu and colleagues[e28] reported on post-operative sensitivity. No studies reported data on allergic reactions or injuries. Worthington and colleagues[e14] concluded that although there may be some differences in harm outcomes between those that received amalgam and resin composite restorations, the differences are not clinically significant (low to very low certainty).

Values and preferences related to direct restorative materials for moderate and advanced caries lesions on primary and permanent teeth

We found no studies conducted in the United States reporting on the relative importance of various clinical outcomes that patients place when receiving a dental restoration for a caries lesion. The panel judged this factor using indirect evidence from studies conducted in people with permanent dentition outside the United States.

Although we did not identify any studies examining PVP related to different esthetic restorative materials, the panel agreed that from the patient perspective, esthetic restorations often are regarded equally, with no preference for one over the other. On the basis of this information, the panel determined that there was probably no important uncertainty or variability in PVP for compomers, conventional glass ionomer cement, resin composites, and resin-modified glass ionomer cement for both primary and permanent dentition.

With respect to amalgam vs esthetic restorations, a study from Norway and Sweden suggests that patients place a higher value on the restoration's esthetics and avoid potential adverse reactions than they do on the expected longevity of the restoration.[e30] In addition, an HTA from Canada[e17] found a high degree of variation among qualitative data on experiences associated with amalgam restorations. The included studies in this report shared experiences from patients who had amalgam restorations removed after unexplained symptoms may have been associated with mercury poisoning. The experiences after removal were highly variable. The report authors note that there was a focus on potential negative outcomes associated with amalgam and a narrow set of perspectives was represented. On the basis of this information, the panel determined that there was important uncertainty or variability in PVP regarding the use of amalgam for both primary and permanent dentition.

For PMCs, the guideline panel considered a 2020 literature review[e31] on the HT and found that 77% of patients from a split-mouth trial[e32] preferred the HT over conventional restorative treatment and that using separators did not influence this preference. The same review also found that the most common reason for a parent to prefer a conventional restoration over a preformed metal

crown was esthetics. Still, most parents agreed with treating with a crown after the dentist explained the advantages. On the basis of this information, the panel determined that there was probably no important uncertainty or variability in PVP for PMCs in primary teeth.

e1. Schwendicke F, Walsh T, Lamont T, et al. Interventions for treating cavitated or dentine carious lesions. *Cochrane Database Syst Rev*. 2021:CD013039.

e2. Pilcher L, Pahlke S, Urquhart O, et al. Direct materials for restoring caries lesions: systematic review and meta-analysis—a report of the American Dental Association Council on Scientific Affairs. *JADA*. 2023;154(2):e1-e98.

e3. Search filters. Scottish Intercollegiate Guidelines Network, Healthcare Improvement Scotland. Accessed March 10, 2022. https://www.sign.ac.uk/what-we-do/methodology/search-filters

e4. Moore PA, Ziegler KM, Lipman RD, et al. Benefits and harms associated with analgesic medications used in the management of acute dental pain: an overview of systematic reviews. *JADA*. 2018;149(4):256-265.e3.

e5. Shea BJ, Reeves BC, Wells G, et al. AMSTAR 2: a critical appraisal tool for systematic reviews that include randomised or non-randomised studies of healthcare interventions, or both. *BMJ*. 2017;358:j4008.

e6. Guyatt GH, Oxman AD, Kunz R, et al.; GRADE Working Group. What is "quality of evidence" and why is it important to clinicians? *BMJ*. 2008;336(7651):995-998.

e7. Alonso-Coello P, Schünemann HJ, Moberg J, et al. GRADE Evidence to Decision (EtD) frameworks: a systematic and transparent approach to making well informed healthcare choices—1, introduction. *BMJ*. 2016;353:i2016.

e8. Piggott T, Brozek J, Nowak A, et al. Using GRADE evidence to decision frameworks to choose from multiple interventions. *J Clin Epidemiol*. 2021;130:117-124.

e9. Connell NT, Flood VH, Brignardello-Petersen R, et al. ASH ISTH NHF WFH 2021 guidelines on the management of von Willebrand disease. *Blood Advances*. 2021;5(1):301-325.

e10. Clinical Practice Guidelines and Dental Evidence. American Dental Association. Accessed September 15, 2022. https://www.ada.org/resources/research/science-and-research-institute/evidence-based-dental-research

e11. BaniHani A, Santamaría RM, Hu S, Maden M, Albadri S. Minimal intervention dentistry for managing carious lesions into dentine in primary teeth: an umbrella review. *Eur Arch Paediatr Dent*. 2022;23(5):667-693.

e12. Pedrotti D, Cavalheiro CP, Casagrande L, et al. Does selective carious tissue removal of soft dentin increase the restorative failure risk in primary teeth? Systematic review and meta-analysis. *JADA*. 2019;150(7):582-590.e1.

e13. Santamaría RM, Abudrya MH, Gül G, Said Mourad MHD, Gomez GF, Zandona AGF. How to intervene in the caries process: dentin caries in primary teeth. *Caries Res*. 2020;54(4):306-323.

e14. Worthington HV, Khangura S, Seal K, et al. Direct composite resin fillings versus amalgam fillings for permanent posterior teeth. *Cochrane Database Syst Rev*. 2021;8:CD005620.

e15. Patini R, Spagnuolo G, Guglielmi F, et al. Clinical effects of mercury in conservative dentistry: a systematic review, meta-analysis, and trial sequential analysis of randomized controlled trials. *Int J Dent*. 2020;2020:8857238.

e16. Gallusi G, Libonati A, Piro M, et al. Is dental amalgam a higher risk factor rather than resin-based restorations for systemic conditions? A systematic review. *Materials (Basel)*. 2021;14(8):1980.

e17. Khangura SD, Seal K, Esfandiari S, et al. *Composite Resin versus Amalgam for Dental Restorations: A Health Technology Assessment*. Canadian Agency for Drugs and Technologies in Health; 2018.

e18. Ribeiro CC, Baratieri LN, Perdigão J, Baratieri NM, Ritter AV. A clinical, radiographic, and scanning electron microscopic evaluation of adhesive restorations on carious dentin in primary teeth. *Quintessence Int*. 1999;30(9):591-599.

e19. Lula EC, Monteiro-Neto V, Alves CM, Ribeiro CC. Microbiological analysis after complete or partial removal of carious dentin in primary teeth: a randomized clinical trial. *Caries Res*. 2009;43(5):354-358.

e20. Mello B, Stafuzza TC, Vitor L, et al. Evaluation of dentin-pulp complex response after conservative clinical procedures in primary teeth. *Int J Clin Pediatr Dent*. 2018;11(3):188-192.

e21. Schwendicke F, Mostajaboldave R, Otto I, Dörfer CE, Burkert S. Patients' preferences for selective versus complete excavation: a mixed-methods study. *J Dent*. 2016;46:47-53.

e22. Oen KT, Thompson VP, Vena D, et al. Attitudes and expectations of treating deep caries: a PEARL Network survey. *Gen Dent*. 2007;55(3):197-203.

e23. Schwendicke F, Meyer-Lueckel H, Dörfer C, Paris S. Attitudes and behaviour regarding deep dentin caries removal: a survey among German dentists. *Caries Res*. 2013;47(6):566-573.

e24. Innes NP, Frencken JE, Bjørndal L, et al. Managing carious lesions: consensus recommendations on terminology. *Adv Dent Res*. 2016;28(2):49-57.

e25. Nascimento MM, Behar-Horenstein LS, Feng X, Guzmán-Armstrong S, Fontana M. Exploring how U.S. dental schools teach removal of carious tissues during cavity preparations. *J Dent Educ*. 2017;81(1):5-13.

e26. Santamaria RM, Innes NP, Machiulskiene V, et al. Acceptability of different caries management methods for primary molars in a RCT. *Int J Paediatr Dent*. 2015;25(1):9-17.

e27. Bernardo M, Luis H, Martin MD, et al. Survival and reasons for failure of amalgam versus composite posterior restorations placed in a randomized clinical trial. *JADA*. 2007;138(6):775-783.

e28. Kemaloglu H, Pamir T, Tezel H. A 3-year randomized clinical trial evaluating two different bonded posterior restorations: amalgam versus resin composite. *Eur J Dent*. 2016;10(1):16-22.

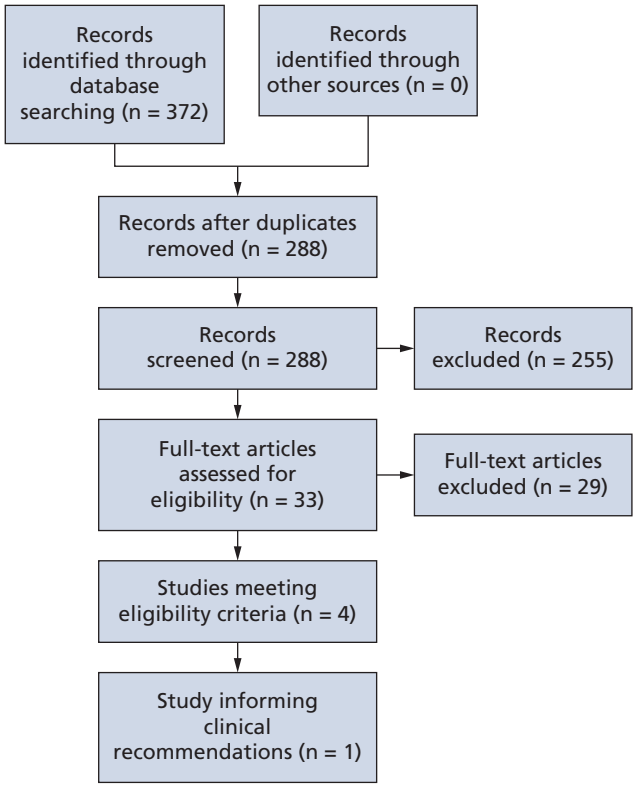
e29. Soncini JA, Maserejian NN, Trachtenberg F, Tavares M, Hayes C. The longevity of amalgam versus compomer/composite restorations in posterior primary and permanent teeth: findings From the New England Children's Amalgam Trial. *JADA*. 2007;138(6):763-772.

e30. Espelid I, Cairns J, Askildsen JE, Qvist V, Gaarden T, Tveit AB. Preferences over dental restorative materials among young patients and dental professionals. *Eur J Oral Sci*. 2006;114(1):15-21.

e31. Altoukhi DH, El-Housseiny AA. Hall technique for carious primary molars: a review of the literature. *Dent J (Basel)*. 2020;8(1):11.

e32. Innes NP, Evans DJ, Stirrups DR. The Hall Technique; a randomized controlled clinical trial of a novel method of managing carious primary molars in general dental practice: acceptability of the technique and outcomes at 23 months. *BMC Oral Health*. 2007;7:18.

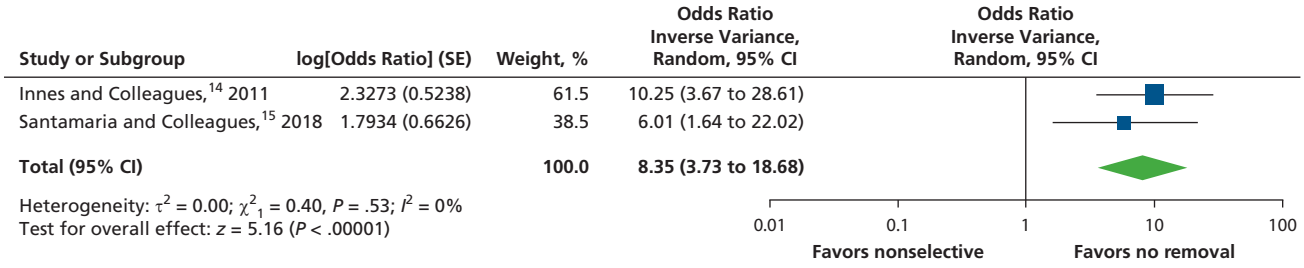
e33. Page MJ, McKenzie JE, Bossuyt PM, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ*. 2021;372:n71.



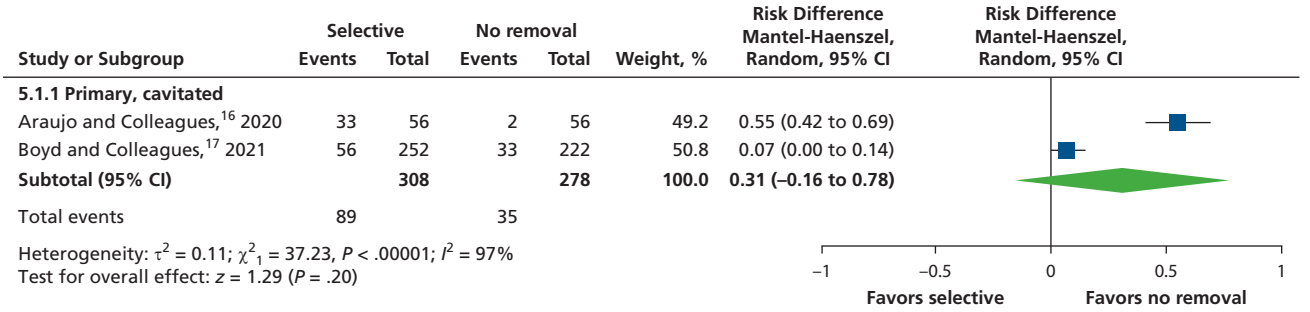
eFigure 1. Preferred Reporting Items for Systematic Reviews and Meta-Analyses flowchart of the screening and study selection process for systematic reviews on carious tissue removal approaches.[e33]

	Schwendicke and Colleagues,[13] 2021	Worthington and Colleagues,[47] 2021
Did the research questions and inclusion criteria for the review include the components of?	●	●
Did the report of the review contain an explicit statement that the review methods were established prior to the conduct of the reivew and did the report justify any significant deviations from the protocol?	●	●
Did the review authors explain their selection of the study designs for inclusion in the review?	●	●
Did the review authors use a comprehensive literature search strategy?	●	●
Did the review authors perform study selection in duplicate?	●	●
Did the review authors perform data extraction in duplicate?	●	●
Did the review authors provide a list of excluded studies and justify the exclusions?	●	●
Did the review authors describe the included studies in adequate detail?	●	●
Did the review authors use a satisfactory technique for assessing the risk of bias (RoB) in individual studies that were included in the review?	●	●
Did the review authors report on the sources of funding for the studies included in the review?	●	●
If meta-analysis was performed, did the review authors use appropriate methods for statistical combination of results (yes, no, no meta-analysis)?	●	●
If meta-analysis was performed, did the review authors assess the potential impact of RoB in individual studies on the results of the meta-analysis or other evidence synthesis?	●	●
Did the review authors account for RoB in individual studies when interpreting or discussing the results of the review?	●	●
Did the review authors provide a satisfactory explanation for, and discussion of, any heterogeneity observed in the results of the review?	●	●
If they performed quantitative synthesis, did the review authors carry out an adequate investigation of publication bias (small study bias) and discuss its likely impact on the results of the review?	●	●
Did the review authors report any potential sources of conflict of interest, including any funding they received for conducting the review?	●	●
Overall confidence (high, moderate, low, critically low)	**High**	**High**

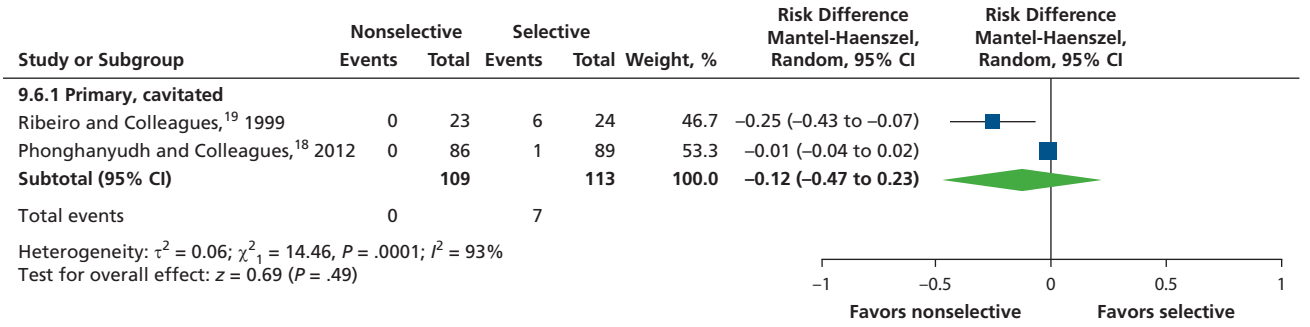
eFigure 2. A MeaSurement Tool to Assess systematic Reviews 2 assessment of included systematic reviews.[e4] Green refers to yes, and yellow refers to partial yes.



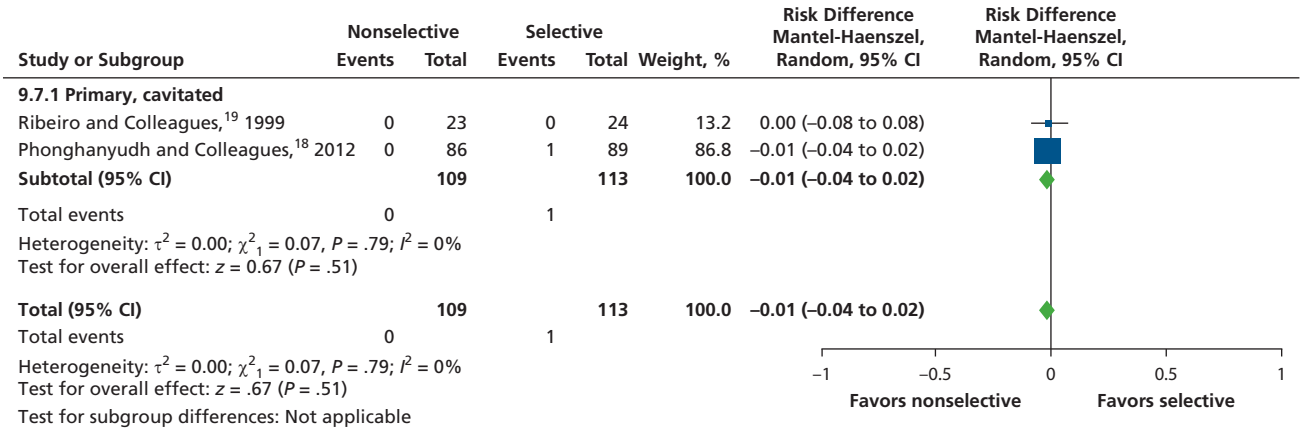
eFigure 3. Forest plot of comparison of nonselective carious tissue removal vs no carious tissue removal for moderate caries lesions on primary teeth for the outcome of failure at 30- to 60-month follow-up.



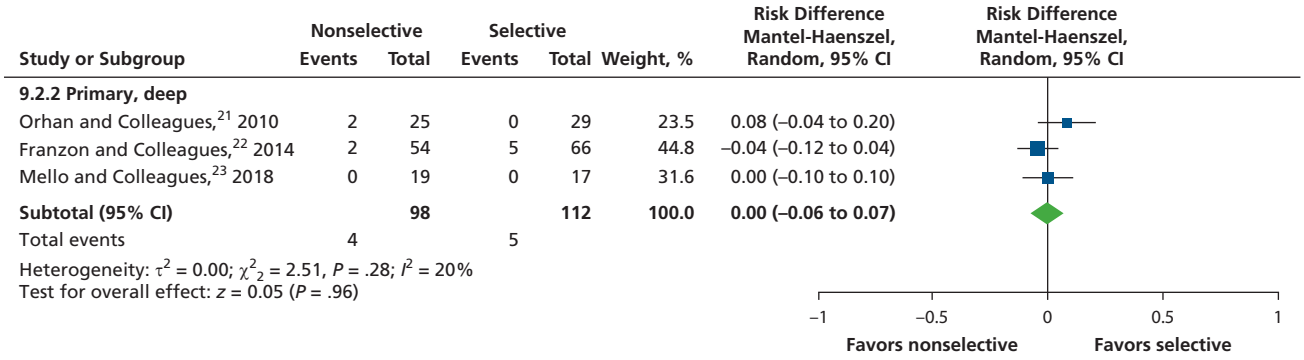
eFigure 4. Forest plot of comparison of selective carious tissue removal vs no carious tissue removal for moderate caries lesions on primary teeth for the outcome of failure at 24- to 36-month follow-up.



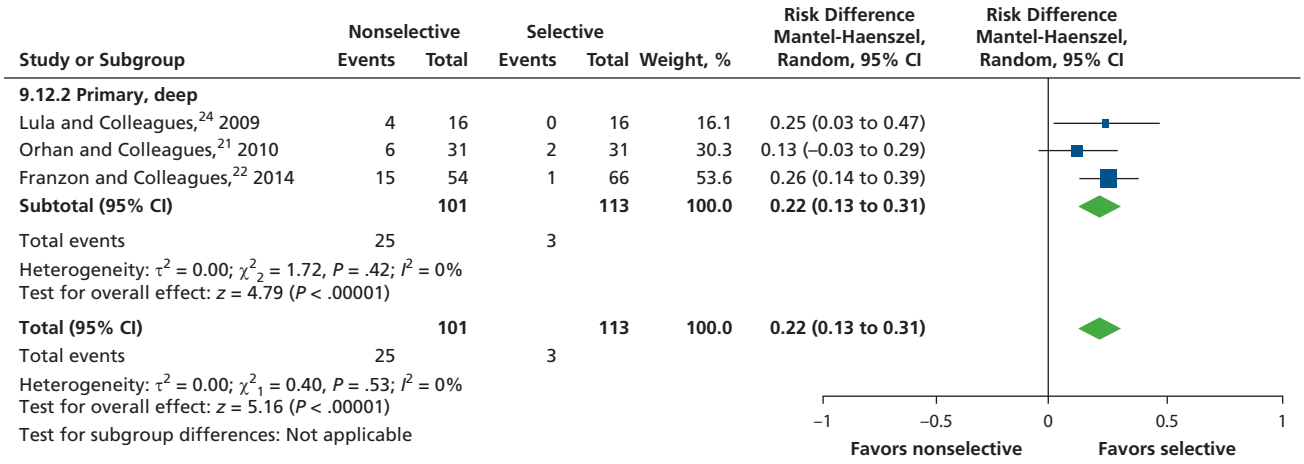
eFigure 5. Forest plot of comparison of nonselective carious tissue removal vs selective carious tissue removal for moderate caries lesions on primary teeth for the outcome of caries progression at 12-month follow-up.



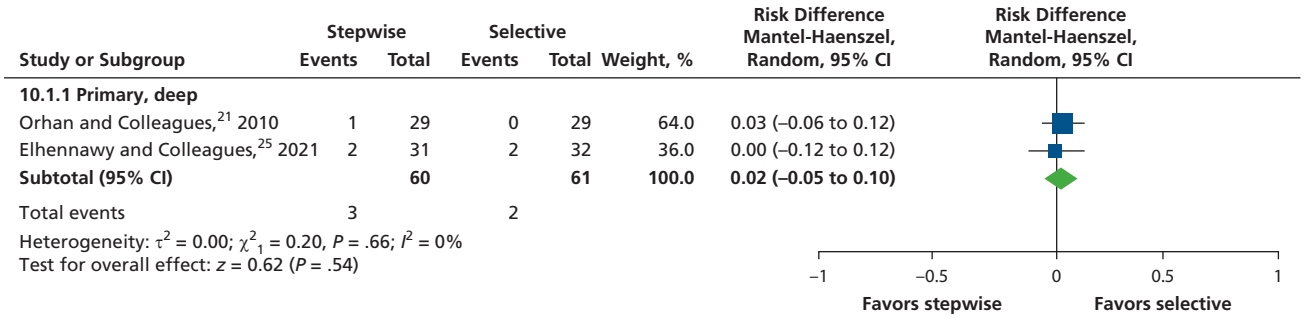
eFigure 6. Forest plot of comparison of nonselective carious tissue removal vs selective carious tissue removal for moderate caries lesions on primary teeth for the outcome of postoperative pain and discomfort at 12-month follow-up.



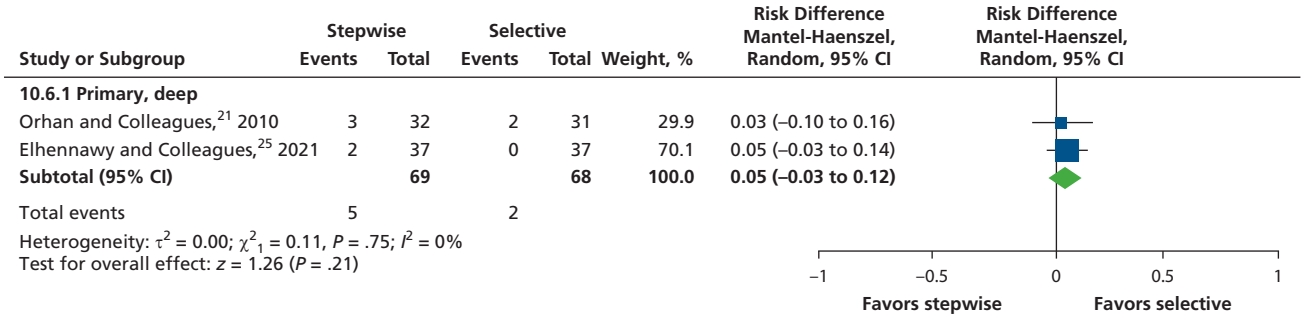
eFigure 7. Forest plot of comparison of nonselective carious tissue removal vs selective carious tissue removal for advanced caries lesions on primary teeth for the outcome of failure at 4- to 24-month follow-up.



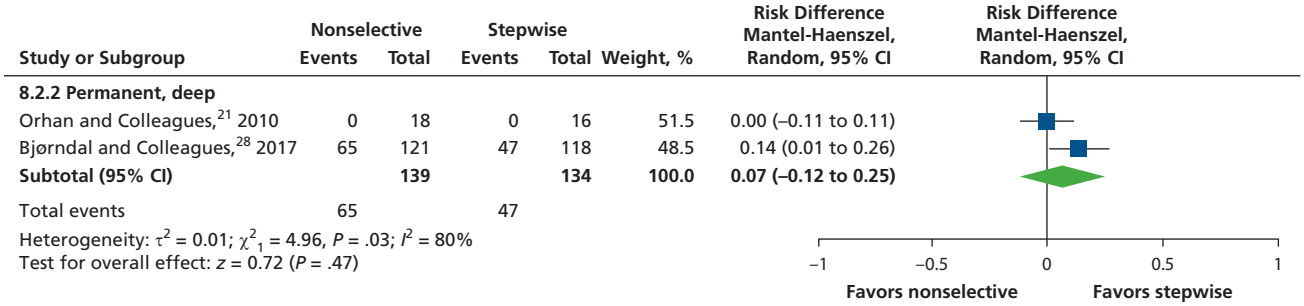
eFigure 8. Forest plot of comparison of nonselective carious tissue removal vs selective carious tissue removal for advanced caries lesions on primary teeth for the outcome of pulp exposure after treatment.



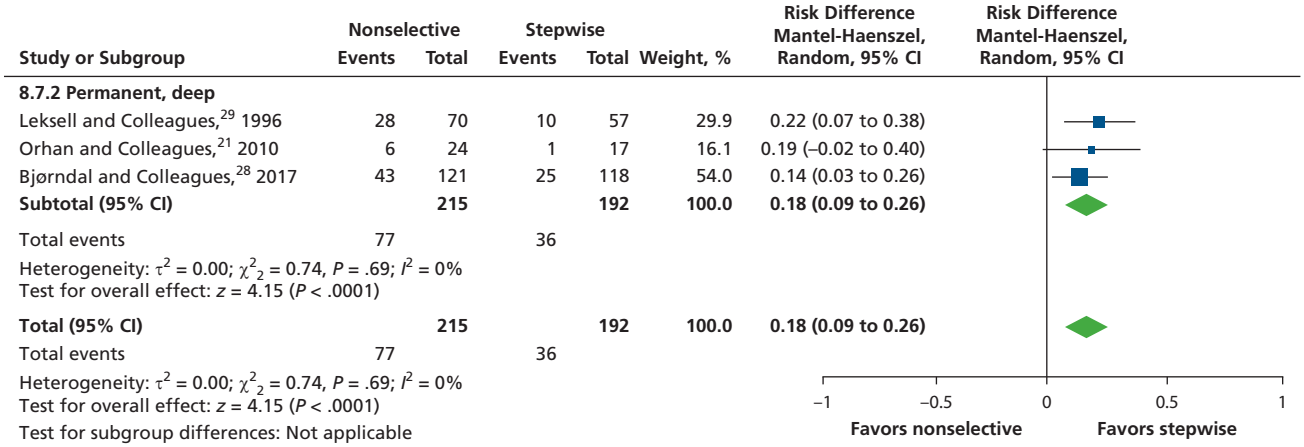
eFigure 9. Forest plot of comparison of stepwise carious tissue removal vs selective carious tissue removal for advanced caries lesions on primary teeth for the outcome of failure at 12- to 24-month follow-up.



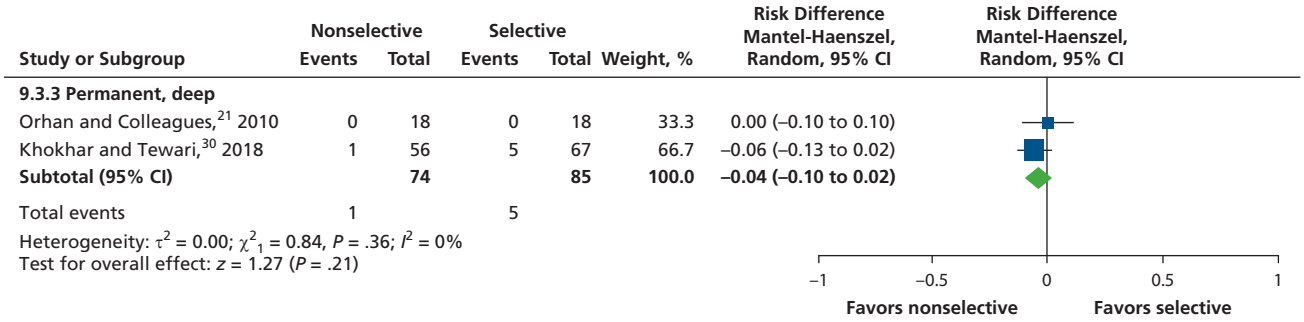
eFigure 10. Forest plot of comparison of stepwise carious tissue removal vs selective carious tissue removal for advanced caries lesions on primary teeth for the outcome of pulp exposure after treatment.



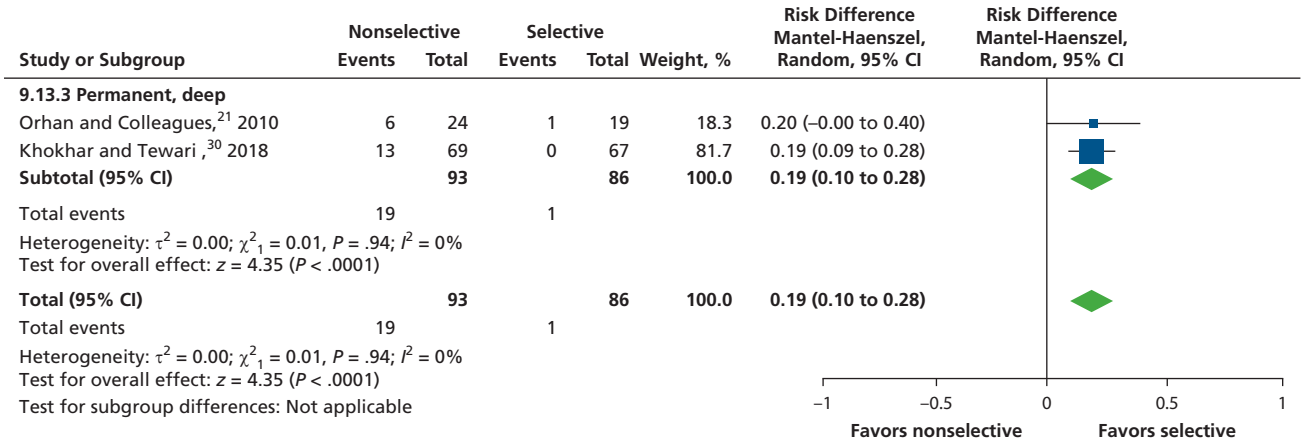
eFigure 11. Forest plot of comparison of nonselective carious tissue removal vs stepwise carious tissue removal for advanced caries lesions on permanent teeth for the outcome of failure at 12- to 60-month follow-up.



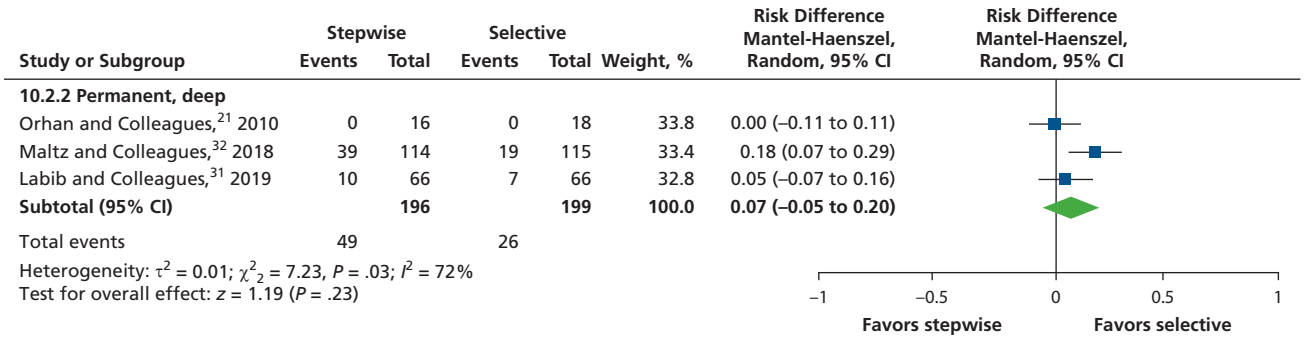
eFigure 12. Forest plot of comparison of nonselective carious tissue removal vs stepwise carious tissue removal for advanced caries lesions on permanent teeth for the outcome of pulp exposure after treatment.



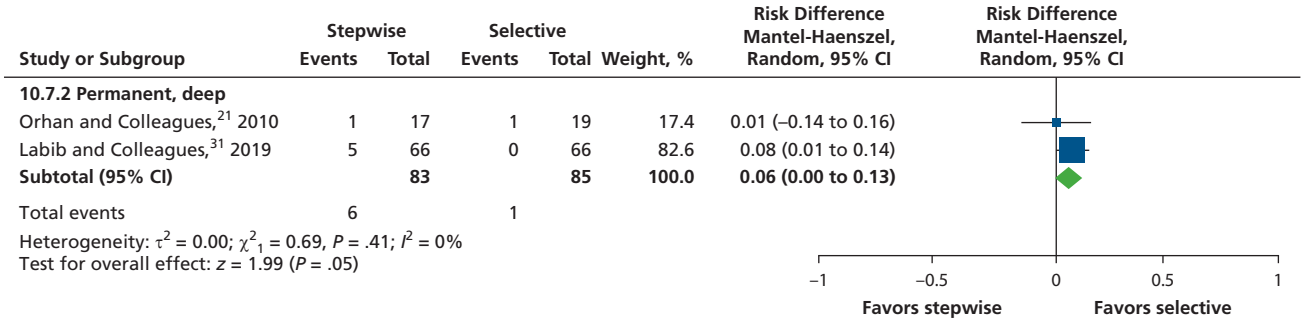
eFigure 13. Forest plot of comparison of nonselective carious tissue removal vs selective carious tissue removal for advanced caries lesions on permanent teeth for outcome of failure at 12- to 18-month follow-up.



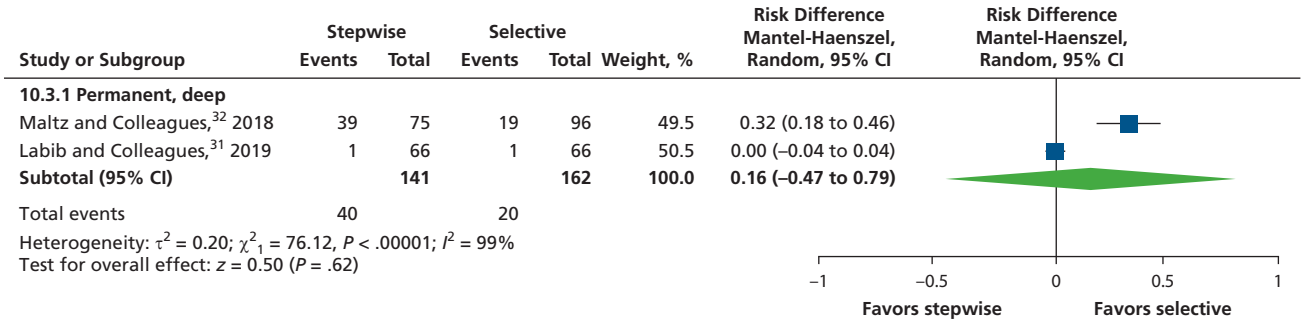
eFigure 14. Forest plot of comparison of nonselective carious tissue removal vs selective carious tissue removal for advanced caries lesions on permanent teeth for the outcome of pulp exposure after treatment.



eFigure 15. Forest plot of comparison of stepwise carious tissue removal vs selective carious tissue removal for advanced caries lesions on permanent teeth for outcome of failure at 12- to 60-month follow-up.



eFigure 16. Forest plot of comparison of stepwise carious tissue removal vs selective carious tissue removal for advanced caries lesions on permanent teeth for the outcome of pulp exposure after treatment.



eFigure 17. Forest plot of comparison of stepwise carious tissue removal vs selective carious tissue removal for advanced caries lesions on permanent teeth for outcome of pulp necrosis at 12-month follow-up.

eTable 1. Characteristics of included systematic reviews.

STUDY	OBJECTIVE	SELECTION CRITERIA	PERTINENT INTERVENTIONS	OUTCOMES	CONFLICTS OF INTEREST	FUNDING SOURCES
Schwendicke and Colleagues,[13] 2021	"To determine the comparative effectiveness of interventions [conventional restoration, selective excavation, stepwise, sealing of carious lesions using sealant materials or preformed metal crowns (Hall technique), or non-restorative cavity control] to treat carious lesions conventionally considered to require restorations (cavitated or micro-cavitated lesions, or occlusal lesions that are clinically noncavitated but clinically/radiographically extend into dentine) in primary or permanent teeth with vital (sensitive) pulps."	"…randomised clinical trials comparing different levels of carious tissue removal, as listed above, against each other, placebo, or no treatment. Participants had permanent or primary teeth (or both), and vital pulps (i.e. no irreversible pulpitis/pulp necrosis), and carious lesions conventionally considered to need a restoration (i.e. cavitated lesions, or non- or micro-cavitated lesions radiographically extending into dentine). The primary outcome was failure, a composite measure of pulp exposure, endodontic therapy, tooth extraction, and restorative complications (including resealing of sealed lesions)."	Nonselective carious tissue removal Selective carious tissue removal Stepwise carious tissue removal No carious tissue removal (Hall technique)	Primary outcomes Failure of therapy as a composite outcome including any combination of: - Signs or symptoms of irreversible pulpitis - Endodontic therapy - Tooth extraction - Restorative failure or retreatment Secondary outcomes - Lesion progression - Participant evaluation of treatment - Efficiency - Safety issues	F.S., W.A., L.B., J.G.R., G.G., C.L., A.M., D.R., M.R., R.M.S., N.P.I.: none T.W.: statistical editor with Cochrane Oral Health T.L.: editor with Cochrane Oral Health J.E.C.: coordinating editor with Cochrane Oral Health M.F.: received grant support from National Institutes of Health, Delta Dental Foundation, DentaQuest, and Colgate; served as grant reviewer for National Institutes of Health; consulted for 3M; served on National Scientific Advisory Committee for Delta Dental Foundation; former member of the Council on Scientific Affairs of the American Dental Association	The University of Manchester, Manchester Academic Health Sciences Centre; National Institute for Health Research, UK; Manchester Biomedical Research Centre, UK; Cochrane Oral Health Global Alliance

eTable 2. Excluded studies.

BIBLIOGRAPHY	REASONS FOR EXCLUSION
Papacarie is more effective in removing caries in the primary dentition and results in less pain perception by the patient. UTHSCSA Dental School CAT Library. August 22, 2018. https://cats.uthscsa.edu/found_cats_view.php?id=3323&vSearch=Papacarie%20more%20effective%20removing%20caries%20primary%20dentition%20results%20less%20pain%20perception%20patient	Not a systematic review, is a systematic review protocol or an overview of systematic reviews
The Hall technique has a similar rate of effectiveness as conventional restorative treatments in the primary dentition. UTHSCSA Dental School CAT Library. November 26, 2019. https://cats.uthscsa.edu/found_cats_view.php?id=3399&vSearch=The%20Hall%20techniq%20effectiveness%20conventional%20restorative%20treatments%20primary%20dentition	Not a systematic review, is a systematic review protocol or an overview of systematic reviews
Aïem E, Joseph C, Garcia A, Smaïl-Faugeron V, Muller-Bolla M. Caries removal strategies for deep carious lesions in primary teeth: systematic review. *Int J Paediatr Dent*. 2020;30(4):392-404.	Not a systematic review, is a systematic review protocol or an overview of systematic reviews
Badar SB, Tabassum S, Khan FR, Ghafoor R. Effectiveness of Hall technique for primary carious molars: a systematic review and meta-analysis. *Int J Clin Pediatr Dent*. 2019;12(5):445-452.	Systematic review authors did not assess the certainty of the evidence using GRADE* or another validated tool Systematic review authors did not report or define the extent of caries remaining
Barros MMAF, Rodrigues MIdeQ, Muniz FWMG, Rodrigues LKA. Selective, stepwise, or nonselective removal of carious tissue: which technique offers lower risk for the treatment of dental caries in permanent teeth? A systematic review and meta-analysis. *Clin Oral Investig*. 2020;24(2):521-532.	Systematic review authors did not assess the certainty of the evidence using GRADE or another validated tool.
Bjørndal L, Simon S, Tomson PL, Duncan HF. Management of deep caries and the exposed pulp. *Int Endod J.* 2019l;52(7):949-973.	Not a systematic review, is a systematic review protocol or an overview of systematic reviews
Brignardello-Petersen R. Stepwise and partial caries removal probably have high success rates up to 3 years after treatment of deep carious lesions, but partial caries removal is more likely to preserve tooth vitality. *JADA*. 2017;148(4):e38.	Not a systematic review, is a systematic review protocol or an overview of systematic reviews
Cardoso M, Coelho A, Lima R, et al. Efficacy and patient's acceptance of alternative methods for caries removal: a systematic review. *J Clin Med*. 2020;9(11):3407.	Systematic review authors did not assess the certainty of the evidence using GRADE or another validated tool Systematic review authors only assessed the effectiveness of head-to-head comparisons of different means to remove caries (that is, mechanical or chemical) There are not at least 2 interventions (including comparators) included in the primary systematic review's PICO† questions that are of interest
Chałas R, Szlązak K, Wójcik-Chęcińska I, et al. Observations of mineralised tissues of teeth in X-ray micro-computed tomography. *Folia Morphol (Warsz)*. 2017;76(2):143-148.	Systematic review authors did not assess the certainty of the evidence using GRADE or another validated tool Systematic review authors only assessed the effectiveness of head-to-head comparisons of different means to remove caries (that is, mechanical or chemical)
Ferreira Zandona AG. Surgical management of caries lesions: selective removal of carious tissues. *Dent Clin North Am.* 2019;63(4):705-713.	Not a systematic review, is a systematic review protocol or an overview of systematic reviews
Giacaman RA, Muñoz-Sandoval C, Neuhaus KW, Fontana M, Chałas R. Evidence-based strategies for the minimally invasive treatment of carious lesions: review of the literature. *Adv Clin Experiment Med*. 2018;27(7):1009-1016.	Systematic review authors did not assess the certainty of the evidence using GRADE or another validated tool
Hamama HH, Yiu CK, Burrow MF, King NM. Systematic review and meta-analysis of randomized clinical trials on chemomechanical caries removal. *Oper Dent*. 2015;40(4):E167-E178.	Systematic review authors only assessed the effectiveness of head-to-head comparisons of different means to remove caries (that is, mechanical or chemical)
Hamouda M, Deery C. What is the best caries removal strategy for primary molars? *Evid Based Dent*. 2021;22(1):20-21.	Not a systematic review, is a systematic review protocol or an overview of systematic reviews
Hoefler V, Nagaoka H, Miller CS. Long-term survival and vitality outcomes of permanent teeth following deep caries treatment with step-wise and partial-caries-removal: a systematic review. *J Dent*. 2016;54:25-32.	Article was published before 2017
Keenan AV, Congiusta MA. Efficacy of using Carisolv in the removal of decayed tooth structure in primary teeth. *Evid Based Dent*. 2016;17(2):44-45.	Not a systematic review, is a systematic review protocol or an overview of systematic reviews
Li T, Zhai X, Song F, Zhu H. Selective versus non-selective removal for dental caries: a systematic review and meta-analysis. *Acta Odontol Scand*. 2018;76(2):135-140.	Follow-up time is not reported Systematic review authors did not assess the certainty of the evidence using GRADE or another validated tool
Lin GSS, Cher CY, Cheah KK, et al. Acceptability of atraumatic restorative treatment and Hall Technique among children, parents, and general dental practitioners: a systematic review and meta-analysis. *Quintessence Int*. 2022;53(2):156-169.	Outcome reported is not of interest
Masson M, Viteri-Garcia A, Verdugo-Paiva F. Stepwise removal compared to complete removal for deep carious lesions. *Medwave*. 2022;22(1):e8227.	Not a systematic review, is a systematic review protocol or an overview of systematic reviews

* GRADE: Grading of Recommendations Assessment, Development and Evaluation.[8-11] † PICO: Problem, intervention, comparison, outcome.

eTable 2. Continued

BIBLIOGRAPHY	REASONS FOR EXCLUSION
Ricketts D, Lamont T, Innes NP, Kidd E, Clarkson JE. WITHDRAWN: Operative caries management in adults and children. *Cochrane Database of Syst Rev.* 2019;7:CD003808.	Article has been withdrawn
Schwendicke F. Caries removal in primary teeth using Papacarie. *Evid Based Dent*. 2018;19(3):74.	Not a systematic review, is a systematic review protocol or an overview of systematic reviews
Schwendicke F, Göstemeyer G. Understanding dentists' management of deep carious lesions in permanent teeth: a systematic review and meta-analysis. *Implement Sci*. 2016;11(1):142.	Article was published before 2017
Schwendicke F, Paris S, Tu YK. Effects of using different criteria for caries removal: a systematic review and network meta-analysis. *J Dent*. 2015; 43(1):1-15.	Article was published before 2017
Schwendicke F, Walsh T, Fontana M, et al. Interventions for treating cavitated or dentine carious lesions. *Cochrane Database of Syst Rev.* 2018;6CD013039.	Not a systematic review, is a systematic review protocol or an overview of systematic reviews
Senthilkumar V, Ramesh S. Systematic review on alternative methods for caries removal in permanent teeth. *J Conserv Dent*. 2020;23(1):2-9.	There are not at least 2 interventions (including comparators) included in the primary systematic review's PICO question that are of interest
Tao S, Li L, Yuan H, Tao S, et al. Erbium laser technology vs traditional drilling for caries removal: a systematic review with meta-analysis. *J Evid Based Dent Prac*. 2017;17(4):324-334	Systematic review authors only assessed the effectiveness of head-to-head comparisons of different means to remove caries (that is, mechanical or chemical)
Tedesco T, Reis TM, Mello-Moura ACV, et al. Management of deep caries lesions with or without pulp involvement in primary teeth: a systematic review and network meta-analysis. *Braz Oral Res*. 2020;35:e004.	Search strategy was not conducted in at least 2 electronic databases or at least 1 search strategy was not included in the main text or the appendix of the article
Verdugo-Paiva F, Zambrano-Achig P, Simancas-Racines D, Viteri-Garcia A. Selective removal compared to complete removal for deep carious lesions. *Medwave*. 2020;20(1):e7758.	Non-English language article Not a systematic review, is a systematic review protocol or an overview of systematic reviews
Wong YJ. Caries removal using lasers. *Evid Based Dent.* 2018;19(2):45.	Not a systematic review, is a systematic review protocol or an overview of systematic reviews
Zambrano-Achig P, Viteri-Garcia A, Verdugo-Paiva F. Chemo-mechanical removal versus conventional removal for deep caries lesion. *Medwave*. 2022;22(1):e8320.	Systematic review authors only assessed the effectiveness of head-to-head comparisons of different means to remove caries (that is, mechanical or chemical)

eTable 3. Absolute effects (95% CI) and certainty of the evidence for nonselective carious tissue removal compared with no carious tissue removal for moderate caries lesions on vital primary teeth.

OUTCOME (FOLLOW-UP, MO)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	RELATIVE EFFECT (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE†)	WHAT HAPPENS
Failure‡ (30-60)	319	2 randomized controlled trials (189)§,¶	Odds ratio, 8.35 (3.73 to 18.68)	Not applicable	Moderate#	Participants receiving nonselective carious tissue removal have 8.35 times the odds of experiencing failure compared with participants receiving no carious tissue removal.

* No studies meeting the selection criteria reported data on caries progression, fracture of the crown, full tooth fracture, injury to adjacent tissue or tooth, longevity of the restoration, need to treat endodontically, patient discomfort during treatment, patient or parent satisfaction, postoperative pain and discomfort, pulp necrosis, pulpal exposure, restoration loss, safety issues due to anesthesia, secondary caries, tooth loss, or time needed to perform the restoration. † The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. ‡ Innes and colleagues[14] defined minor failure as crown associated with impaction of eruption first permanent molar, restoration fracture, restoration loss, reversible pulpitis, or secondary caries and major failure as dental abscess or irreversible pulpitis, internal root resorption, interradicular radiolucency, or restoration loss. Santamaria and colleagues[15] defined minor failure as caries progression, restoration loss, reversible pulpitis, and secondary caries and major failure as dental abscess and irreversible pulpitis. § Innes and colleagues.[14] ¶ Santamaría and colleagues.[15] # Rated down 1 level owing to serious issues of risk of bias.

eTable 4. Absolute effects (95% CI) and certainty of the evidence for selective carious tissue removal compared with no carious tissue removal for moderate caries lesions on vital primary teeth.

OUTCOME (FOLLOW-UP, MO)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT, RISK DIFFERENCE (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE†)	WHAT HAPPENS
Failure‡ (24-36)	586	2 randomized controlled trials (400)§,¶	0.31 (−0.16 to 0.78)	16 fewer to 78 more	Very low#,**,††,‡‡	There is very low certainty evidence regarding the difference between selective carious tissue removal and no carious tissue removal for the outcome of failure.
Patient Satisfaction (36)	131	1 randomized controlled trial (131)§	0.00 (−0.03 to 0.03)	3 fewer to 3 more	Moderate#	Among participants receiving selective carious tissue removal, there were 0 more events (ranging from 3 fewer to 3 more) of patient satisfaction compared with those receiving no carious tissue removal (Hall technique). There is probably little to no difference between selective carious tissue removal and no carious tissue removal for the outcome of patient satisfaction.

* No studies meeting the selection criteria reported data on caries progression, fracture of the crown, full tooth fracture, injury to adjacent tissue or tooth, longevity of the restoration, need to treat endodontically, patient discomfort during treatment, postoperative pain and discomfort, pulp necrosis, pulpal exposure, restoration loss, safety issues due to anesthesia, secondary caries, tooth loss, or time needed to perform the restoration. † The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. ‡ Araujo and colleagues[16] defined minor failure as restoration fracture or wear, restoration loss, reversible pulpitis, and secondary caries for the atraumatic restorative treatment group and crown perforation, crown loss, and reversible pulpitis for the Hall technique group. Major failure was defined as dental abscess or fistula requiring pulpotomy or extraction, irreversible pulpitis, restoration or crown loss, and tooth fracture. Boyd and colleagues[17] defined minor failure as ectopic first permanent molar adjacent to crown, restoration loss, restoration wear, and secondary caries. Major failure was defined as interradicular radiolucency, irreversible pulpitis or abscess requiring pulp treatment or extraction, and pulpally involved restoration loss. § Araujo and colleagues.[16] ¶ Boyd and colleagues.[17] # Rated down 1 level owing to serious issues of risk of bias. ** Rated down 2 levels owing to very serious issues of inconsistency ($I^2 = 92\%$). †† Rated down 2 levels owing to very serious issues of imprecision. ‡‡ Using a threshold of 1.26%, the lower bound of the confidence interval suggests an important difference favoring selective carious tissue removal, whereas the upper bound suggests an important benefit of no carious tissue removal.

eTable 5. Absolute effects (95% CI) and certainty of the evidence for nonselective carious tissue removal compared with selective carious tissue removal for moderate caries lesions on vital primary teeth.

OUTCOME (FOLLOW-UP)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT, RISK DIFFERENCE (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE†)	WHAT HAPPENS
Caries Progression (12 Mo)	222	2 RCTs‡ (215)§,¶	−0.12 (−0.47 to 0.23)	47 fewer to 23 more	Very low#,**,††,‡‡	There is very low certainty evidence regarding the difference between nonselective carious tissue removal and selective carious tissue removal for the outcome of caries progression.
Failure§§ (12 Mo)	177	1 RCT (177) §	−0.04 (−0.15 to 0.06)	15 fewer to 6 more	Very low#,††,¶¶	There is very low certainty evidence regarding the difference between nonselective carious tissue removal and selective carious tissue removal for the outcome of failure.
Postoperative Pain and Discomfort (12 Mo)	222	2 RCTs (215)§,¶	−0.01 (−0.04 to 0.02)	4 fewer to 2 more	Very low#,††,##	There is very low certainty evidence regarding the difference between nonselective carious tissue removal and selective carious tissue removal for the outcome of postoperative pain and discomfort.
Pulp Exposure (Postprocedural)	186	1 RCT (186) §	0.02 (−0.01 to 0.06)	1 fewer to 6 more	Very low#,††,***	There is very low certainty evidence regarding the difference between nonselective carious tissue removal and selective carious tissue removal for the outcome of pulp exposure.
Pulp Necrosis (12 Mo)	48	1 RCT (38)¶	0.04 (−0.07 to 0.15)	7 fewer to 15 more	Very low#,††,***	There is very low certainty evidence regarding the difference between nonselective carious tissue removal and selective carious tissue removal for the outcome of pulp necrosis.

* For the outcome of restoration loss, there were 0 events in both treatment arms of the included study. No studies meeting the selection criteria reported data on fracture of the crown, full tooth fracture, injury to adjacent tissue or tooth, longevity of the restoration, need to treat endodontically, patient discomfort during treatment, patient or parent satisfaction, restoration loss, safety issues due to anesthesia, secondary caries, tooth loss, or time needed to perform the restoration. † The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. ‡ RCT: Randomized controlled trial. § Phonghanyudh and colleagues.[18] ¶ Ribeiro and colleagues.[19] # Rated down 1 level owing to serious issues of risk of bias. ** Rated down 2 levels owing to very serious issues of inconsistency (I^2=93%). †† Rated down 2 levels owing to very serious issues of imprecision. ‡‡ Using a threshold of 0.62%, the lower bound of the confidence interval suggests an important difference favoring nonselective carious tissue removal, whereas the upper bound suggests an important benefit of selective carious tissue removal. §§ Phonghanyudh and colleagues[18] described failure as considerable wear of the restoration requiring repair or retreatment, clinical or radiographic signs of irreversible pulpitis, marginal defect, pulp exposure, or restoration loss. ¶¶ Using a threshold of 1.80%, the lower bound of the confidence interval suggests an important difference favoring nonselective carious tissue removal, whereas the upper bound suggests an important benefit of selective carious tissue removal. ## Using a threshold of 0.09%, the lower bound of the confidence interval suggests an important difference favoring nonselective carious tissue removal, whereas the upper bound suggests an important benefit of selective carious tissue removal. *** Using a threshold of 0.0%, the lower bound of the confidence interval suggests an important difference favoring nonselective carious tissue removal, whereas the upper bound suggests an important benefit of selective carious tissue removal.

eTable 6. Absolute effects (95% CI) and certainty of the evidence for nonselective carious tissue removal compared with selective carious tissue removal for advanced caries lesions on vital primary teeth.

OUTCOME (FOLLOW-UP)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE†)	WHAT HAPPENS
Failure‡ (4-24 Mo)	210	3 RCTs§ (146)¶,#,**	RD††, 0.00 (−0.06 to 0.07)	6 fewer to 7 more	Very low‡‡,§§,¶¶	There is very low certainty evidence regarding the difference between nonselective carious tissue removal and selective carious tissue removal for the outcome of failure.
Pulp Exposure (Postprocedural)	214	3 RCTs (136)¶,**,##	RD, 0.22 (0.13 to 0.31)	13 more to 31 more	Moderate‡‡	Among participants receiving nonselective carious tissue removal, there were 22 more events (ranging from 13 more to 31 more) of pulp exposure per 100 restorations compared with those receiving selective carious tissue removal. Nonselective carious tissue removal likely increases the risk of experiencing pulp exposure by an important amount compared with selective carious tissue removal.
Pulp Necrosis (6 Mo)	31	1 RCT (26)##	RD, 0.07 (−0.10 to 0.23)	10 fewer to 23 more	Very low‡‡,§§,***	There is very low certainty evidence regarding the difference between nonselective carious tissue removal and selective carious tissue removal for the outcome of pulp necrosis.
Time Needed to Perform the Restoration (6 Mo)	120	1 RCT (79)¶	Mean difference, 10.20 (5.42 to 14.98)	Not applicable	Moderate‡‡	Nonselective carious tissue removal increased the time needed to perform restoration by 10.20 minutes (ranging from 5.42 to 14.98 minutes longer) when compared with selective carious tissue removal. By comparison, the mean time needed to perform selective carious tissue removal was 17.9 minutes.

* For the outcomes of postoperative pain, pulpal complications due to infection, and restoration loss, there were 0 events in both treatment arms of the included studies. No studies meeting the selection criteria reported data on caries progression, fracture of the crown, full tooth fracture, injury to adjacent tissue or tooth, longevity of the restoration, need to treat endodontically, patient discomfort during treatment, patient or parent satisfaction, postoperative pain and discomfort, safety issues due to anesthesia, secondary caries, or tooth loss. † The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. ‡ Franzon and colleagues[22] defined failure as internal or external pathological resorption, the presence of a fistula, radiolucency at the furcation or in the periapical region, swelling, and spontaneous pain and mobility not compatible with root resorption. Orhan and colleagues[21] defined failure as abnormal tooth mobility, fistula, pathologic tooth resorption, radiolucencies at the interradicular or periapical regions, sensitivity to percussion and palpation, spontaneous pain, or swelling in periodontal tissues. Mello and colleagues[23] defined failure as abscess or fistula, advanced rhizolysis, color alteration, furcal or periapical lesion, internal or external root resorption pain, sensitivity to percussion, and tooth mobility. § RCT: Randomized controlled trial. ¶ Franzon and colleagues.[22] # Mello and colleagues.[23] ** Orhan and colleagues.[21] †† RD: Risk difference. ‡‡ Rated down 1 level owing to serious issues of risk of bias. §§ Rated down 2 levels owing to very serious issues of imprecision. ¶¶ Using a threshold of 0.45%, the lower bound of the confidence interval suggests an important difference favoring nonselective carious tissue removal, whereas the upper bound suggests an important benefit of selective carious tissue removal. ## Lula and colleagues.[24] *** Using a threshold of 0.0%, the lower bound of the confidence interval suggests an important difference favoring nonselective carious tissue removal, whereas the upper bound suggests an important benefit of selective carious tissue removal.

eTable 7. Absolute effects (95% CI) and certainty of the evidence for stepwise carious tissue removal compared with selective carious tissue removal for advanced caries lesions on vital primary teeth.

OUTCOME (FOLLOW-UP)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT, RISK DIFFERNCE (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE†)	WHAT HAPPENS
Failure‡ (12-24 Mo)	121	2 RCTs§ (137)¶,#	0.02 (–0.05 to 0.10)	5 fewer to 10 more	Very low**,††,‡‡	There is very low certainty evidence regarding the difference between stepwise carious tissue removal and selective carious tissue removal for the outcome of failure.
Pulp Exposure (Postprocedural)	137	2 RCTs (137)¶,#	0.05 (–0.03 to 0.12)	3 fewer to 12 more	Very low**,††,§§	There is very low certainty evidence regarding the difference between stepwise carious tissue removal and selective carious tissue removal for the outcome of pulp exposure.
Tooth Loss¶¶ (24 Mo)	63	1 RCT (63)¶	0.03 (–0.05 to 0.12)	5 fewer to 12 more	Very low**,††,##	There is very low certainty evidence regarding the difference between stepwise carious tissue removal and selective carious tissue removal for the outcome of tooth loss.

* No studies meeting the selection criteria reported data on caries progression, fracture of the crown, full tooth fracture, injury to adjacent tissue or tooth, longevity of the restoration, need to treat endodontically, patient discomfort during treatment, patient or parent satisfaction, postoperative pain and discomfort, pulp necrosis, restoration loss, safety issues due to anesthesia, secondary caries, or time needed to perform the restoration. † The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. ‡ Orhan and colleagues[21] defined failure as abnormal tooth mobility, fistula, pathological tooth resorption, radiolucencies at the interradicular or periapical regions, sensitivity to percussion and palpation, spontaneous pain, or swelling in periodontal tissues. Elhennawy and colleagues[25] defined failure as endodontic or restorative complications. § RCT: Randomized controlled trial. ¶ Elhennway and colleagues.[25] # Orhan and colleagues.[21] ** Rated down 1 level owing to serious issues of risk of bias. †† Rated down 2 levels owing to very serious issues of imprecision. ‡‡ Using a threshold of 0.33%, the lower bound of the confidence interval suggests an important difference favoring stepwise carious tissue removal, whereas the upper bound suggests an important benefit of selective carious tissue removal. §§ Using a threshold of 0.29%, the lower bound of the confidence interval suggests an important difference favoring stepwise carious tissue removal, whereas the upper bound suggests an important difference favoring selective carious tissue removal. ¶¶ Tooth loss was due to extraction. ## Using a threshold of 0.0%, the lower bound of the confidence interval suggests an important difference favoring stepwise carious tissue removal, whereas the upper bound suggests an important benefit of selective carious tissue removal.

eTable 8. Absolute effects (95% CI) and certainty of the evidence for selective carious tissue removal compared with no carious tissue removal for advanced caries lesions on vital primary teeth.

OUTCOME (FOLLOW-UP, MO)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT, RISK DIFFERENCE (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE†)	WHAT HAPPENS
Failure‡ (24)	74	1 randomized controlled trial (74) §	−0.06 (−0.21 to 0.10)	21 fewer to 10 more	Very low¶,#,**	There is very low certainty evidence regarding the difference between selective carious tissue removal and no carious tissue removal for the outcome of failure.

* No studies meeting the selection criteria reported data on caries progression, fracture of the crown, full tooth fracture, injury to adjacent tissue or tooth, longevity of the restoration, need to treat endodontically, patient discomfort during treatment, patient or parent satisfaction, post-operative pain and discomfort, pulp necrosis, pulpal exposure, restoration loss, safety issues due to anesthesia, secondary caries, tooth loss, or time needed to perform the restoration. † The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. ‡ Chompu-inwai and colleagues[20] defined failure as abscess formation, postoperative pain, pathologic mobility, pain on percussion, or swelling. § Chompu-inwai and colleagues.[20] ¶ Rated down 1 level owing to serious issues of risk of bias. # Rated down 2 levels owing to very serious issues of imprecision. ** Using a threshold of 1.51%, the lower bound of the confidence interval suggests an important difference favoring selective carious tissue removal, whereas the upper bound suggests an important benefit of no carious tissue removal.

eTable 9. Absolute effects (95% CI) and certainty of the evidence for nonselective carious tissue removal compared with stepwise carious tissue removal for advanced caries lesions on vital primary teeth.

OUTCOME (FOLLOW-UP)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT, RISK DIFFERENCE (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE†)	WHAT HAPPENS
Failure‡ (12 Mo)	54	1 randomized controlled trial (54)§	0.05 (–0.08 to 0.17)	8 fewer to 17 more	Very low¶,#,**	There is very low certainty evidence regarding the difference between nonselective carious tissue removal and stepwise carious tissue removal for the outcome of failure.
Pulp Exposure (Postprocedural)	63	1 randomized controlled trial (63)§	0.10 (–0.07 to 0.27)	7 fewer to 27 more	Very low¶,#,††	There is very low certainty evidence regarding the difference between nonselective carious tissue removal and stepwise carious tissue removal for the outcome of pulp exposure.

* No studies meeting the selection criteria reported data on caries progression, fracture of the crown, full tooth fracture, injury to adjacent tissue or tooth, longevity of the restoration, need to treat endodontically, patient discomfort during treatment, patient or parent satisfaction, postoperative pain and discomfort, pulp necrosis, restoration loss, safety issues due to anesthesia, secondary caries, tooth loss, or time needed to perform the restoration. † The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. ‡ Orhan and colleagues[21] defined failure as abnormal tooth mobility, fistula, pathological tooth resorption, radiolucencies at the interradicular or periapical regions, sensitivity to percussion and palpation, spontaneous pain, or swelling in periodontal tissues. § Orhan and colleagues.[21] ¶ Rated down 1 level owing to serious issues of risk of bias. # Rated down 2 levels owing to very serious issues of imprecision. ** Using a threshold of 0.34%, the lower bound of the confidence interval suggests an important difference favoring nonselective carious tissue removal, whereas the upper bound suggests an important benefit of stepwise carious tissue removal. †† Using a threshold of 0.94%, the lower bound of the confidence interval suggests an important difference favoring nonselective carious tissue removal, whereas the upper bound suggests an important benefit of stepwise carious tissue removal.

eTable 10. Absolute effects (95% CI) and certainty of the evidence for nonselective carious tissue removal compared with stepwise carious tissue removal for advanced caries lesions on vital permanent teeth.

OUTCOME (FOLLOW-UP)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT, RISK DIFFERENCE (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE†)	WHAT HAPPENS
Failure‡ (12-60 Mo)	273	2 RCTs§ (273)¶,#	0.07 (−0.12 to 0.25)	12 fewer to 25 more	Very low**,††,‡‡,§§	There is very low certainty evidence regarding the difference between nonselective carious tissue removal and stepwise carious tissue removal for the outcome of failure.
Pulp Exposure (Postprocedural)	407	3 RCTs (481)¶,#,¶¶	0.18 (0.09 to 0.26)	9 more to 26 more	Moderate**,§§	Among participants receiving nonselective carious tissue removal, there were 18 more events (ranging from 9 more to 26 more) of pulp exposure per 100 restorations compared with those receiving stepwise carious tissue removal. Nonselective carious tissue removal likely increases the risk of experiencing pulp exposure by an important amount compared with stepwise carious tissue removal.
Pulp Necrosis (60 Mo)	239	1 RCT (239)¶	0.02 (−0.02 to 0.07)	2 fewer to 7 more	Very low**,††,§§,##	There is very low certainty evidence regarding the difference between nonselective carious tissue removal and stepwise carious tissue removal for the outcome of pulp necrosis.
Tooth Loss* (60 Mo)**	239	1 RCT (239)¶	0.00 (−0.03 to 0.03)	3 fewer to 3 more	Very low**,††,§§,†††	There is very low certainty evidence regarding the difference between nonselective carious tissue removal and stepwise carious tissue removal for the outcome of tooth loss.
Patient Discomfort During Treatment	239	1 RCT (239)¶	0.01 (−0.02 to 0.04)	2 fewer to 4 more	Very low**,††,§§,‡‡‡	There is very low certainty evidence regarding the difference between nonselective carious tissue removal and stepwise carious tissue removal for the outcome of patient discomfort during treatment.

* No studies meeting the selection criteria reported data on caries progression, fracture of the crown, full tooth fracture, injury to adjacent tissue or tooth, longevity of the restoration, need to treat endodontically, patient or parent satisfaction, postoperative pain and discomfort, restoration loss, safety issues due to anesthesia, secondary caries, or time needed to perform the restoration. † The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. ‡ Bjørndal and colleagues[28] defined failure as no pulp vitality with apical radiolucency, pulp exposure, pulp vitality with apical radiolucency, and unbearable pain. Orhan and colleagues[21] defined failure as abnormal tooth mobility, fistula, pathologic tooth resorption, radiolucencies at the interradicular or periapical regions, sensitivity to percussion and palpation, spontaneous pain, or swelling in periodontal tissues. § RCT: Randomized controlled trial. ¶ Bjørndal and colleagues.[28] # Orhan and colleagues.[21] ** Rated down 1 level owing to serious issues of risk of bias. †† Rated down 2 levels owing to very serious issues of imprecision. ‡‡ Using a threshold of 3.51%, the lower bound of the confidence interval suggests a negligible difference favoring nonselective carious tissue removal, whereas the upper bound suggests an important benefit of stepwise carious tissue removal. §§ Rated down 1 level owing to serious issues of indirectness when used to inform clinical recommendations for caries removal approaches for moderate caries lesions on vital permanent teeth. ¶¶ Leksell and colleagues.[29] ## Using a threshold of 0.25%, the lower bound of the confidence interval suggests an important difference favoring nonselective carious tissue removal, whereas the upper bound suggests an important benefit of stepwise carious tissue removal. *** Tooth loss was due to extraction. ††† Using a threshold of 0.17%, the lower bound of the confidence interval suggests an important difference favoring nonselective carious tissue removal, whereas the upper bound suggests an important benefit of stepwise carious tissue removal. ‡‡‡ Using a threshold of 0.08%, the lower bound of the confidence interval suggests an important difference favoring nonselective carious tissue removal, whereas the upper bound suggests an important benefit of stepwise carious tissue removal.

eTable 11. Absolute effects (95% CI) and certainty of the evidence for nonselective carious tissue removal compared with selective carious tissue removal for advanced cavitated caries lesions on vital permanent teeth.

OUTCOME (FOLLOW-UP)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT, RISK DIFFERENCE (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE†)	WHAT HAPPENS
Failure‡ (12-18 Mo)	159	2 RCTs (159)§,¶	−0.04 (−0.10 to 0.02)	10 fewer to 2 more	Very low#,**,††,‡‡	There is very low certainty evidence regarding the difference between nonselective carious tissue removal and selective carious tissue removal for the outcome of failure.
Pulp Exposure (Postprocedural)	179	2 RCTs (179)§,¶	0.19 (0.10 to 0.28)	10 more to 28 more	Moderate#,‡‡	Among participants receiving nonselective carious tissue removal, there were 19 more events (ranging from 10 more to 28 more) of pulp exposure per 100 restorations compared with those receiving selective carious tissue removal. Nonselective carious tissue removal likely increases the risk of experiencing pulp exposure by an important amount compared with selective carious tissue removal.

* No studies meeting the selection criteria reported data on caries progression, fracture of the crown, full tooth fracture, injury to adjacent tissue or tooth, longevity of the restoration, need to treat endodontically, patient discomfort during treatment, patient or parent satisfaction, postoperative pain and discomfort, pulp necrosis, restoration loss, safety issues due to anesthesia, secondary caries, tooth loss, or time needed to perform the restoration. † The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. ‡ Orhan and colleagues[21] defined failure as abnormal tooth mobility, fistula, pathologic tooth resorption, radiolucencies at the inter-radicular or periapical regions, sensitivity to percussion and palpation, spontaneous pain, or swelling in periodontal tissues. Khokhar and Tewari[30] defined failure as negative response to cold and electric pulp test, periapical alteration, or signs and symptoms of irreversible pulpitis. § Khokhar and Tewari.[30] ¶ Orhan and colleagues.[21] # Rated down 1 level owing to serious issues of risk of bias. ** Rated down 2 levels owing to very serious issues of imprecision. †† Using a threshold of 0.59%, the lower bound of the confidence interval suggests an important difference favoring nonselective carious tissue removal, whereas the upper bound suggests an important benefit of selective carious tissue removal. ‡‡ Rated down 1 level owing to serious issues of indirectness when used to inform clinical recommendations for caries removal approaches for moderate caries lesions on vital permanent teeth.

eTable 12. Absolute effects (95% CI) and certainty of the evidence for stepwise carious tissue removal compared with selective carious tissue removal for advanced caries lesions on vital permanent teeth.

OUTCOME (FOLLOW-UP)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT, RISK DIFFERENC (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE†)	WHAT HAPPENS
Failure‡ (12-60 Mo)	395	3 RCTs§ (395)¶,#,**	0.07 (−0.05 to 0.20)	5 fewer to 20 more	Very low††,‡‡,§§,¶¶,##	There is very low certainty evidence regarding the difference between stepwise carious tissue removal and selective carious tissue removal for the outcome of failure.
Pulp Exposure (Postprocedural)	168	2 RCTs (168)¶,**	0.06 (0.00 to 0.13)	0 more to 13 more	Very low††,§§,##,***	There is very low certainty evidence regarding the difference between stepwise carious tissue removal and selective carious tissue removal for the outcome of pulp exposure.
Pulp Necrosis (12 Mo)	303	2 RCTs (303)¶,#	0.16 (−0.47 to 0.79)	47 fewer to 79 more	Very low††,§§,##,†††	There is very low certainty evidence regarding the difference between stepwise carious tissue removal and selective carious tissue removal for the outcome of pulp necrosis.
Pulpal Complications Due to Infection (12 Mo)	132	1 RCT (132)¶	−0.03 (−0.09 to 0.03)	9 fewer to 3 more	Very low††,§§,##,‡‡‡	There is very low certainty evidence regarding the difference between stepwise carious tissue removal and selective carious tissue removal for the outcome of pulpal complications due to infection.

* No studies meeting the selection criteria reported data on caries progression, fracture of the crown, full tooth fracture, injury to adjacent tissue or tooth, longevity of the restoration, need to treat endodontically, patient discomfort during treatment, patient or parent satisfaction, postoperative pain and discomfort, pulp necrosis, restoration loss, safety issues due to anesthesia, secondary caries, tooth loss, or time needed to perform the restoration. † The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. ‡ Orhan and colleagues[21] defined failure as abnormal tooth mobility, fistula, pathologic tooth resorption, radiolucencies at the interradicular or periapical regions, sensitivity to percussion and palpation, spontaneous pain, or swelling in periodontal tissues. Labib and colleagues[31] defined failure as lack of restoration integrity, pulp exposure, and pulp necrosis. Maltz and colleagues[32] defined failure as pulp necrosis. § RCT: Randomized controlled trial. ¶ Labib and colleagues.[31] # Maltz and colleagues.[32] ** Orhan and colleagues.[21] †† Rated down 1 level owing to serious issues of risk of bias. ‡‡ Rated down 2 levels owing to very serious issues of inconsistency (I^2= 72%). §§ Rated down two levels owing to very serious issues of imprecision. ¶¶ Using a threshold of 1.31%, the lower bound of the confidence interval suggests an important difference favoring stepwise carious tissue removal, whereas the upper bound suggests an important benefit of selective carious tissue removal. ## Rated down 1 level owing to serious issues of indirectness when used to inform clinical recommendations for caries removal approaches for moderate caries lesions on vital permanent teeth. *** Using a threshold of 0.12%, the lower bound of the confidence interval suggests no difference between stepwise carious tissue removal and selective carious tissue removal, whereas the upper bound suggests an important benefit of selective carious tissue removal. ††† Using a threshold of 1.23%, the lower bound of the confidence interval suggests an important difference favoring stepwise carious tissue removal, whereas the upper bound suggests an important benefit of selective carious tissue removal. ‡‡‡ Using a threshold of 0.45%, the lower bound of the confidence interval suggests an important difference favoring stepwise carious tissue removal, whereas the upper bound suggests an important benefit of selective carious tissue removal.

eTable 13. Absolute effects (95% CI) and certainty of the evidence for nanocomposite compared with hybrid resin composite for Class III restorations on vital anterior permanent teeth.

OUTCOME (FOLLOW-UP)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT, RISK DIFFERENCE (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE†)	WHAT HAPPENS
Postoperative Pain and Discomfort (1 Wk)	114	1 randomized controlled trial (38)‡	0.00 (−0.09 to 0.09)	9 fewer to 9 more	Low§,¶,#	Among participants receiving nanocomposite restorations, there were 0 more events (ranging from 9 fewer to 9 more) of postoperative pain and discomfort per 100 restorations compared with those receiving hybrid resin composite restorations. Nanocomposite may result in little to no difference in postoperative pain and discomfort compared with hybrid resin composite.
Unacceptable Color Match (12 Mo)	114	1 randomized controlled trial (38)‡	0.03 (−0.05 to 0.11)	5 fewer to 11 more	Low§,¶,**	Among participants receiving nanocomposite restorations, there were 3 more events (ranging from 5 fewer to 11 more) of unacceptable color match per 100 restorations compared with those receiving hybrid resin composite restorations. Nanocomposite may increase the risk of experiencing unacceptable color match by an important amount compared with hybrid resin composite.

* For the outcomes of marginal discoloration or staining, secondary caries, unacceptable anatomic form, and unacceptable marginal adaptation, there were 0 events in both treatment arms of the included studies. No studies meeting the selection criteria reported data on caries progression, fracture of the crown, full tooth fracture, longevity of the restoration, need to treat endodontically, oral health–related quality of life, patient discomfort during treatment, patient or parent satisfaction with treatment, pulp vitality, pulpal complications due to infection, pulpal exposure, restoration failure (or repair OR replacement of the restoration), restoration fracture, restoration longevity reported in unit of time, restoration loss, restoration survival reported as a hazard ratio, time needed to perform the restoration, tooth loss, anaphylaxis, kidney function, neurobehavioral assessment, physical development, or psychosocial function. † The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. ‡ Loguercio and colleagues.[33] § Rated down 2 levels owing to very serious issues of imprecision. ¶ Using a threshold of 0.53%, the lower bound of the confidence interval suggests an important difference favoring nanocomposite, whereas the upper bound suggests an important benefit of hybrid resin composite. # Rated down 1 level owing to serious issues of indirectness when used to inform clinical recommendations for Class III restorations for moderate and advanced lesions on vital primary teeth. ** Using a threshold of 0.26%, the lower bound of the confidence interval suggests an important difference favoring nanocomposite, whereas the upper bound suggests an important benefit of hybrid resin composite.

eTable 14. Absolute effects (95% CI) and certainty of the evidence for resin-modified glass ionomer cement compared with hybrid resin composite for Class V restorations on vital anterior and posterior permanent teeth combined.

OUTCOME (FOLLOW-UP, MO)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT, RISK DIFFERENCE (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE†)	WHAT HAPPENS
Restoration Loss (36)	102	1 randomized controlled trial (30)‡	−0.08 (−0.20 to 0.05)	20 fewer to 5 more	Low§,¶,#,**	Among participants receiving resin-modified glass ionomer cement restorations, there were 8 fewer events (ranging from 20 fewer to 5 more) of restoration loss per 100 participants compared with those receiving hybrid resin composite restorations. Resin-modified glass ionomer cement may decrease the risk of experiencing restoration loss by an important amount compared with hybrid resin composite.
Unacceptable Marginal Adaptation (36)	90	1 randomized controlled trial (30)‡	−0.05 (−0.17 to 0.07)	17 fewer to 7 more	Low§,#,**,††	Among participants receiving resin-modified glass ionomer cement restorations, there were 5 fewer events (ranging from 17 fewer to 7 more) of unacceptable marginal adaptation per 100 participants compared with those receiving hybrid resin composite restorations. Resin-modified glass ionomer cement may decrease the risk of experiencing unacceptable marginal adaptation by an important amount compared with hybrid resin composite.

* For the outcomes of postoperative pain and discomfort and secondary caries, there were 0 events in both treatment arms of the included studies. No studies meeting the selection criteria reported data on caries progression, fracture of the crown, full tooth fracture, longevity of the restoration, marginal discoloration or staining, need to treat endodontically, oral health–related quality of life, patient discomfort during treatment, patient or parent satisfaction with treatment, pulp vitality, pulpal complications due to infection, pulpal exposure, restoration failure (or repair or replacement of the restoration), restoration fracture, restoration longevity reported in unit of time, restoration survival reported as a hazard ratio, time needed to perform the restoration, tooth loss, unacceptable anatomic form, unacceptable color match, anaphylaxis, kidney function, neurobehavioral assessment, physical development, or psychosocial function. † The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. ‡ Koc Vural and colleagues.[34] § Rated down 2 levels owing to very serious issues of imprecision. ¶ Using a threshold of 1.57%, the lower bound of the confidence interval suggests an important difference favoring resin-modified glass ionomer cement while the upper bound suggests an important benefit of hybrid resin composite. # Rated down 1 level owing to serious issues of indirectness when used to inform clinical recommendations for Class V restorations for moderate and advanced lesions on vital anterior and posterior primary teeth. ** Rated down 1 level owing to serious issues of indirectness when used to inform clinical recommendations for Class I restorations for moderate and advanced lesions on vital anterior permanent teeth. †† Using a threshold of 1.16%, the lower bound of the confidence interval suggests an important difference favoring resin-modified glass ionomer cement, whereas the upper bound suggests an important benefit of hybrid resin composite.

eTable 15. Absolute effects (95% CI) and certainty of the evidence for resin-modified glass ionomer cement compared with conventional glass ionomer cement for Class V restorations on vital anterior and posterior permanent teeth combined.

OUTCOME (FOLLOW-UP)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT, RISK DIFFERENCE (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE†)	WHAT HAPPENS
Restoration Failure‡ (Up to 24 Mo)	49	1 randomized controlled trial (not reported)§	0.23 (−0.01 to 0.46)	1 fewer to 46 more	Very low¶,#,**,††,‡‡	There is very low certainty evidence regarding the difference between resin-modified glass ionomer cement and conventional glass ionomer cement for the outcome of restoration failure.

* No studies meeting the selection criteria reported data on caries progression, fracture of the crown, full tooth fracture, longevity of the restoration, need to treat endodontically, oral health–related quality of life, patient discomfort during treatment, patient or parent satisfaction with treatment, postoperative pain and discomfort, unacceptable color match, marginal discoloration, pulp vitality, pulpal complications due to infection, pulpal exposure, unacceptable anatomic form, unacceptable marginal adaptation, secondary caries, restoration fracture, restoration longevity reported in unit of time, restoration loss, restoration survival reported as a hazard ratio, time needed to perform the restoration, tooth loss, anaphylaxis, kidney function, neurobehavioral assessment, physical development, or psychosocial function. † The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. ‡ Restoration failure was defined as unacceptable anatomic form and unacceptable marginal adaptation by McComb and colleagues.[35] § McComb and colleagues.[35] ¶ Rated down 2 levels owing to very serious issues of risk of bias. # Rated down 2 levels owing to very serious issues of imprecision. ** Using a threshold of 6.67%, the lower bound of the confidence interval suggests a negligible benefit of resin-modified glass ionomer cement, whereas the upper bound suggests an important benefit of conventional glass ionomer cement. †† Rated down 1 level owing to serious issues of indirectness when used to inform clinical recommendations for Class V restorations for moderate and advanced lesions on vital anterior and posterior primary teeth. ‡‡ Rated down 1 level owing to serious issues of indirectness when used to inform clinical recommendations for Class I restorations for moderate and advanced lesions on vital anterior permanent teeth.

eTable 16. Absolute effects (95% CI) and certainty of the evidence for conventional glass ionomer cement compared with hybrid resin composite for Class V restorations on vital anterior and posterior permanent teeth combined.

OUTCOME (FOLLOW-UP, MO)*	RESTORATION, NO	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT, (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE†)	WHAT HAPPENS
Restoration Failure‡ (24)	54	1 randomized controlled trial (27)§	0.19 (0.01 to 0.36)	1 more to 36 more	Very low¶,#,**,††,‡‡	There is very low certainty evidence regarding the difference between conventional glass ionomer cement and hybrid resin composite for the outcome of restoration failure.
Secondary Caries (24)	54	1 randomized controlled trial (27)§	−0.19 (−0.38 to 0.01)	38 fewer to 1 more	Very low¶,#,††,‡‡,§§	There is very low certainty evidence regarding the difference between conventional glass ionomer cement and hybrid resin composite for the outcome of secondary caries.

* No studies meeting the selection criteria reported data on caries progression, fracture of the crown, full tooth fracture, longevity of the restoration, marginal discoloration or staining, need to treat endodontically, oral health–related quality of life, patient discomfort during treatment, patient or parent satisfaction with treatment, postoperative pain and discomfort, pulp vitality, pulpal complications due to infection, pulpal exposure, restoration fracture, restoration longevity reported in unit of time, restoration loss, restoration survival reported as a hazard ratio, time needed to perform the restoration, tooth loss, unacceptable anatomic form, unacceptable color match, unacceptable marginal adaptation, anaphylaxis, kidney function, neurobehavioral assessment, physical development, or psychosocial function. † The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. ‡ Reasons for restoration failure were not specified by De Moor and colleagues.[36] § De Moor and colleagues.[36] ¶ Rated down 1 level owing to serious issues of risk of bias. # Rated down 2 levels owing to very serious issues of imprecision. ** Using a threshold of 7.78%, the lower bound of the confidence interval suggests a negligible benefit of hybrid resin composite, whereas the upper bound suggests an important benefit of hybrid resin composite. †† Rated down 1 level owing to serious issues of indirectness when used to inform clinical recommendations for Class V restorations for moderate and advanced lesions on vital anterior and posterior primary teeth. ‡‡ Rated down 1 level owing to serious issues of indirectness when used to inform clinical recommendations for Class I restorations for moderate and advanced lesions on vital, anterior, permanent teeth. §§ Using a threshold of 2.59%, the lower bound of the confidence interval suggests an important difference favoring conventional glass ionomer cement, whereas the upper bound suggests a negligible benefit of hybrid resin composite.

eTable 17. Absolute effects (95% CI) and certainty of the evidence for amalgam compared with conventional glass ionomer cement for Class II restorations on vital posterior primary teeth.

OUTCOME (FOLLOW-UP, MO)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT, RISK DIFFERENCE (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE†)	WHAT HAPPENS
Secondary Caries (25)	64	1 RCT‡ (not reported)§	−0.01 (−0.11 to 0.10)	11 fewer to 10 more	Very low¶,#,**	There is very low certainty evidence regarding the difference between amalgam and conventional glass ionomer cement for the outcome of secondary caries.
Unacceptable Anatomic Form (25)	64	1 RCT (not reported)§	−0.43 (−0.58 to −0.27)	58 fewer to 27 fewer	Very low¶,††	There is very low certainty evidence regarding the difference between amalgam and conventional glass ionomer cement for the outcome of unacceptable anatomic form.
Unacceptable Marginal Adaptation (25)	57	1 RCT (not reported)§	−0.26 (−0.47 to −0.05)	47 fewer to 5 fewer	Very low¶,††	There is very low certainty evidence regarding the difference between amalgam and conventional glass ionomer cement for the outcome of unacceptable marginal adaptation.

* No studies meeting the selection criteria reported data on caries progression, fracture of the crown, full tooth fracture, longevity of the restoration, need to treat endodontically, oral health–related quality of life, patient discomfort during treatment, patient or parent satisfaction with treatment, postoperative pain and discomfort, pulp vitality, pulpal complications due to infection, pulpal exposure, restoration failure (or repair or replacement of the restoration), restoration fracture, restoration longevity reported in unit of time, restoration loss, restoration survival reported as a hazard ratio, time needed to perform the restoration, tooth loss, anaphylaxis, kidney function, neurobehavioral assessment, physical development, or psychosocial function. † The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. ‡ RCT: Randomized controlled trial. § Fuks and colleagues.[38] ¶ Rated down 2 levels owing to very serious issues of risk of bias. # Rated down 2 levels owing to very serious issues of imprecision. ** Using a threshold of 0.50%, the lower bound of the confidence interval suggests an important difference favoring conventional glass ionomer cement, whereas the upper bound suggests an important benefit from amalgam. †† Rated down 2 levels owing to very serious issues of imprecision due to low sample size.

eTable 18. Absolute effects (95% CI) and certainty of the evidence for hybrid resin composite compared with conventional glass ionomer cement for Class II restorations on vital posterior primary teeth.

OUTCOME (FOLLOW-UP, MO)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT, RISK DIFFERENCE (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE†)	WHAT HAPPENS
Restoration Loss (12-24)	199	2 randomized controlled trials (116)‡,§	−0.09 (−0.16 to −0.02)	16 fewer to 2 fewer	Moderate¶,#	Among participants receiving hybrid resin composite restorations, there were 9 fewer events (ranging from 16 fewer to 2 fewer) of lack of restoration retention per 100 restorations compared with those receiving conventional glass ionomer cement restorations. Hybrid resin composite probably decreases the risk of experiencing restoration loss by an important amount compared with conventional glass ionomer cement.
Secondary Caries (12-24)	184	2 randomized controlled trials (116)‡,§	0.02 (−0.02 to 0.06)	2 fewer to 6 more	Low#,**,††	Among participants receiving hybrid resin composite restorations, there were 2 more events (ranging from 2 fewer to 6 more) of secondary caries per 100 restorations compared with those receiving conventional glass ionomer cement restorations. Hybrid resin composite may increase the risk of experiencing secondary caries by an important amount compared with conventional glass ionomer cement.

* For the outcomes of postoperative pain and discomfort, unacceptable anatomic form, and unacceptable marginal adaptation, there were 0 events in both treatment arms of the included studies. No studies meeting the selection criteria reported data on caries progression, fracture of the crown, full tooth fracture, longevity of the restoration, need to treat endodontically, oral health–related quality of life, patient discomfort during treatment, patient or parent satisfaction with treatment, pulp vitality, pulpal complications due to infection, pulpal exposure, restoration failure (or repair or replacement of the restoration), restoration fracture, restoration longevity reported in unit of time, restoration survival reported as a hazard ratio, time needed to perform the restoration, tooth loss, anaphylaxis, kidney function, neurobehavioral assessment, physical development, or psychosocial function. † The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. ‡ Kupietzky and colleagues.[39] § Akman and colleagues.[40] ¶ Rated down 1 level owing to serious issues of inconsistency ($I^2 = 49\%$). # Rated down 2 levels owing to very serious issues of indirectness when used to inform clinical recommendations for Class I restorations for moderate and advanced caries lesions on vital posterior primary teeth. ** Rated down 2 levels owing to very serious issues of imprecision. †† Using a threshold of 0.0%, the lower bound of the confidence interval suggests an important difference favoring hybrid resin composite, whereas the upper bound suggests an important benefit from conventional glass ionomer cement.

eTable 19. Absolute effects (95% CI) and certainty of the evidence for macrofilled resin composite compared with conventional glass ionomer cement for Class II restorations on vital posterior primary teeth.

OUTCOME (FOLLOW-UP, MO)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT, RISK DIFFERENCE (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE†)	WHAT HAPPENS
Restoration Failure‡ (24)	147	1 RCT§ (not reported)¶	−0.05 (−0.18 to 0.09)	18 fewer to 9 more	Low#,**	Among participants receiving macrofilled resin composite restorations, there were 5 fewer events (ranging from 18 fewer to 9 more) of restoration failure per 100 restorations compared with those receiving conventional glass ionomer cement restorations. Macrofilled resin composite may increase the risk of experiencing restoration failure by an important amount compared with conventional glass ionomer cement.
Secondary Caries (24)	147	1 RCT (not reported)¶	−0.04 (−0.18 to 0.10)	18 fewer to 10 more	Low#,††	Among participants receiving macrofilled resin composite restorations, there were 4 fewer events (ranging from 18 fewer to 10 more) of secondary caries per 100 restorations compared with those receiving conventional glass ionomer cement restorations. Macrofilled resin composite may decrease the risk of experiencing secondary caries by an important amount compared with conventional glass ionomer cement.
Unacceptable Anatomic Form (24)	147	1 RCT (not reported)¶	−0.06 (−0.19 to 0.08)	19 fewer to 8 more	Low#,‡‡	Among participants receiving macrofilled resin composite restorations, there were 6 fewer events (ranging from 19 fewer to 8 more) of unacceptable anatomic form per 100 restorations compared with those receiving conventional glass ionomer cement restorations. Macrofilled resin composite may decrease the risk of experiencing unacceptable anatomic form by an important amount compared with conventional glass ionomer cement.
Unacceptable Marginal Adaptation (24)	147	1 RCT (not reported)¶	−0.06 (−0.20 to 0.07)	20 fewer to 7 more	Low#,**	Among participants receiving macrofilled resin composite restorations, there were 6 fewer events (ranging from 20 fewer to 7 more) of unacceptable marginal adaptation per 100 restorations compared with those receiving conventional glass ionomer cement restorations. Macrofilled resin composite may decrease the risk of experiencing unacceptable marginal adaptation by an important amount compared with conventional glass ionomer cement.

* No studies meeting the selection criteria reported data on caries progression, fracture of the crown, full tooth fracture, longevity of the restoration, need to treat endodontically, oral health–related quality of life, patient discomfort during treatment, patient or parent satisfaction with treatment, postoperative pain and discomfort, pulp vitality, pulpal complications due to infection, pulpal exposure, restoration fracture, restoration longevity reported in unit of time, restoration loss, restoration survival reported as a hazard ratio, time needed to perform the restoration, tooth loss, anaphylaxis, kidney function, neurobehavioral assessment, physical development, or psychosocial function. † The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. ‡ Restoration failure was defined as restoration loss, secondary caries, and other unspecified reasons by Ersin and colleagues.[41] § RCT: Randomized controlled trial. ¶ Ersin and colleagues.[41] # Rated down 2 levels owing to very serious issues of imprecision. ** Using a threshold of 2.50%, the lower bound of the confidence interval suggests an important difference favoring macrofilled resin composite, whereas the upper bound suggests an important benefit from conventional glass ionomer cement. †† Using a threshold of 2.78%, the lower bound of the confidence interval suggests an important difference favoring macrofilled resin composite, whereas the upper bound suggests an important benefit from conventional glass ionomer cement. ‡‡ Using a threshold of 2.43%, the lower bound of the confidence interval suggests an important difference favoring macrofilled resin composite, whereas the upper bound suggests an important benefit from conventional glass ionomer cement.

eTable 20. Absolute effects (95% CI) and certainty of the evidence for nanocomposite compared with conventional glass ionomer cement for Class II restorations on vital posterior primary teeth.

OUTCOME (FOLLOW-UP, MO)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT, RISK DIFFERENCE (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE†)	WHAT HAPPENS
Restoration Loss (12)	68	1 randomized controlled trial (26)‡	−0.03 (−0.11 to 0.05)	11 fewer to 5 more	Low§,¶,#	Among participants receiving nanocomposite restorations, there were 3 fewer events (ranging from 11 fewer to 5 more) of restoration loss per 100 restorations compared with those receiving conventional glass ionomer cement restorations. Nanocomposite may decrease the risk of experiencing restoration loss by an important amount compared with conventional glass ionomer cement.

* For the outcomes of postoperative pain and discomfort, secondary caries, unacceptable anatomic form, and unacceptable marginal adaptation, there were 0 events in both treatment arms of the included study. No studies meeting the selection criteria reported data on caries progression, fracture of the crown, full tooth fracture, longevity of the restoration, need to treat endodontically, oral health–related quality of life, patient discomfort during treatment, patient or parent satisfaction with treatment, pulp vitality, pulpal complications due to infection, pulpal exposure, restoration failure (or repair or replacement of the restoration), restoration fracture, restoration longevity reported in unit of time, restoration survival reported as a hazard ratio, time needed to perform the restoration, tooth loss, anaphylaxis, kidney function, neurobehavioral assessment, physical development, or psychosocial function. † GRADE: Grading of Recommendations Assessment, Development and Evaluation. The GRADE Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. ‡ Akman and Tosun.[40] § Rated down 2 levels owing to very serious issues of imprecision. ¶ Using a threshold of 0.29%, the lower bound of the confidence interval suggests an important difference favoring nanocomposite, whereas the upper bound suggests an important benefit from conventional glass ionomer cement. # Rated down 2 levels owing to very serious issues of indirectness when used to inform clinical recommendations for Class I restorations for moderate and advanced caries lesions on vital posterior primary teeth.

eTable 21. Absolute effects (95% CI) and certainty of the evidence for resin-modified glass ionomer cement compared with conventional glass ionomer cement for Class II restorations on vital posterior primary teeth.

OUTCOME (FOLLOW-UP, MO)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT, RISK DIFFERENCE (95% CI)	ANTICIPATED ABOSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE†)	WHAT HAPPENS
Restoration Failure‡ (36)	114	1 RCT§ (not reported)¶	−0.14 (−0.25 to −0.03)	25 fewer to 3 fewer	Moderate#	Among participants receiving resin-modified glass ionomer cement restorations, there were 14 fewer events (ranging from 25 fewer to 3 fewer) of restoration failure per 100 restorations compared with those receiving conventional glass ionomer cement restorations. Resin-modified glass ionomer cement probably decreases the risk of experiencing restoration failure by an important amount compared with conventional glass ionomer cement.
Restoration Fracture (36)	114	1 RCT (not reported)¶	0.00 (−0.05 to 0.05)	5 fewer to 5 more	Very low#,**,††	There is very low certainty evidence regarding the difference between resin-modified glass ionomer cement and conventional glass ionomer for the outcome of restoration fracture.
Restoration Loss (36)	114	1 RCT (not reported)¶	−0.08 (−0.16 to 0.004)	16 fewer to 0 more	Very low#,**,‡‡	There is very low certainty evidence regarding the difference between resin-modified glass ionomer cement and conventional glass ionomer for the outcome of restoration loss.
Secondary Caries (36)	114	1 RCT (not reported)¶	−0.07 (−0.14 to 0.004)	14 fewer to 0 more	Very low#,**,§§	There is very low certainty evidence regarding the difference between resin-modified glass ionomer cement and conventional glass ionomer for the outcome of secondary caries.

* For the outcome of pulpal complications due to infection (36-month follow-up), there were 0 events in both treatment arms of the included studies. No studies meeting the selection criteria reported data on caries progression, fracture of the crown, full tooth fracture, longevity of the restoration, need to treat endodontically, oral health–related quality of life, patient discomfort during treatment, patient or parent satisfaction with treatment, postoperative pain and discomfort, pulp vitality, pulpal exposure, restoration longevity reported in unit of time, restoration survival reported as a hazard ratio, time needed to perform the restoration, tooth loss, unacceptable anatomic form, unacceptable marginal adaptation, anaphylaxis, kidney function, neurobehavioral assessment, physical development, or psychosocial function. † The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. ‡ Restoration failure was defined as restoration loss, restoration fracture, and secondary caries by Hübel and Mejàre.[42] § RCT: Randomized controlled trial. ¶ Hübel and Mejàre.[42] # Rated down 1 level owing to serious issues of risk of bias. ** Rated down 2 levels owing to very serious issues of imprecision. †† Using a threshold of 0.16%, the lower bound of the confidence interval suggests an important difference favoring resin-modified glass ionomer cement, whereas the upper bound suggests an important benefit of conventional glass ionomer cement. ‡‡ Using a threshold of 0.98%, the lower bound of the confidence interval suggests an important difference favoring resin-modified glass ionomer cement, whereas the upper bound suggests a negligible benefit of conventional glass ionomer cement. §§ Using a threshold of 0.66%, the lower bound of the confidence interval suggests an important difference favoring resin-modified glass ionomer cement, whereas the upper bound suggests a negligible benefit of conventional glass ionomer cement.

eTable 22. Absolute effects (95% CI) and certainty of the evidence for hybrid resin composite compared with resin-modified glass ionomer cement for Class II restorations on vital posterior primary teeth.

OUTCOME (FOLLOW-UP, MO)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT, RISK DIFFERENCE (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE†)	WHAT HAPPENS
Restoration Failure‡ (24)	241	2 RCTs§ (not reported)¶,#	0.02 (−0.07 to 0.11)	7 fewer to 11 more	Very low**,††,‡‡	There is very low certainty evidence regarding the difference between hybrid resin composite and resin-modified glass ionomer cement for the outcome of restoration failure.
Restoration Fracture (24)	127	1 RCT (not reported)¶	−0.02 (−0.06 to 0.03)	6 fewer to 3 more	Very low**,††,§§	There is very low certainty evidence regarding the difference between hybrid resin composite and resin-modified glass ionomer cement for the outcome of restoration fracture.
Restoration Loss (24)	231	2 RCTs (not reported)¶,#	0.03 (−0.02 to 0.07)	2 fewer 7 more	Very low**,††,¶¶	There is very low certainty evidence regarding the difference between hybrid resin composite and resin-modified glass ionomer cement for the outcome of restoration loss.
Secondary Caries (12-24)	329	3 RCTs (not reported)¶,#,##	0.05 (−0.003 to 0.10)	0 fewer to 10 more	Very low**,††,***	There is very low certainty evidence regarding the difference between hybrid resin composite and resin-modified glass ionomer cement for the outcome of secondary caries.
Unacceptable Anatomic Form (12-24)	200	2 RCTs (not reported)¶,##	0.02 (−0.07 to 0.04)	7 fewer to 4 more	Very low**,††,†††	There is very low certainty evidence regarding the difference between hybrid resin composite and resin-modified glass ionomer cement for the outcome of anatomic form.
Unacceptable Marginal Adaptation (12-24)	300	3 RCTs (not reported)¶,#,##	−0.02 (−0.06 to 0.03)	6 fewer to 3 more	Very low**,††,‡‡‡	There is very low certainty evidence regarding the difference between hybrid resin composite and resin-modified glass ionomer cement for the outcome of marginal adaptation.

* No studies meeting the selection criteria reported data on caries progression, fracture of the crown, full tooth fracture, longevity of the restoration, need to treat endodontically, oral health–related quality of life, patient discomfort during treatment, patient or parent satisfaction with treatment, postoperative pain and discomfort, pulp vitality, pulpal complications due to infection, pulpal exposure, restoration longevity reported in unit of time, restoration survival reported as a hazard ratio, time needed to perform the restoration, tooth loss, anaphylaxis, kidney function, neurobehavioral assessment, physical development, or psychosocial function. † The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. ‡ Restoration failure was defined as restoration loss, restoration fracture, secondary caries, unacceptable anatomic form, and unacceptable marginal adaptation by Andersson-Wenckert and Sunnegårdh-Grönberg.[43] Reasons for restoration failure were not specified by Dermata and colleagues.[44] § RCT: Randomized controlled trial. ¶ Andersson-Wenckert and Sunnegårdh-Grönberg.[43] # Dermata and colleagues.[44] ** Rated down 1 level owing to serious issues of risk of bias. †† Rated down 2 levels owing to very serious issues of imprecision. ‡‡ Using a threshold of 1.27%, the lower bound of the confidence interval suggests an important difference favoring hybrid resin composite, whereas the upper bound suggests an important benefit from resin-modified glass ionomer cement. §§ Using a threshold of 0.15%, the lower bound of the confidence interval suggests an important difference favoring hybrid resin composite, whereas the upper bound suggests an important benefit from resin-modified glass ionomer cement. ¶¶ Using a threshold of 0.17%, the lower bound of the confidence interval suggests an important difference favoring hybrid resin composite, whereas the upper bound suggests an important benefit from resin-modified glass ionomer cement. ## El-Housseiny and colleagues.[47] *** Using a threshold of 0.35%, the lower bound of the confidence interval suggests a negligible difference favoring hybrid resin composite, whereas the upper bound suggests an important benefit from resin-modified glass ionomer cement. ††† Using a threshold of 0.49%, the lower bound of the confidence interval suggests an important difference favoring hybrid resin composite, whereas the upper bound suggests an important benefit from resin-modified glass ionomer cement. ‡‡‡ Using a threshold of 0.51%, the lower bound of the confidence interval suggests an important difference favoring hybrid resin composite, whereas the upper bound suggests an important benefit from resin-modified glass ionomer cement.

eTable 23. Absolute effects (95% CI) and certainty of the evidence for compomer compared with conventional glass ionomer cement for Class II restorations on vital posterior primary teeth.

OUTCOME (FOLLOW-UP, MO)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT, RISK DIFFERENCE (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE†)	WHAT HAPPENS
Restoration Failure‡ (36)	184	1 randomized controlled trial (184)§	0.00 (−0.14 to 0.14)	14 fewer to 14 more	Low¶,#	Among participants receiving compomer restorations, there were 0 more events (ranging from 14 fewer to 14 more) of restoration failure per 100 restorations compared with those receiving conventional glass ionomer cement restorations. Compomer may result in little to no difference in restoration failure compared with conventional glass ionomer cement.

* No studies meeting the selection criteria reported data on caries progression, fracture of the crown, full tooth fracture, longevity of the restoration, need to treat endodontically, oral health–related quality of life, patient discomfort during treatment, patient or parent satisfaction with treatment, postoperative pain and discomfort, pulp vitality, pulpal complications due to infection, pulpal exposure, restoration fracture, restoration longevity reported in unit of time, restoration loss, restoration survival reported as a hazard ratio, secondary caries, time needed to perform the restoration, tooth loss, unacceptable anatomic form, unacceptable marginal adaptation, anaphylaxis, kidney function, neurobehavioral assessment, physical development, or psychosocial function. † The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. ‡ Restoration failure was defined as defined as restoration loss, secondary caries, unacceptable anatomic form, unacceptable marginal adaptation by Olegário and colleagues.[37] § Olegário and colleagues.[37] ¶ Rated down 2 levels owing to very serious issues of imprecision. # Using a threshold of 4.35%, the lower bound of the confidence interval suggests an important difference favoring compomer, whereas the upper bound suggests an important benefit from conventional glass ionomer cement.

eTable 24. Absolute effects (95% CI) and certainty of the evidence for preformed metal crowns (Hall technique) compared with conventional glass ionomer cement (atraumatic restorative treatment) for Class II restorations on vital posterior primary teeth.

OUTCOME (FOLLOW-UP)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT, RD† OR MEAN DIFFERENCE (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE‡)	WHAT HAPPENS
Oral Health–Related Quality of Life (OHRQoL) Assessed With Scale From 0 to 100, in Which a Higher Score Is Associated With a Lower OHRQoL and a Positive Mean Difference Is Associated With a Greater Improvement in OHRQoL in the Intervention Group (Posttreatment)	123	1 RCT§ (123)¶	Mean difference, 0.73 (−4.70 to 6.10)	4.70 points fewer to 6.10 points more	Moderate#,**	Among participants receiving preformed metal crowns (Hall technique), the mean improvement from baseline in oral health–related quality of life was greater by 0.73 points (of 100) compared with participants receiving conventional glass ionomer cement restorations (atraumatic restorative treatment). Preformed metal crowns probably result in a negligible improvement in oral health–related quality of life compared to conventional glass ionomer cement restorations (atraumatic restorative treatment).
Patient Satisfaction (Postoperative)	131	1 RCT (131)¶	RD, 0.00 (−0.03 to 0.03)	3 fewer to 3 more	Moderate#,**	Among participants receiving preformed metal crowns (Hall technique), there were 0 more events (ranging from 3 fewer to 3 more) of patient satisfaction compared with those receiving conventional glass ionomer cement restorations (atraumatic restorative treatment). Preformed metal crowns (Hall technique) probably result in little to no difference in patient satisfaction compared with conventional glass ionomer cement restorations (atraumatic restorative treatment).
Restoration Failure†† (36 Mo)	112	1 RCT (112)¶	RD, −0.55 (−0.69 to −0.42)	69 fewer to 42 fewer	Moderate#,**	Among participants receiving preformed metal crowns (Hall technique), there were 55 fewer events (ranging from 69 fewer to 42 fewer) of restoration failure form per 100 restorations compared with those receiving conventional glass ionomer cement restorations (atraumatic restorative treatment). Preformed metal crowns (Hall technique) probably decreases the risk of restoration failure by an important amount compared with conventional glass ionomer cement restorations (atraumatic restorative treatment).

* No studies meeting the selection criteria reported data on caries progression, fracture of the crown, full tooth fracture, longevity of the restoration, need to treat endodontically, patient discomfort during treatment, postoperative pain and discomfort, pulp vitality, pulpal complications due to infection, pulpal exposure, restoration fracture, restoration longevity reported in unit of time, restoration loss, restoration survival reported as a hazard ratio, secondary caries, time needed to perform the restoration, tooth loss, unacceptable anatomic form, unacceptable marginal adaptation, anaphylaxis, kidney function, neurobehavioral assessment, physical development, or psychosocial function. † RD: Risk difference. ‡ The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. § RCT: Randomized controlled trial. ¶ Araujo and colleagues.[16] # Rated down 1 level owing to serious issues of risk of bias. ** Rated down 2 levels owing to very serious issues of indirectness when used to inform clinical recommendations for Class I restorations for moderate and advanced caries lesions on vital posterior primary teeth. †† Restoration failure was defined as restoration loss, restoration fracture, and other unspecified reasons by Araujo and colleagues.[16]

eTable 25. Absolute effects (95% CI) and certainty of the evidence for compomer compared with conventional glass ionomer cement for Class I restorations on vital posterior primary teeth.

OUTCOME (FOLLOW-UP, MO)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT, RISK DIFFERENCE (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE†)	WHAT HAPPENS
Restoration Failure‡ (36)	162	1 randomized controlled trial (162)§	0.05 (−0.07 to 0.17)	7 fewer to 17 more	Low¶,#	Among participants receiving compomer restorations, there were 5 more events (ranging from 7 fewer to 17 more) of restoration failure per 100 restorations compared with those receiving conventional glass ionomer cement restorations. Compomer may increase the risk of experiencing restoration failure by an important amount compared with conventional glass ionomer cement.

* No studies meeting the selection criteria reported data on caries progression, fracture of the crown, full tooth fracture, longevity of the restoration, need to treat endodontically, oral health–related quality of life, patient discomfort during treatment, patient or parent satisfaction with treatment, postoperative pain and discomfort, pulp vitality, pulpal complications due to infection, pulpal exposure, restoration fracture, restoration longevity reported in unit of time, restoration loss, restoration survival reported as a hazard ratio, secondary caries, time needed to perform the restoration, tooth loss, unacceptable anatomic form, unacceptable marginal adaptation, anaphylaxis, kidney function, neurobehavioral assessment, physical development, or psychosocial function. † The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. ‡ Restoration failure was defined as restoration loss, secondary caries, unacceptable anatomic form, and unacceptable marginal adaptation by Olegário and colleagues.[37] § Olegário and colleagues.[37] ¶ Rated down 2 levels owing to very serious issues of imprecision. # Using a threshold of 1.67%, the lower bound of the confidence interval suggests an important difference favoring compomer, whereas the upper bound suggests an important benefit from conventional glass ionomer cement.

eTable 26. Absolute effects (95% CI) and certainty of the evidence for macrofilled resin composite compared with conventional glass ionomer cement for Class I restorations on vital posterior primary teeth.

OUTCOME (FOLLOW-UP, MO)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT, RISK DIFFERENCE (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE†)	WHAT HAPPENS
Restoration Failure‡ (24)	177	1 RCT§ (not reported)¶	0.05 (–0.02 to 0.12)	2 fewer to 12 more	Low#,**	Among participants receiving macrofilled resin composite restorations, there were 5 more events (ranging from 2 fewer to 12 more) of restoration failure per 100 restorations compared with those receiving conventional glass ionomer cement restorations. Macrofilled resin composite may increase the risk of experiencing restoration failure by an important amount compared with conventional glass ionomer cement.
Secondary Caries (24)	177	1 RCT (not reported)¶	–0.05 (–0.14 to 0.05)	14 fewer to 5 more	Low#,††	Among participants receiving macrofilled resin composite restorations, there were 5 fewer events (ranging from 14 fewer to 5 more) of secondary caries per 100 restorations compared with those receiving conventional glass ionomer cement restorations. Macrofilled resin composite may decrease the risk of experiencing secondary caries by an important amount compared with conventional glass ionomer cement.
Unacceptable Anatomic Form (24)	177	1 RCT (not reported)¶	–0.01 (–0.06 to 0.04)	6 fewer to 4 more	Low#,**	Among participants receiving macrofilled resin composite restorations, there were 1 fewer event (ranging from 6 fewer to 4 more) of unacceptable anatomic form per 100 restorations compared with those receiving conventional glass ionomer cement restorations. Macrofilled resin composite may decrease the risk of experiencing unacceptable anatomic form by an important amount compared with conventional glass ionomer cement.
Unacceptable Marginal Adaptation (24)	177	1 RCT (not reported)¶	0.002 (–0.04 to 0.05)	4 fewer to 5 more	Low#,‡‡	Among participants receiving macrofilled resin composite restorations, there were 0 more events (ranging from 4 fewer to 5 more) of unacceptable marginal adaptation per 100 restorations compared with those receiving conventional glass ionomer cement restorations. Macrofilled resin composite may increase the risk of experiencing unacceptable marginal adaptation by a negligible amount compared with conventional glass ionomer cement.

* No studies meeting the selection criteria reported data on caries progression, fracture of the crown, full tooth fracture, longevity of the restoration, need to treat endodontically, oral health–related quality of life, patient discomfort during treatment, patient or parent satisfaction with treatment, postoperative pain and discomfort, pulp vitality, pulpal complications due to infection, pulpal exposure, restoration fracture, restoration longevity reported in unit of time, restoration loss, restoration survival reported as a hazard ratio, time needed to perform the restoration, tooth loss, anaphylaxis, kidney function, neurobehavioral assessment, physical development, or psychosocial function. † The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. ‡ Restoration failure was defined as restoration loss, secondary caries, and other unspecified reasons by Ersin and colleagues.[41] § RCT: Randomized controlled trial. ¶ Ersin and colleagues.[41] # Rated down 2 levels owing to very serious issues of imprecision. ** Using a threshold of 0.33%, the lower bound of the confidence interval suggests an important difference favoring macrofilled resin composite, whereas the upper bound suggests an important benefit from conventional glass ionomer cement. †† Using a threshold of 1.52%, the lower bound of the confidence interval suggests an important difference favoring macrofilled resin composite, whereas the upper bound suggests an important benefit from conventional glass ionomer cement. ‡‡ Using a threshold of 0.22%, the lower bound of the confidence interval suggests an important difference favoring macrofilled resin composite, whereas the upper bound suggests an important benefit from conventional glass ionomer cement.

eTable 27. Absolute effects (95% CI) and certainty of the evidence for amalgam compared with resin-modified glass ionomer cement for Class I and Class II restorations combined on vital posterior primary teeth.

OUTCOME (FOLLOW-UP, MO)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT, RISK DIFFERENCE (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE†)	WHAT HAPPENS
Restoration Failure‡ (24)	44	1 RCT§ (not reported)¶	0.05 (−0.10 to 0.20)	10 fewer to 20 more	Very low#,**,††,‡‡	There is very low certainty evidence regarding the difference between amalgam and resin-modified glass ionomer cement for the outcome of restoration failure.
Secondary Caries (24)	44	1 RCT (not reported)¶	−0.03 (−0.25 to 0.18)	25 fewer to 18 more	Very low#,**,‡‡,§§	There is very low certainty evidence regarding the difference between amalgam and resin-modified glass ionomer cement for the outcome of secondary caries.
Unacceptable Anatomic Form (24)	44	1 RCT (not reported)¶	0.05 (−0.10 to 0.20)	10 fewer to 20 more	Very low#,**,††,‡‡	There is very low certainty evidence regarding the difference between amalgam and resin-modified glass ionomer cement for the outcome of unacceptable anatomic form.
Unacceptable Marginal Adaptation (24)	44	1 RCT (not reported)¶	0.05 (−0.10 to 0.20)	10 fewer to 20 more	Very low#,**,††,‡‡	There is very low certainty evidence regarding the difference between amalgam and resin-modified glass ionomer cement for the outcome of unacceptable marginal adaptation.

* No studies meeting the selection criteria reported data on caries progression, fracture of the crown, full tooth fracture, longevity of the restoration, need to treat endodontically, oral health–related quality of life, patient discomfort during treatment, patient or parent satisfaction with treatment, postoperative pain and discomfort, pulp vitality, pulpal complications due to infection, pulpal exposure, restoration fracture, restoration longevity reported in unit of time, restoration loss, restoration survival reported as a hazard ratio, time needed to perform the restoration, tooth loss, anaphylaxis, kidney function, neurobehavioral assessment, physical development, or psychosocial function. † The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. ‡ Reasons for restoration failure were not specified by Daou and colleagues.[45] § RCT: Randomized controlled trial. ¶ Daou and colleagues.[45] # Rated down 2 levels owing to very serious issues of risk of bias. ** Rated down 2 levels owing to very serious issues of imprecision. †† Using a threshold of 0.43%, the lower bound of the confidence interval suggests an important difference favoring amalgam, whereas the upper bound suggests an important benefit from resin-modified glass ionomer cement. ‡‡ Rated down 1 level owing to serious issues of indirectness when used to inform clinical recommendations for Class I restorations for moderate and advanced caries lesions on vital posterior primary teeth. §§ Using a threshold of 1.74%, the lower bound of the confidence interval suggests an important difference favoring amalgam, whereas the upper bound suggests an important benefit from resin-modified glass ionomer cement.

eTable 28. Absolute effects (95% CI) and certainty of the evidence for conventional glass ionomer cement compared with resin-modified glass ionomer cement for Class I and Class II restorations combined on vital posterior primary teeth.

OUTCOME (FOLLOW-UP, MO)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT, RISK DIFFERENCE (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE†)	WHAT HAPPENS
Postoperative Pain and Discomfort (6)	42	1 RCT‡ (24)§	0.05 (−0.23 to 0.33)	23 fewer to 33 more	Very low¶,#,**,††	There is very low certainty evidence regarding the difference between conventional glass ionomer cement and resin-modified glass ionomer cement for the outcome of postoperative pain and discomfort.
Restoration Loss (6)	46	1 RCT (24)§	0.00 (−0.24 to 0.24)	24 fewer to 24 more	Very low¶,#,††,‡‡	There is very low certainty evidence regarding the difference between conventional glass ionomer cement and resin-modified glass ionomer cement for the outcome of restoration loss.
Secondary Caries (6)	40	1 RCT (24)§	0.20 (−0.10 to 0.50)	10 fewer to 50 more	Very low¶,#,††,§§	There is very low certainty evidence regarding the difference between conventional glass ionomer cement and resin-modified glass ionomer cement for the outcome of secondary caries.
Unacceptable Anatomic Form (6)	40	1 RCT (24)§	−0.05 (−0.25 to 0.15)	25 fewer to 15 more	Very low¶,#,††,¶¶	There is very low certainty evidence regarding the difference between conventional glass ionomer cement and resin-modified glass ionomer cement for the outcome of anatomic form.
Unacceptable Marginal Adaptation (6)	40	1 RCT (24)§	0.25 (−0.05 to 0.55)	5 fewer to 55 more	Very low¶,#,††,##	There is very low certainty evidence regarding the difference between conventional glass ionomer cement and resin-modified glass ionomer cement for the outcome of marginal adaptation.

* No studies meeting the selection criteria reported data on caries progression, fracture of the crown, full tooth fracture, longevity of the restoration, need to treat endodontically, oral health–related quality of life, patient discomfort during treatment, patient or parent satisfaction with treatment, pulp vitality, pulpal complications due to infection, pulpal exposure, restoration failure (or repair or replacement of the restoration), restoration fracture, restoration longevity reported in unit of time, restoration survival reported as a hazard ratio, time needed to perform the restoration, tooth loss, anaphylaxis, kidney function, neurobehavioral assessment, physical development, or psychosocial function. † The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. ‡ RCT: Randomized controlled trial. § Mufti.[46] ¶ Rated down 2 levels owing to very serious issues of risk of bias. # Rated down 2 levels owing to very serious issues of imprecision. ** Using a threshold of 2.86%, the lower bound of the confidence interval suggests an important difference favoring conventional glass ionomer cement, whereas the upper bound suggests an important benefit of resin-modified glass ionomer cement. †† Rated down 1 level owing to serious issues of indirectness when used to inform clinical recommendations for Class I restorations for moderate and advanced caries lesions on vital posterior primary teeth. ‡‡ Using a threshold of 2.17%, the lower bound of the confidence interval suggests an important difference favoring conventional glass ionomer cement, whereas the upper bound suggests an important benefit of resin-modified glass ionomer cement. §§ Using a threshold of 3.5%, the lower bound of the confidence interval suggests an important difference favoring conventional glass ionomer cement, whereas the upper bound suggests an important benefit of resin-modified glass ionomer cement. ¶¶ Using a threshold of 1.5%, the lower bound of the confidence interval suggests an important difference favoring conventional glass ionomer cement, whereas the upper bound suggests an important benefit of resin-modified glass ionomer cement. ## Using a threshold of 4.5%, the lower bound of the confidence interval suggests an important difference favoring conventional glass ionomer cement, whereas the upper bound suggests an important benefit of resin-modified glass ionomer cement.

eTable 29. Absolute effects (95% CI) and certainty of the evidence for compomer compared with conventional glass ionomer cement for Class I restorations on vital posterior permanent teeth.

OUTCOME (FOLLOW-UP, MO)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT, RISK DIFFERENCE (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE†)	WHAT HAPPENS
Restoration Loss (6)	60	1 randomized controlled trial (60)‡	0.10 (–0.02 to 0.22)	2 fewer to 22 more	Low§,¶	Among participants receiving compomer restorations, there were 10 more events (ranging from 2 fewer to 22 more) of restoration loss per 100 restorations compared with those receiving conventional glass ionomer cement restorations. Compomer may increase the risk of experiencing restoration loss by an important amount compared with conventional glass ionomer cement.

* No studies meeting the selection criteria reported data on caries progression, fracture of the crown, full tooth fracture, longevity of the restoration, need to treat endodontically, oral health–related quality of life, patient discomfort during treatment, patient or parent satisfaction with treatment, postoperative pain and discomfort, pulp vitality, pulpal complications due to infection, pulpal exposure, restoration failure, restoration fracture, restoration longevity reported in unit of time, restoration survival reported as a hazard ratio, secondary caries, time needed to perform the restoration, tooth loss, unacceptable anatomic form, unacceptable marginal adaptation, anaphylaxis, kidney function, neurobehavioral assessment, physical development, or psychosocial function. † The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. ‡ Mundada and colleagues.[67] § Rated down 2 levels owing to very serious issues of imprecision. ¶ Using a threshold of 0.0%, the lower bound of the confidence interval suggests an important difference favoring compomer, whereas the upper bound suggests an important benefit of conventional glass ionomer cement.

eTable 30. Absolute effects (95% CI) and certainty of the evidence for resin-modified glass ionomer cement compared with conventional glass ionomer cement for Class I restorations on vital posterior permanent teeth.

OUTCOME (FOLLOW-UP, MO)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT, RISK DIFFERENCE (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE†)	WHAT HAPPENS
Restoration Failure‡ (24)	50	1 randomized controlled trial (not reported)§	−0.19 (−0.37 to −0.02)	37 fewer to 2 fewer	Low¶,#	Among participants receiving resin-modified glass ionomer cement restorations, there were 19 fewer events (ranging from 37 fewer to 2 fewer) of restoration failure per 100 restorations compared with those receiving conventional glass ionomer cement restorations. Resin-modified glass ionomer cement may decrease the risk of experiencing restoration failure by an important amount compared with conventional glass ionomer cement.

* For the outcome of restoration loss, there were 0 events in both treatment arms of the included study. No studies meeting the selection criteria reported data on caries progression, fracture of the crown, full tooth fracture, longevity of the restoration, need to treat endodontically, oral health–related quality of life, patient discomfort during treatment, patient or parent satisfaction with treatment, postoperative pain and discomfort, pulp vitality, pulpal complications due to infection, pulpal exposure, restoration fracture, restoration longevity reported in unit of time, restoration survival reported as a hazard ratio, secondary caries, time needed to perform the restoration, tooth loss, unacceptable anatomic form, unacceptable marginal adaptation, anaphylaxis, kidney function, neurobehavioral assessment, physical development, or psychosocial function. † The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. ‡ Reasons for restoration failure were not specified by Ercan and colleagues.[68] § Ercan and colleagues.[68] ¶ Rated down 2 levels owing to very serious issues of imprecision. # Using a threshold of 1.90%, the lower bound of the confidence interval suggests an important difference favoring resin-modified glass ionomer cement, whereas the upper bound suggests a negligible difference favoring conventional glass ionomer cement.

eTable 31. Absolute effects (95% CI) and certainty of the evidence for conventional glass ionomer cement compared with hybrid resin composite for Class I restorations on vital posterior permanent teeth.

OUTCOME (FOLLOW-UP)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT, RISK DIFFERENCE (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE†)	WHAT HAPPENS
Postoperative Pain and Discomfort (Up to 9 Mo)	118	2 randomized controlled trials (79)‡,§	−0.03 (−0.10 to 0.03)	10 fewer to 3 more	Low¶,#	Among participants receiving conventional glass ionomer cement restorations, there were 3 fewer events (ranging from 10 fewer to 3 more) of postoperative pain and discomfort per 100 restorations compared with those receiving hybrid resin composite restorations. Conventional glass ionomer cement may decrease the risk of experiencing postoperative pain and discomfort by an important amount compared with hybrid resin composite.

* For the outcomes of restoration failure, restoration loss, secondary caries, unacceptable anatomic form, and unacceptable marginal adaptation, there were 0 events in both treatment arms for the included studies. No studies meeting the selection criteria reported data on caries progression, fracture of the crown, full tooth fracture, longevity of the restoration, need to treat endodontically, oral health–related quality of life, patient discomfort during treatment, patient or parent satisfaction with treatment, pulp vitality, pulpal complications due to infection, pulpal exposure, restoration fracture, restoration longevity reported in unit of time, restoration survival reported as a hazard ratio, time needed to perform the restoration, tooth loss, anaphylaxis, kidney function, neurobehavioral assessment, physical development, or psychosocial function. † The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. ‡ Gurgan and colleagues.[69] § Kharma and colleagues.[70] ¶ Rated down 2 levels owing to very serious issues of imprecision. # Using a threshold of 0.34%, the lower bound of the confidence interval suggests an important difference favoring conventional glass ionomer cement, whereas the upper bound suggests an important benefit of hybrid resin composite.

eTable 32. Absolute effects (95% CI) and certainty of the evidence for nanocomposite compared with hybrid resin composite for Class I restorations on vital posterior permanent teeth.

OUTCOME (FOLLOW-UP)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT, RISK DIFFERENCE (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE†)	WHAT HAPPENS
Postoperative Pain and Discomfort (1 Wk-24 Mo)	245	3 RCTs‡ (not reported)§,¶,#	−0.01 (−0.05 to 0.03)	5 fewer to 3 more	Low**,††	Among participants receiving nanocomposite restorations, there was 1 fewer event (ranging from 5 fewer to 3 more) of postoperative pain and discomfort per 100 restorations compared with those receiving hybrid resin composite restorations. Nanocomposite may decrease the risk of experiencing postoperative pain and discomfort by an important amount compared with hybrid resin composite.
Restoration Failure‡‡ (18-36 Mo)	182	2 RCTs (59)§,#	−0.02 (−0.08 to 0.05)	8 fewer to 5 more	Low**,§§	Among participants receiving nanocomposite restorations, there were 2 fewer events (ranging from 8 fewer to 5 more) of restoration failure per 100 restorations compared with those receiving hybrid resin composite restorations. Nanocomposite may decrease the risk of experiencing restoration failure by an important amount compared with hybrid resin composite.
Restoration Fracture (36 Mo)	80	1 RCT (24)§	−0.05 (−0.16 to 0.06)	16 fewer to 6 more	Low**,¶¶	Among participants receiving nanocomposite restorations, there were 5 fewer events (ranging from 16 fewer to 6 more) of restoration fracture per 100 restorations compared with those receiving hybrid resin composite restorations. Nanocomposite may decrease the risk of experiencing restoration fracture by an important amount compared with hybrid resin composite.
Secondary Caries (18-36 Mo)	242	3 RCTs (not reported)§,¶,#	0.01 (−0.03 to 0.04)	3 fewer to 4 more	Low**,##	Among participants receiving nanocomposite restorations, there was 1 more event (ranging from 3 fewer to 4 more) of secondary caries per 100 restorations compared with those receiving hybrid resin composite restorations. Nanocomposite may increase the risk of experiencing secondary caries by an important amount compared with hybrid resin composite.
Unacceptable Anatomic Form (18-36 Mo)	242	3 RCTs (not reported)§,¶,#	0.02 (−0.03 to 0.06)	3 fewer to 6 more	Low**,***	Among participants receiving nanocomposite restorations, there were 2 more events (ranging from 3 fewer to 6 more) of unacceptable anatomic form per 100 restorations compared with those receiving hybrid resin composite restorations. Nanocomposite may increase the risk of experiencing unacceptable anatomic form by an important amount compared with hybrid resin composite.
Unacceptable Marginal Adaptation (18-36 Mo)	242	3 RCTs (not reported)§,¶,#	−0.01 (−0.07 to 0.04)	7 fewer to 4 more	Low**,†††	Among participants receiving nanocomposite restorations, there was 1 fewer event (ranging from 7 fewer to 4 more) of unacceptable marginal adaptation per 100 restorations compared with those receiving hybrid resin composite restorations. Nanocomposite may decrease the risk of experiencing unacceptable marginal adaptation by an important amount compared with hybrid resin composite.

* For the outcome of restoration loss, there were 0 events in both treatment arms for the included studies. No studies meeting the selection criteria reported data on caries progression, fracture of the crown, full tooth fracture, longevity of the restoration, need to treat endodontically, oral health–related quality of life, patient discomfort during treatment, patient or parent satisfaction with treatment, pulp vitality, pulpal complications due to infection, pulpal exposure, restoration longevity reported in unit of time, restoration survival reported as a hazard ratio, time needed to perform the restoration, tooth loss, anaphylaxis, kidney function, neurobehavioral assessment, physical development, or psychosocial function. † The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. ‡ RCT: Randomized controlled trial. § Shi and colleagues.[71] ¶ Atabek and colleagues.[72] # Sadeghi and colleagues.[73] ** Rated down 2 levels owing to very serious issues of imprecision. †† Using a threshold of 0.19%, the lower bound of the confidence interval suggests an important difference favoring nanocomposite, whereas the upper bound suggests an important benefit of hybrid resin composite. ‡‡ Restoration failure was defined as restoration fracture and other unspecified reasons by Shi and colleagues[71] and was defined as secondary caries and other unspecified reasons by Sadeghi and colleagues.[73] §§ Using a threshold of 0.68%, the lower bound of the confidence interval suggests an important difference favoring nanocomposite, whereas the upper bound suggests an important benefit of hybrid resin composite. ¶¶ Using a threshold of 1.0%, the lower bound of the confidence interval suggests an important difference favoring nanocomposite, whereas the upper bound suggests an important benefit of hybrid resin composite. ## Using a threshold of 0.0%, the lower bound of the confidence interval suggests an important difference favoring nanocomposite, whereas the upper bound suggests an important benefit of hybrid resin composite. *** Using a threshold of 0.38%, the lower bound of the confidence interval suggests an important difference favoring nanocomposite, whereas the upper bound suggests an important benefit of hybrid resin composite. ††† Using a threshold of 0.58%, the lower bound of the confidence interval suggests an important difference favoring nanocomposite, whereas the upper bound suggests an important benefit of hybrid resin composite.

eTable 33. Absolute effects (95% CI) and certainty of the evidence for amalgam compared with hybrid resin composite for Class I and Class II restorations combined on vital posterior permanent teeth.

OUTCOME (FOLLOW-UP, MO)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT, RD† OR MD‡ (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE§)	WHAT HAPPENS
Fracture of the Crown (12)	98	1 RCT¶ (not reported)#	RD, 0.02 (−0.03 to 0.08)	3 fewer to 8 more	Very low**,††,‡‡,§§,¶¶	There is very low certainty evidence regarding the difference between amalgam and hybrid resin composite for the outcome of fracture of the crown.
Patient or Parent Satisfaction With Treatment Assessed With Scale From 0 to 10, in Which 0 Is Very Pleased and 10 Is Dissatisfied (12)	98	1 RCT (not reported)#	Participants receiving both amalgam and composite restorations were less satisfied with the appearance of amalgam restorations (average score, 2.5) compared with hybrid resin composite restorations (average score, 0.9) (MD, 1.6) at 12-months follow-up. Standard deviations and exact *P* values were not provided. However, study authors reported a statistically significant difference between the interventions.		Very low**,§§,¶¶,##	–
Postoperative Pain and Discomfort (12-36)	264	2 RCTs (not reported)#,***	RD, −0.01 (−0.04 to 0.02)	4 fewer to 2 more	Very low††,§§,¶¶,†††,‡‡‡	There is very low certainty evidence regarding the difference between amalgam and hybrid resin composite for the outcome of postoperative pain and discomfort up.
Postoperative Pain and Discomfort Assessed With Visual Analog Scale From 0 to 10, in Which 0 Is Very Comfortable and 10 Is Uncomfortable (12)	98	1 RCT (not reported)#	Participants receiving both amalgam and composite restorations experienced more discomfort with amalgam restorations (average score, 1.4) compared with the hybrid resin composite (average score, 1.2) (MD, 0.2) at 12-months follow-up. Standard deviations and exact *P* values were not provided. However, study authors reported no statistically significant difference between the interventions.		Very low**,§§,¶¶,##	–

* No studies meeting the selection criteria reported data on caries progression, full tooth fracture, longevity of the restoration, need to treat endodontically, oral health–related quality of life, patient discomfort during treatment, pulp vitality, pulpal complications due to infection, pulpal exposure, restoration longevity reported in unit of time, restoration loss, restoration survival reported as a hazard ratio, time needed to perform the restoration, tooth loss, anaphylaxis, kidney function, neurobehavioral assessment, physical development, or psychosocial function. † RD: Risk difference. ‡ MD: Mean difference. § The Grading of Recommendations Assessment, Development and Evaluation(GRADE) Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. ¶ RCT: Randomized controlled trial. # Wilson and colleagues.[59] ** Rated down 1 level owing to serious issues of risk of bias. †† Rated down 2 levels owing to very serious issues of imprecision. ‡‡ Using a threshold of 0.0%, the lower bound of the confidence interval suggests an important difference favoring amalgam, whereas the upper bound suggests an important benefit of hybrid resin composite. §§ Rated down 1 level owing to serious issues of indirectness when used to inform clinical recommendations for Class I restorations for moderate and advanced caries lesions on vital posterior permanent teeth. ¶¶ Rated down 1 level owing to serious issues of indirectness when used to inform clinical recommendations for Class II restorations for moderate and advanced caries lesions on vital posterior permanent teeth. ## Rated down 2 levels owing to very serious issues of imprecision due to low sample size. *** Bryant and Hodge.[60] ††† Rated down 2 levels owing to very serious issues of risk of bias. ‡‡‡ Using a threshold of 0.13%, the lower bound of the confidence interval suggests an important difference favoring amalgam, whereas the upper bound suggests a negligible benefit of hybrid resin composite. §§§ Restoration failure was defined as pulpal complications, restoration fracture, unacceptable anatomic form, unacceptable marginal adaptation, secondary caries, and unspecified reasons by Wilson and colleagues[59] and Bryant and Hodge.[60] ¶¶¶ Rated down 1 level owing to serious issues of inconsistency ($I^2 = 82\%$). ### Using a threshold of 0.50%, the lower bound of the confidence interval suggests an important difference favoring amalgam, whereas the upper bound suggests an important benefit of hybrid resin composite. **** Collins and colleagues.[61] †††† Using a threshold of 1.59%, the lower bound of the confidence interval suggests an important difference favoring amalgam, whereas the upper bound suggests a negligible benefit of hybrid resin composite. ‡‡‡‡ Using a threshold of 0.27%, the lower bound of the confidence interval suggests an important difference favoring amalgam, whereas the upper bound suggests an important benefit of hybrid resin composite. §§§§ Using a threshold of 0.47%, the lower bound of the confidence interval suggests an important difference favoring amalgam, whereas the upper bound suggests an important benefit of hybrid resin composite. ¶¶¶¶ Using a threshold of 0.09%, the lower bound of the confidence interval suggests an important difference favoring amalgam, whereas the upper bound suggests an important benefit of hybrid resin composite. #### Using a threshold of 0.56%, the lower bound of the confidence interval suggests an important difference favoring amalgam, whereas the upper bound suggests an important benefit of hybrid resin composite. ***** Using a threshold of 0.18%, the lower bound of the confidence interval suggests an important difference favoring amalgam, whereas the upper bound suggests an important benefit of hybrid resin composite. ††††† Using a threshold of 0.65%, the lower bound of the confidence interval suggests an important difference favoring amalgam, whereas the upper bound suggests an important benefit of hybrid resin composite.

eTable 33. Continued

OUTCOME (FOLLOW-UP, MO)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT, RD† OR MD‡ (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE§)	WHAT HAPPENS
Restoration Failure§§§ (12-36)	264	2 RCTs (not reported)#,***	RD, −0.04 (−0.08 to 0.004)	8 fewer to 0 more	Very low††,§§,¶¶,†††,¶¶¶,###	There is very low certainty evidence regarding the difference between amalgam and hybrid resin composite for the outcome of restoration failure at 12-36 month follow-up.
Restoration Failure§§§ (96)	159	1 RCT (52)****	RD, −0.10 (−0.20 to −0.01)	20 fewer to 1 fewer	Very low††,§§,¶¶,†††,††††	There is very low certainty evidence regarding the difference between amalgam and hybrid resin composite for the outcome of restoration failure at 96-month follow-up.
Restoration Fracture (36)	166	1 RCT (48)***	RD, −0.03 (−0.07 to 0.01)	7 fewer to 1 more	Very low ††,§§,¶¶,†††,‡‡‡‡	There is very low certainty evidence regarding the difference between amalgam and hybrid resin composite for the outcome of restoration fracture at 36-month follow-up.
Restoration Fracture (96)	159	1 RCT (52)****	RD, −0.01 (−0.07 to 0.06)	7 fewer to 6 more	Very low††,§§,¶¶,†††,§§§§	There is very low certainty evidence regarding the difference between amalgam and hybrid resin composite for the outcome of restoration fracture at 96-month follow-up.
Secondary Caries (36)	166	1 RCT (48)***	RD, −0.01 (−0.04 to 0.02)	4 fewer to 2 more	Very low††,§§,¶¶,†††,¶¶¶¶	There is very low certainty evidence regarding the difference between amalgam and hybrid resin composite for the outcome of secondary caries at 36-month follow-up.
Secondary Caries (96)	159	1 RCT (52)****	RD, −0.04 (−0.09 to 0.02)	9 fewer to 2 more	Very low††,§§,¶¶,†††,####	There is very low certainty evidence regarding the difference between amalgam and hybrid resin composite for the outcome of secondary caries at 96-month follow-up.
Unacceptable Anatomic Form (36)	166	1 RCT (48)***	RD, −0.25 (−0.41 to -0.10)	41 fewer to 10 fewer	Low§§,¶¶,†††	Among participants receiving amalgam restorations, there were 25 fewer events (ranging from 41 fewer to 10 fewer) of unacceptable anatomic form per 100 restorations compared with those receiving hybrid resin composite restorations at 36-month follow-up. Amalgam may decrease the risk of unacceptable anatomic form by an important amount compared with hybrid resin composite at 36-month follow-up.
Unacceptable Anatomic Form (96)	143	1 RCT (46)****	RD, −0.02 (−0.09 to 0.06)	9 fewer to 6 more	Low§§,¶¶,†††	Among participants receiving amalgam restorations, there were 2 fewer events (ranging from 9 fewer to 6 more) of unacceptable anatomic form per 100 restorations compared with those receiving hybrid resin composite restorations at 96-month follow-up. Amalgam may decrease the risk of unacceptable anatomic form by a negligible amount compared with hybrid resin composite at 96-month follow-up.
Unacceptable Marginal Adaptation (36)	166	1 RCT (48)***	RD, −0.02 (−0.05 to 0.02)	5 fewer to 2 more	Very low††,§§,¶¶,†††,*****	There is very low certainty evidence regarding the difference between amalgam and hybrid resin composite for the outcome of unacceptable marginal adaptation at 36-month follow-up.
Unacceptable Marginal Adaptation (96)	143	1 RCT (46)****	RD, −0.03 (−0.10 to 0.05)	10 fewer to 5 more	Very low††,§§,¶¶,†††,†††††	There is very low certainty evidence regarding the difference between amalgam and hybrid resin composite for the outcome of unacceptable marginal adaptation at 96-month follow-up.

eTable 34. Absolute effects (95% CI) and certainty of the evidence for macrofilled resin composite compared with hybrid resin composite for Class I and Class II restorations combined on vital posterior permanent teeth.

OUTCOME (FOLLOW-UP, MO)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT, RISK DIFFERENCE (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE†)	WHAT HAPPENS
Restoration Loss (36)	59	1 randomized controlled trial (14)‡	−0.03 (−0.12 to 0.06)	12 fewer to 6 more	Very low§,¶,#,**,††	There is very low certainty evidence regarding the difference between macrofilled resin composite and hybrid resin composite for the outcome of restoration loss.
Unacceptable Anatomic Form (168)	14	1 randomized controlled trial (7)‡‡	−0.14 (−0.46 to 0.18)	46 fewer to 18 more	Low¶,**,††,§§	Among participants receiving macrofilled resin composite restorations, there were 14 fewer events (ranging from 46 fewer to 18 more) of unacceptable anatomic form per 100 restorations compared with those receiving hybrid resin composite restorations. Macrofilled resin composite may decrease the risk of experiencing unacceptable anatomic form by an important amount compared with hybrid resin composite.

* For the outcomes of postoperative pain and discomfort (36-month follow-up), secondary caries (12-, 36-, and 168-month follow-ups), unacceptable anatomic form (12- and 36-month follow-ups), and unacceptable marginal adaptation (12-, 36-, and 168-month follow-ups), there were 0 events in both treatment arms of the included studies. No studies meeting the selection criteria reported data on caries progression, fracture of the crown, full tooth fracture, longevity of the restoration, need to treat endodontically, oral health–related quality of life, patient discomfort during treatment, patient or parent satisfaction with treatment, pulp vitality, pulpal complications due to infection, pulpal exposure, restoration failure (or repair or replacement of the restoration), restoration fracture, restoration longevity reported in unit of time, restoration survival reported as a hazard ratio, time needed to perform the restoration, tooth loss, anaphylaxis, kidney function, neurobehavioral assessment, physical development, or psychosocial function. † The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. ‡ Loguercio and colleagues.[62] § Rated down 1 level owing to serious issues of risk of bias. ¶ Rated down 2 levels owing to very serious issues of imprecision. # Using a threshold of 0.34%, the lower bound of the confidence interval suggests an important difference favoring macrofilled resin composite, whereas the upper bound suggests an important benefit from hybrid resin composite. ** Rated down 1 level owing to serious issues of indirectness when used to inform clinical recommendations for Class I restorations for moderate and advanced caries lesions on vital posterior permanent teeth. †† Rated down 1 level owing to serious issues of indirectness when used to inform clinical recommendations for Class II restorations for moderate and advanced caries lesions on vital posterior permanent teeth. ‡‡ Espindola-Castro and colleagues.[63] §§ Using a threshold of 1.43%, the lower bound of the confidence interval suggests an important difference favoring macrofilled resin composite, whereas the upper bound suggests an important benefit for hybrid resin composite.

eTable 35. Absolute effects (95% CI) and certainty of the evidence for hybrid resin composite compared with conventional glass ionomer cement for Class II restorations on vital posterior permanent teeth.

OUTCOME (FOLLOW-UP, MO)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT, RISK DIFFERENCE (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE†)	WHAT HAPPENS
Restoration Failure‡ (24)	53	1 RCT§ (not reported)¶	−0.47 (−0.64 to −0.30)	64 fewer to 30 fewer	Low#	Among participants receiving hybrid resin composite restorations, there were 47 fewer events (ranging from 64 fewer to 30 fewer) of restoration failure per 100 restorations compared with those receiving conventional glass ionomer cement restorations at 24-month follow-up. Hybrid resin composite may decrease the risk of experiencing restoration failure by an important amount compared with conventional glass ionomer cement at 24-month follow-up.
Restoration Failure ** **(120)**	60	1 RCT (26)††	−0.07 (−0.17 to 0.04)	17 fewer to 4 more	Low‡‡,§§	Among participants receiving hybrid resin composite restorations, there were 7 fewer events (ranging from 17 fewer to 4 more) of restoration failure per 100 restorations compared with those receiving conventional glass ionomer cement restorations at 10-year follow-up. Hybrid resin composite may decrease the risk of experiencing restoration failure by an important amount compared with conventional glass ionomer at 10-year follow-up.
Restoration Loss (24)	67	1 RCT (not reported)¶	−0.44 (−0.61 to −0.26)	61 fewer to 26 fewer	Low#	Among participants receiving hybrid resin composite restorations, there were 44 fewer events (ranging from 61 fewer to 26 fewer) of restoration loss per 100 restorations compared with those receiving conventional glass ionomer cement restorations at 24-month follow-up. Hybrid resin composite may decrease the risk of experiencing restoration loss by an important amount compared with conventional glass ionomer cement at 24-month follow-up.
Restoration Loss (120)	60	1 RCT (26)††	−0.07 (−0.17 to 0.04)	17 fewer to 4 more	Low‡‡,§§	Among participants receiving hybrid resin composite restorations, there were 7 fewer events (ranging from 17 fewer to 4 more) of restoration loss per 100 restorations compared with those receiving conventional glass ionomer cement restorations 120-month follow-up. Hybrid resin composite may decrease the risk of experiencing restoration loss by an important amount compared with conventional glass ionomer cement 120-month follow-up.
Unacceptable Anatomic Form (24-36)	105	2 RCTs (not reported)¶,††	−0.02 (−0.09 to 0.04)	9 fewer to 4 more	Low‡‡,¶¶	Among participants receiving hybrid resin composite restorations, there were 2 fewer events (ranging from 9 fewer to 4 more) of unacceptable anatomic form per 100 restorations compared with those receiving conventional glass ionomer cement composite restorations. Hybrid resin composite may decrease the risk of experiencing unacceptable anatomic form by an important amount compared with conventional glass ionomer cement.
Unacceptable Marginal Adaptation (24-36)	105	2 RCTs (not reported)¶,††	−0.02 (−0.09 to 0.04)	9 fewer to 4 more	Low‡‡,¶¶	Among participants receiving hybrid resin composite restorations, there were 2 fewer events (ranging from 9 fewer to 4 more) of unacceptable marginal adaptation per 100 restorations compared with those receiving conventional glass ionomer cement restorations. Hybrid resin composite may decrease the risk of experiencing unacceptable marginal adaptation by an important amount compared with conventional glass ionomer cement.

* For the outcomes of postoperative pain and discomfort (1-week and 24-month follow-ups), secondary caries (24-, 36-, 72-, and 120-month follow-ups), unacceptable anatomic form (72- and 120-month follow-ups), and unacceptable marginal adaption (72- and 120-month follow-ups), there were 0 events in both treatment arms of the included studies. No studies meeting the selection criteria reported data on caries progression, fracture of the crown, full tooth fracture, longevity of the restoration, need to treat endodontically, oral health–related quality of life, patient discomfort during treatment, patient or parent satisfaction with treatment, pulp vitality, pulpal complications due to infection, pulpal exposure, restoration fracture, restoration longevity reported in unit of time, restoration survival reported as a hazard ratio, time needed to perform the restoration, tooth loss, anaphylaxis, kidney function, neurobehavioral assessment, physical development, or psychosocial function. † The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. ‡ Restoration failure was defined as restoration loss and restoration fracture by Balkaya and colleagues.[74] § RCT: Randomized controlled trial. ¶ Balkaya and colleagues.[74] # Rated down 2 levels owing to very serious issues of imprecision due to low sample size. ** Restoration failure was defined as restoration loss and restoration fracture by Gurgan and colleagues.[69] †† Gurgan and colleagues.[69] ‡‡ Rated down 2 levels owing to very serious issues of imprecision. §§ Using a threshold of 0.67%, the lower bound of the confidence interval suggests an important difference favoring hybrid resin composite, whereas the upper bound suggests an important benefit of conventional glass ionomer cement. ¶¶ Using a threshold of 0.22%, the lower bound of the confidence interval suggests an important difference favoring hybrid resin composite, whereas the upper bound suggests an important benefit of conventional glass ionomer cement.

eTable 36. Absolute effects (95% CI) and certainty of the evidence for resin-modified glass ionomer cement compared with conventional glass ionomer cement for Class II restorations on vital posterior permanent teeth.

OUTCOME (FOLLOW-UP, MO)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT, RISK DIFFERENCE (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE†)	WHAT HAPPENS
Restoration Failure‡ (24)	38	1 RCT§ (not reported)¶	−0.71 (−0.93 to −0.48)	93 fewer to 48 fewer	Low#	Among participants receiving resin-modified glass ionomer cement restorations, there were 71 fewer events (ranging from 93 fewer to 48 fewer) of restoration failure per 100 restorations compared with those receiving conventional glass ionomer cement restorations. Resin-modified glass ionomer cement may decrease the risk of experiencing restoration failure by an important amount compared with conventional glass ionomer cement.
Restoration Loss (24)	38	1 RCT (not reported)¶	−0.35 (−0.58 to −0.12)	58 fewer to 12 fewer	Low#	Among participants receiving resin-modified glass ionomer cement restorations, there were 35 fewer events (ranging from 58 fewer to 12 fewer) of restoration loss per 100 restorations compared with those receiving conventional glass ionomer cement restorations. Resin-modified glass ionomer cement may decrease the risk of experiencing restoration loss by an important amount compared with conventional glass ionomer cement.
Unacceptable Anatomic Form (24)	38	1 RCT (not reported)¶	−0.48 (−0.74 to −0.23)	74 fewer to 23 fewer	Low#	Among participants receiving resin-modified glass ionomer cement restorations, there were 48 fewer events (ranging from 74 fewer to 23 fewer) of unacceptable anatomic form per 100 restorations compared with those receiving conventional glass ionomer cement restorations. Resin-modified glass ionomer cement may decrease the risk of experiencing unacceptable anatomic form by an important amount compared with conventional glass ionomer cement.
Unacceptable Marginal Adaptation (24)	38	1 RCT (not reported)¶	−0.48 (−0.74 to −0.23)	74 fewer to 23 fewer	Low#	Among participants receiving resin-modified glass ionomer cement restorations, there were 48 fewer events (ranging from 74 fewer to 23 fewer) of unacceptable marginal adaptation per 100 restorations compared with those receiving conventional glass ionomer cement restorations. Resin-modified glass ionomer cement may decrease the risk of experiencing unacceptable marginal adaptation by an important amount compared with conventional glass ionomer cement.

* No studies meeting the selection criteria reported data on caries progression, fracture of the crown, full tooth fracture, longevity of the restoration, need to treat endodontically, oral health–related quality of life, patient discomfort during treatment, patient or parent satisfaction with treatment, postoperative pain and discomfort, pulp vitality, pulpal complications due to infection, pulpal exposure, restoration fracture, restoration longevity reported in unit of time, restoration survival reported as a hazard ratio, secondary caries, time needed to perform the restoration, tooth loss, anaphylaxis, kidney function, neurobehavioral assessment, physical development, or psychosocial function. † The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. ‡ Reasons for restoration failure were not specified by Ercan and colleagues.[68] § RCT: Randomized controlled trial. ¶ Ercan and colleagues.[68] # Rated down 2 levels owing to very serious issues of imprecision due to low sample size.

eTable 37. Absolute effects (95% CI) and certainty of the evidence for hybrid resin composite (conventional restorative treatment) compared with conventional glass ionomer cement (atraumatic restorative treatment) for Class II restorations on vital posterior permanent teeth.

OUTCOME (FOLLOW-UP)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT, RISK DIFFERENCE OR MEAN DIFFERENCE (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE†)	WHAT HAPPENS
Restoration Failure‡ (24 Mo)	271	1 randomized controlled trial (not reported)§	Risk difference, −0.02 (−0.05 to 0.02)	5 fewer to 2 more	Very low¶,#,**	There is very low certainty evidence regarding the difference between hybrid resin composite restorations (conventional restorative treatment [CRT]) and conventional glass ionomer cement restorations (atraumatic restorative treatment [ART]) for the outcome of restoration failure.
Time Needed to Perform Restoration (Posttreatment)	272	1 randomized controlled trial (not reported)§	Mean difference, 0.87 min (0.32 to 1.42)	0.32 more to 1.42 more	Moderate¶	Hybrid resin composite (CRT) increased the time needed to perform restoration by 0.87 minutes (52.2 seconds) (ranging from 0.32 to 1.42 minutes longer) when compared with conventional glass ionomer cement (ART) restorations. By comparison, the mean time needed to perform restoration in the conventional glass ionomer cement (ART) arm was 20.5 minutes.

* For the outcome of pulpal exposure (immediately following treatment), there were 0 events in both treatment arms of the included study. No studies meeting the selection criteria reported data on caries progression, fracture of the crown, full tooth fracture, longevity of the restoration, marginal need to treat endodontically, oral health–related quality of life, patient discomfort during treatment, patient or parent satisfaction with treatment, postoperative pain and discomfort, pulp vitality, pulpal complications due to infection, secondary caries, restoration fracture, restoration longevity reported in unit of time, restoration loss, restoration survival reported as a hazard ratio, tooth loss, unacceptable anatomic form, unacceptable marginal adaptation, anaphylaxis, kidney function, neurobehavioral assessment, physical development, or psychosocial function. † The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. ‡ Restoration failure was defined as marginal discoloration or staining, unacceptable anatomic form, and unacceptable marginal adaptation by Molina and colleagues.[75] § Molina and colleagues.[75] ¶ Rated down 1 level owing to serious issues of risk of bias. # Rated down 2 levels owing to very serious issues of imprecision. ** Using a threshold of 0.31%, the lower bound of the confidence interval suggests an important difference favoring hybrid resin composite (CRT), whereas the upper bound suggests an important benefit of conventional glass ionomer cement (ART).

eTable 38. Absolute effects (95% CI) and certainty of the evidence for nanocomposite compared with hybrid resin composite for Class I and Class II restorations combined on vital posterior permanent teeth.

OUTCOME (FOLLOW-UP)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT, RISK DIFFERENCE (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE†)	WHAT HAPPENS
Postoperative Pain and Discomfort (Up to 1 Mo)	157	3 randomized controlled trials (77)‡,§,¶	0.00 (−0.06 to 0.06)	6 fewer to 6 more	Very low#,**,††,‡‡	There is very low certainty evidence regarding the difference between nanocomposite and hybrid resin composite for the outcome of postoperative pain and discomfort.
Unacceptable Marginal Adaptation (Up to 36 Mo)	157	3 randomized controlled trials (77)‡,§,¶	−0.02 (−0.09 to 0.04)	9 fewer to 4 more	Very low#,**,‡‡,§§	There is very low certainty evidence regarding the difference between nanocomposite and hybrid resin composite for the outcome of unacceptable marginal adaptation.

* For the outcomes of restoration failure, restoration loss, secondary caries, and unacceptable anatomic form, there were 0 events in both treatment arms of the included studies. No studies meeting the selection criteria reported data on caries progression, fracture of the crown, full tooth fracture, longevity of the restoration, need to treat endodontically, oral health–related quality of life, patient discomfort during treatment, patient or parent satisfaction with treatment, pulp vitality, pulpal complications due to infection, pulpal exposure, restoration fracture, restoration longevity reported in unit of time, restoration survival reported as a hazard ratio, time needed to perform the restoration, tooth loss, anaphylaxis, kidney function, neurobehavioral assessment, physical development, or psychosocial function. † The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. ‡ Hoseinifar and colleagues.[64] § Palaniappan and colleagues.[65] ¶ Dresch and colleagues.[66] # Rated down 1 level owing to serious issues of risk of bias. ** Rated down 2 levels owing to very serious issues of imprecision. †† Using a threshold of 0.38%, the lower bound of the confidence interval suggests an important difference favoring nanocomposite, whereas the upper bound suggests an important benefit of hybrid resin composite. ‡‡ Rated down 1 level owing to serious issues of indirectness when used to inform clinical recommendations for Class II restorations for moderate and advanced caries lesions on vital posterior permanent teeth. §§ Using a threshold of 0.51%, the lower bound of the confidence interval suggests an important difference favoring nanocomposite, whereas the upper bound suggests an important benefit of hybrid resin composite.

eTable 39. Absolute effects (95% CI) and certainty of the evidence for resin-modified glass ionomer cement compared with conventional glass ionomer cement for root surface caries lesions on vital anterior and posterior permanent teeth combined.

OUTCOME (FOLLOW-UP, MO)*	RESTORATIONS, NO.	STUDIES (PARTICIPANTS), NO.	ABSOLUTE EFFECT, RISK DIFFERENCE (95% CI)	ANTICIPATED ABSOLUTE EFFECTS, 95% CI	CERTAINTY OF THE EVIDENCE (GRADE†)	WHAT HAPPENS
Restoration Failure‡ (12-24)	147	1 randomized controlled trial (not reported)§	0.01 (−0.11 to 0.13)	11 fewer to 13 more	Low¶,#	Among participants receiving resin-modified glass ionomer cement restorations, there was 1 more event (ranging from 11 fewer to 13 more) of restoration failure per 100 restorations compared with those receiving conventional glass ionomer cement restorations. Resin-modified glass ionomer cement may increase the risk of experiencing restoration failure by a negligible amount compared with conventional glass ionomer cement.

* No studies meeting the selection criteria reported data on caries progression, fracture of the crown, full tooth fracture, longevity of the restoration, marginal discoloration or staining, need to treat endodontically, oral health–related quality of life, patient discomfort during treatment, patient or parent satisfaction with treatment, postoperative pain and discomfort, pulp vitality, pulpal complications due to infection, pulpal exposure, restoration fracture, restoration longevity reported in unit of time, restoration loss, restoration survival reported as a hazard ratio, secondary caries, time needed to perform the restoration, tooth loss, unacceptable anatomic form, unacceptable color match, unacceptable marginal adaptation, anaphylaxis, kidney function, neurobehavioral assessment, physical development, or psychosocial function. † The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group grades of evidence are as follows: High certainty: Very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very low certainty: Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect. ‡ Restoration failure was defined as restoration loss, restoration fracture, and secondary caries by Hayes and colleagues.[76] § Hayes and colleagues.[76] ¶ Rated down 2 levels owing to very serious issues of imprecision. # Using a threshold of 1.51%, the lower bound of the confidence interval suggests an important benefit of resin-modified glass ionomer cement, whereas the upper bound suggests an important benefit of conventional glass ionomer cement.

OREGON BOARD OF DENTISTRY

NEWS

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President's Message

Charles 'Chip' Dunn

Dear Oregon Dental Community, As a proud public member of the board, I am deeply honored to serve as the newly elected President of the Oregon Board of Dentistry. It is with great pride and reassurance that I take on this role, knowing that there are dedicated dental professionals who regulate the dental field with the highest regard and respect for public well-being. The presence of dental professionals in our regulatory board provides a sense of security and confidence to the public. We understand the importance of upholding the highest standards in dental practice, ensuring that patients receive safe and quality care. With your expertise and commitment, we can maintain the integrity of the dental profession and foster trust within our community.

As a public member, my perspective is shaped by the understanding that our primary responsibility is to safeguard the interests of the public. I am dedicated to working hand in hand with dental professionals to ensure that our regulations and oversight prioritize patient safety and welfare. Together, we can strike a balance between the evolving landscape of dentistry and the need for stringent regulations that uphold public health.

I want to express my heartfelt appreciation to the dental professionals who tirelessly contribute their expertise and knowledge to the Oregon Board of Dentistry, as well as, to all the dental professionals that serve our Oregon residence. Your commitment to excellence and unwavering dedication to serving the public are invaluable. It is through your collective efforts that we can continue to enhance the dental profession and meet the evolving needs of our community.

In closing, I want to reaffirm my commitment to representing the public and promoting the highest standards of dental practice. With the collaborative spirit and expertise of our dental professionals, we will ensure that the dental field in Oregon remains regulated with the utmost care and consideration for public well-being. ■

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What's Inside

A Word From the Executive Director

Stephen Prisby

One of the perks of my job is to work with a new Oregon Board of Dentistry (OBD) President every year. It was my honor to present a certificate recognizing Dr. Jose Javier for his service as OBD President from 4/2022 – 4/2023. The Board elected our public members to be the officers from April 2023 until April 2024. Chip Dunn will serve as OBD President and Jennifer Brixey will serve as OBD Vice President.

The 2023 Legislative session concluded with new pieces of legislation that affect our Licensees and all state agencies.

New laws and OBD Committee work have funneled a variety of rules to our Board and to public rulemaking hearings.

Please see the article later in this newsletter for more information on 17 rule changes, which were effective July 1, 2023.

Once again, the only piece of legislation that came from the OBD was our budget bill, HB 5011. The OBD budget included provisions to help fund the Oregon Wellness Program and there is an article in this newsletter to summarize this program which is available to all OBD Licensees. The Legislature approved some fee increases as well. The fee increases are for initial applications and the license renewal fee went up modestly for dentists - an increase of $50 and for dental hygienists and dental therapists - an increase of $25.

The OBD last implemented fee increases in 2015.

I suggest you take a few minutes and read the articles in this newsletter to review the recent rule changes and other important issues the OBD Staff felt was important for our Licensees to be aware of and stay up to date on as well.

If you have any questions or comments, I look forward to hearing from you.

Stephen.Prisby@obd.oregon.gov or 971-673-3200

Board Openings in Spring of 2024

The Oregon Board of Dentistry consists of ten board members. Six must be Oregon licensed dentists, one of which must be a dental specialist, two dental hygienists, and two public members. In the spring of 2024, three board member positions will be available when the second/final terms of service conclude for Dr. Jose Javier, Alicia Riedman, RDH and Jennifer Brixey.

A Board term of service is four years, with board members eligible to serve two terms. The Governor appoints the board member and the Senate confirms them. The Governor's office will review and consider the applicant's geographic location, ethnic background, diversity, disciplinary history (if any) and other factors important to the Governor. An Oregon licensed dentist, who resides in Oregon, may apply for a dentist position on the Board. An Oregon licensed dental hygienist, who resides in Oregon, may apply for a dental hygienist position on the Board. The public member also of course must be an Oregon resident.

The professional associations usually review the Board openings and submit names for consideration to serve on the Board. However, anyone who is interested and qualified may submit their name for consideration to serve on the Board. Someone does not need an association's support or endorsement to be a board member. The Oregon Board of Dentistry has been very fortunate that there has been good interest in serving on the Board. The Board rarely has vacancies left unfilled due to lack of candidates.

There is more information about service on the Board in this Newsletter. On the OBD website at the bottom of the OBD home page under Board/Staff Openings, there is a document providing an overview of desired requirements of a board member, responsibilities and other important information with links to the Governor's page for board service as well.

Interested in becoming a board member?

Thank you for your interest in becoming an Oregon Board of Dentistry (OBD) Board Member. Volunteers like you are crucial to the foundation of a government duly represented by its citizens.

A Board term of service is four years. Board members may serve two terms. The Governor appoints the Board member and the Senate confirms them. The Governor's office will review and consider the applicant's geographic location, ethnic background, diversity, disciplinary history (if any) and other factors important to the Governor.

◊ An Oregon licensed Dentist, who resides in Oregon, may apply for a dentist position on the Board.
◊ An Oregon licensed Dental Hygienist, who resides in Oregon, may apply for a dental hygienist position on the Board.
◊ Any interested Oregon citizen may apply for a public position on the Board.

An OBD Board Member is actively involved, within the context of the agency's regulatory governance model, policy-making, strategic planning, and oversight responsibilities necessary for the success and well-being of the OBD, consumers, Licensees and other stakeholders.

Some Requirements:
◊ Commitment to the mission of the OBD and willing to actively seek information that helps guide discussions and decisions regarding achievement of the mission.
◊ Commitment to complete training and professional development required by State of Oregon.
◊ Understanding and acceptance of the OBD's legal, fiscal and ethical responsibilities to OBD and Oregon.
◊ Maintain the confidentiality of relevant investigatory information and other private records.
◊ Active participation with other Board members in assessing the performance of the OBD's Executive Director.
◊ Active collaboration with other Board members in decision making.
◊ Ability to maintain an objective viewpoint on issues that impact Licensees you may be familiar with or know in some way.
◊ Ability to maintain an objective viewpoint on larger issues that impact oral health care in the state.
◊ Willingness to volunteer to serve on committees or to serve when asked by the Chair.
◊ Willingness to volunteer to attend national meetings with American Association of Dental Boards and testing agencies.
◊ Support OBD decisions by speaking with one voice.
◊ Prepare in advance for OBD meetings.
◊ Regular attendance at and active meaningful participation in OBD meetings (there are typically six meetings per year) and related OBD committee meetings, strategic planning and ad hoc committees.
◊ Maintain a positive working relationship with the OBD Board Members, Executive Director and OBD Staff.
◊ Understanding of Executive Limitations: Constraints on Board authority that establish the prudence and ethical boundaries within which all Board activity and decisions must take place.
◊ Understanding of Governance Process: Understanding the ways in which the Board conceives, carries out and monitors its own tasks.
◊ Understanding of Board – Executive Director Linkage: The delegation of power between the Board and the Executive Director and monitoring its use.
◊ Understanding the roles and duties each Board member plays and the executive director: respecting these boundaries and roles.

It truly is a volunteer position, with Board members needing to be engaged in all areas that impact safe dentistry, dental therapy & dental hygiene - licensure, discipline, education, etc… Statute and rule allow a per diem which in 2022 -2023 was set at $157 per full day of board service.

It is estimated that Board Members typically attend 6 board meetings and 2 - 4 committee meetings per year which roughly translates to about 120 – 140 hours of work per year. The Board also undergoes strategic planning every three to four years and updates rules in the Dental Practice Act almost annually.

The OBD strives to meet in person and utilizes remote meetings in response to pandemics, weather issues or for emergency meetings to consult on unsafe licensees that need the Board's immediate attention.

For more information you can review Oregon Revised Statutes - ORS 679.230 & 679.250 and the OBD website to look at past history of meetings and minutes, newsletters along with other Board documents.

Please contact the executive director if you have any questions or interest in serving on the Board.

Stephen.Prisby@obd.oregon.gov ■

Board Members

CHARLES 'CHIP' DUNN.
PRESIDENT
HAPPY VALLEY

SECOND TERM EXPIRES 2025

JENNIFER BRIXEY
VICE PRESIDENT
PORTLAND

SECOND TERM EXPIRES 2024

Reza Sharifi, D.M.D.
PORTLAND

SECOND TERM EXPIRES 2027

Alicia Riedman, R.D.H.
EUGENE

SECOND TERM EXPIRES 2024

JOSE JAVIER D.D.S.
BEND

SECOND TERM EXPIRES 2024

AARATI KALLURI, D.D.S.
HILLSBORO

FIRST TERM EXPIRES 2025

SHEENA KANSAL, D.D.S.
PORTLAND

FIRST TERM EXPIRES 2025

TERRENCE CLARK, D.M.D.
WEST LINN

FIRST TERM EXPIRES 2026

MICHELLE ALDRICH, D.M.D.
SALEM

FIRST TERM EXPIRES 2026

SHARITY LUDWIG, R.D.H.
BEND

FIRST TERM EXPIRES 2026

Scheduled Board Meetings

2023 -24

- October 27, 2023
- December 15, 2023
- February 23, 2024
- April 26, 2024
- June 14, 2024
- August 23, 2024
- October 25, 2024
- December 13, 2024

New OBD Advisory Committee

At the August 25, 2023 Board Meeting the Oregon Board of Dentistry (OBD) will consider establishing a new standing Advisory Committee named the "Dental Assistant Workforce Shortage Advisory Committee (DAWSAC)" per ORS 679.280, to review, discuss and make recommendations to the Board on addressing workforce shortages in accordance with HB 3223 (2023).

The section of HB 3223 relevant to this is included for reference:

> SECTION 5. (1) The Oregon Board of Dentistry shall convene an advisory committee of at least seven members to study the dental assistant workforce shortage and to review the requirements for dental assistant certification in other states. The committee shall provide advice to the board on a quarterly basis on how to address the dental workforce shortage in this state.
>
> (2) (a) In appointing members to the advisory committee, the board shall prioritize diversity of geographic representation, background, culture and experience.
>
> (b) A majority of the members appointed to the committee must have experience workinng as dental assistants.
>
> SECTION 6. This 2023 Act takes effect on the 91st day after the date on which the 2023 regular session of the Eighty-second Legislative Assembly adjourns sine die.

This advisory committee would meet no less than four times per calendar year once established, and generally be scheduled concurrently with regular OBD Board Meetings. The OBD President could designate two Co-Chairs of the Committee whom will be OBD Board Members. Preference could be given to Board Members who have past experience working as a dental assistant.

The advisory committee could include five representatives from the Oregon dental assistant community who are currently or have worked as an Oregon dental assistant. The OBD President could select the members, and utilize the legislative criteria, if more than five people volunteer to serve on this advisory committee.

The advisory committee could also include one representative from each of the professional associations: The Oregon Dental Association, The Oregon Dental Hygienists' Association

and the Oregon Dental Assistants Association and eventually one from the Oregon Dental Therapy Association (should that be established).

The Advisory Committee members should bring relevant topics and agenda items to the meetings, be meaningfully engaged on the relevant issues, offer solutions and assist in gathering information.

The inaugural advisory committee meeting would most likely be scheduled for fall of 2023, in conjunction with the Oct 27th Board Meeting. ■

INVITATION TO PARTICIPATE

ANGELA SMORRA D.M.D.

The Board of Dentistry and other state agencies operate under a system of administrative rules to ensure fairness and consistency in procedures and decisions. Periodically, these Oregon Administrative Rules (OAR) must be amended in response to evolving standards, new statutes and other circumstances. OAR are written and amended within the agency's statutory authority granted by the Legislature. Rules go through various stages of review before being permanently adopted. The Board strives to publicly share proposed changes through Board meetings and Committee meetings along with updates to all licensees and interested parties through email as well.

All members of our dental profession, and members of the public, are welcome to attend Board and Committee Meetings which are open to the public. Your feedback and participation strengthen our community and can bring new ideas to the table.

The Board has standing Committees and may create new ones. These Committees are comprised of representatives from all three professional associations representing dentists, dental hygienists and dental assistants. The Committees also include representatives from the dental therapy community as well - either licensees or educators. Committees discuss and review potential changes to the OAR.

The full Board considers the Committees' recommendations and can move them to a public rulemaking hearing for public testimony or back to a Committee to be refined and discussed further. Official notice of public rulemaking has been discussed at various board and committee meetings. We also provide information to all of our licensees by posting information on the OBD's website, sharing through email blasts and publishing in the Secretary of State's Bulletin.

The Board held a public rulemaking hearing on May 10, regarding these 17 rule changes. The Board amended 13 rules, repealed 3 rules and created 1 new rule. They became effective July 1, 2023. A current Dental Practice Act is available on our website.

OBD Rule Changes

The Oregon Board of Dentistry and other state agencies operate under a system of administrative rules to ensure fairness and consistency in procedures and decisions. Periodically, these Oregon Administrative Rules (OARs) must be adopted, amended or repealed. OARs are written within the agency's statutory authority granted by the Legislature.

Official Notice of rulemaking is provided in the Secretary of State's Bulletin. Due to space constraints in this newsletter, a brief summary of the rule changes is provided. The Board's website and staff can provide you an updated Dental Practice Act or other documents related to the rule changes.

RULE CHANGES – 17 rule changes effective July 1, 2023

CHAPTER 818
OREGON BOARD OF DENTISTRY
FILING CAPTION: The Board is amending 13 rules, repealing 3 rules and creating 1 new rule.
EFFECTIVE DATE: 07/01/2023

AMEND: 818-001-0002
RULE TITLE: Definitions
RULE SUMMARY: Removes reference to CPR to clarify BLS as the requirement.

AMEND: 818-012-0005
RULE TITLE: Scope of Practice
RULE SUMMARY: Changes effective date of implant rule and splits Botulinum Type A /dermal filler requirement into 10 hours each.

AMEND: 818-012-0007
RULE TITLE: Procedures, Record Keeping and Reporting of Vaccines

RULE SUMMARY: Amending title of rule to add "of Vaccines" for clarification.

AMEND: 818-012-0030
RULE TITLE: Unprofessional Conduct
RULE SUMMARY: Adds in requirement to comply with health care interpreter law and clarifies patient records rule.

AMEND: 818-012-0032
RULE TITLE: Diagnostic Records
RULE SUMMARY: Clarifies what information should be included in patient records.

AMEND: 818-015-0005
RULE TITLE: General Provisions
RULE SUMMARY: Clarifies acceptable advertising for licensees.

REPEAL: 818-015-0007
RULE TITLE: Specialty Advertising
RULE SUMMARY: Repealing this rule.

AMEND: 818-021-0012
RULE TITLE: Specialties Recognized
RULE SUMMARY: Clarifies specialties recognized by the Board in rule.

AMEND: 818-021-0015
RULE TITLE: Certification as a Specialist
RULE SUMMARY: Removes reference to repealed rule.

AMEND: 818-021-0017
RULE TITLE: Application to Practice as a Specialist
RULE SUMMARY: Adding one hour pain management requirement to be consistent with other rules.

REPEAL: 818-021-0030
RULE TITLE: Dismissal from Examination
RULE SUMMARY: Repeal outdated exam rule.

REPEAL: 818-021-0040
RULE TITLE: Examination Review Procedures
RULE SUMMARY: Repeal outdated exam rule.

AMEND: 818-021-0060
RULE TITLE: Continuing Education — Dentists
RULE SUMMARY: Removes examination requirement, clarifies certificate of completion details and also changes effective date of dental implant rule.

AMEND: 818-021-0070
RULE TITLE: Continuing Education — Dental Hygienists
RULE SUMMARY: Removes examination requirement and clarifies certificate of completion details.

AMEND: 818-021-0076
RULE TITLE: Continuing Education - Dental Therapists
RULE SUMMARY: Removes examination requirement and clarifies certificate of completion details.

ADOPT: 818-021-0084
RULE TITLE: Temporary Voluntary Practice Approval
RULE SUMMARY: Implementing a new rule to be in compliance with HB 4096 (2022), for temporary volunteer practice limited to 30 days or less per year.

AMEND: 818-042-0040
RULE TITLE: Prohibited Acts
RULE SUMMARY: Clarifies that dental assistants can perform teeth whitening.

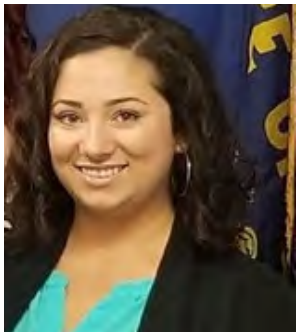
Effective August 1, 2023, the OBD increased our fees. The fee increases are needed to cover the ongoing costs and expenses of the OBD. The last fee increase was in 2015. The OBD is funded primarily (96%) by its Licensees, so the fee increase is needed and justified to cover the OBD's related expenses in its operation.

<u>818-001-0087</u>
<u>Fees</u>
(1) The Board adopts the following fees:
(a) Biennial License Fees:
(A) Dental —$440
(B) Dental — retired — $0
(C) Dental Faculty — $385
(D) Volunteer Dentist — $0
(E) Dental Hygiene —$255
(F) Dental Hygiene — retired — $0
(G) Volunteer Dental Hygienist — $0
(H) Dental Therapy - $255
(I) Dental Therapy - retired - $0
(b) Biennial Permits, Endorsements or Certificates:
(A) Nitrous Oxide Permit — $40
(B) Minimal Sedation Permit — $75
(C) Moderate Sedation Permit — $75
(D) Deep Sedation Permit — $75
(E) General Anesthesia Permit — $140
(F) Radiology — $75
(G) Expanded Function Dental Assistant — $50
(H) Expanded Function Orthodontic Assistant — $50
(I) Instructor Permits — $40
(J) Dental Hygiene Restorative Functions Endorsement — $50
(K) Restorative Functions Dental Assistant — $50
(L) Anesthesia Dental Assistant — $50
(M) Dental Hygiene, Expanded Practice Permit — $75
(N) Non-Resident Dental Background Check - $100.00

(c) Applications for Licensure:
(A) Dental — General and Specialty — $445
(B) Dental Faculty — $405
(C) Dental Hygiene — $210
(D) Dental Therapy - $210
(E) Licensure Without Further Examination — Dental, Dental Hygiene and Dental Therapy — $890
(F) Licensure Without Further Examination — Dental Hygiene and Dental Therapy — $820.
(d) Examinations:
(e) Jurisprudence — $0
(f) Duplicate Wall Certificates — $50.
(2) Fees must be paid at the time of application and are not refundable.
(3) The Board shall not refund moneys under $5.01 received in excess of amounts due or to which the Board has no legal interest unless the person who made the payment or the person's legal representative requests a refund in writing within one year of payment to the Board. ■

Sedation course warning

Samantha Plumlee, Examination & Licensing Manager



As the licensing manager for the Board, I am frequently asked by dentists, "will the Board accept a minimal sedation course that is completed entirely online?". The answer is, and always has been, NO.

The Oregon Dental Practice Act, OAR 818-026-0050(1)(c) states that applicants for minimal sedation permits must complete "a comprehensive training program consisting of at least 16 hours of training [which] 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".

The relevant section of the current ADA Guidelines for Teaching Pain Control and Sedation reads: "Competency courses in inhalation sedation techniques must afford participants with sufficient clinical experience to enable them to achieve competency. This experience must be provided under the supervision of qualified faculty and must be evaluated. The course director must certify the competency of participants upon satisfactory completion of training. Records of the didactic instruction and clinical experience, including the number of patients treated by each participant must be maintained and available". Additionally, the ADA Guidelines state "Competency courses must be presented where adequate facilities are available for proper patient care, including drugs and equipment for the management of emergencies".

Online courses that do not include hands-on clinical experience demonstrated by the course attendee and supervised/evaluated by qualified faculty, do not meet the requirements outlined in the ADA Guidelines above, and are therefore not acceptable when applying for a minimal sedation permit.

In recent years, we have seen an uptick in CE providers offering courses in minimal sedation that make statements such as, this course "can be completed from the safety and comfort of your own home", or "by taking this series, one does not have to take off work and travel". These statements sound too good to be true because they are. CE providers may tell unsuspecting dentists that their course does meet current ADA guidelines, because the course includes a live-stream or video of oral sedation procedures being performed on a patient by a faculty member. The Oregon Board of Dentistry does not consider these types of "clinical" course elements to be in adherence with the current ADA Guidelines. While these types of courses may be allowable in some states, this is not the case for Oregon.

Before investing your hard-earned money in a sedation CE course, please be vigilant and review the rules set forth by the Oregon Dental Practice Act to ensure that your selected course will meet Oregon's requirements. If you ever have questions about whether a course will meet our requirements, I urge you to contact our office and ask questions prior to registering for a sedation course. ■

818-021-0115
DISPLAY OF LICENSES

Every licensee of the Board shall have conspicuously displayed their current license in every office where that licensee practices in plain sight of the licensee's patients.

Licenses are available for printing 24/7 on the licensee portal!

https://online.oregondentistry.org/#/

Dental Implant Rule Changes
New CE Requirements Effective January 2024

Beginning January 1, 2024, Oregon dentists will be required to complete 56 hours of hands on clinical implant course(s), at an appropriate postgraduate level, prior to surgically placing dental implants. The Oregon Board of Dentistry (OBD) recommends that proof of meeting the training requirements be maintained indefinitely, as copies may be requested at random audits or complaint investigations.

Graduates of specialty training programs in Oral and Maxillofacial Surgery, Periodontics, and Prosthodontics that comply with CODA standard 4 curriculum guidelines (or similar educational requirements) who have been trained to competency in surgical implant placement may qualify to surgically place implants with documentation of completing the required training.
Only hours completed as part of CODA accredited graduate dental programs, or through education providers that are AGD PACE or ADA CERP approved will qualify to meet the initial 56-hour training requirement.

Additionally, beginning January 1, 2024, Oregon dentists will be required to complete seven hours of continuing education related to the placement and/or restoration of dental implants each licensure renewal period. Dentists renewing in Spring 2024, and all subsequent renewing dentists, will be required to complete the required 7 hours of dental implant CE to be in compliance, if they are placing dental implants.

Below are the most frequently asked questions from our Implant Rules FAQ document on the OBD website. For the full document, please visit: https://www.oregon.gov/dentistry

What language (effective January 1, 2024) was added to the Scope of Practice Rule OAR 818- 012-0005?

(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.

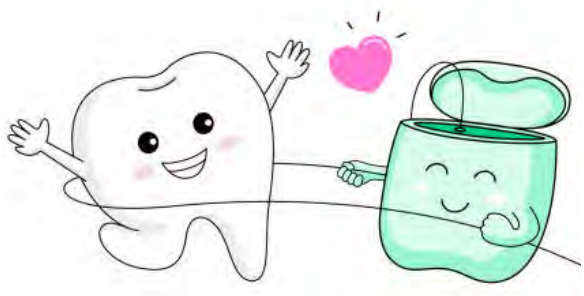
(5)A dentist placing endosseous implants must complete at least seven (7) hours of continuing education related to the placement and or restoration of dental implants every licensure renewal period (Effective January 1, 2024.)

What language (effective January 1, 2024) was added to the Continuing Education Rules of OAR 818-021-0060?

(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.)

How and why did the OBD decide to implement these rule changes regarding dental implants?

The OBD investigated 82 dental implants cases between February 2014 and August 2017. Of those cases, 41% resulted in Disciplinary Action, which was equally distributed between specialists and general practitioners. During Strategic Planning in 2016, the OBD identified dental implant complications and the subsequent complaints as a significant problem in Oregon. Dental implant safety was codified in the OBD's 2017-2020 Strategic Plan as a priority issue, and it has remained an ongoing safety concern of the Board through the present. At the April 21, 2017 Board Meeting, in order to effectively protect the public, and per ORS 679.280, the OBD established an ad hoc Committee named the "Dental Implant Safety Workgroup" to research, review, and discuss dental implants, implant complications, and the resulting investigations. The Workgroup's ultimate goal was to advise the OBD on the most effective actions to protect the public and educate dentists regarding dental implants. The Workgroup included OBD Board Members, OBD Staff and Licensees (both specialists and general practitioners).



If you would like more detail on the communications and timeline for the dental implant rule changes, you can find that document on the home page of the OBD website: https://www.oregon.gov/dentistry

I am concerned that I will not be able to obtain proof of completion of my 56 hours of hands on clinical implant training, because some or all of those hours were completed long ago. Many records retention policies limit to seven years or less. Will I just be "out of luck" if I can't pull together proof of certain courses?

This information will be reviewed on a case-by-case basis, typically as part of a CE audit or an investigation. It is expected that the Licensee would put in their best effort to obtain this information in the event that the training was completed many years ago. The Board will review all relevant information and circumstances before taking any action.

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

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 OAR 818-012-0005(4).

Does the course need to include practice on human patients? Or can it be on a manikin/typodont or an animal jaw?

The Board does not specify whether or not the implants need to be placed in a human. As long as the course meets the requirements of OAR 818-012-0005(4) it is acceptable.

Do the 56 hours of hands on clinical course(s) need to be direct patient care? Or can didactic course instruction be included in the 56 hours?

The Board defers to the course instructor to define "clinical hands on," and determine how many hours of the course are dedicated to topics and format as stated in the rule. This could include some didactic instruction, provided it is under direct supervision as stated in the rule. ■

OHP Now Covers Dental Therapist Services

Oregon Health Authority | Oregon Health Plan

Dental practices with licensed dental therapists on their care team can now bill OHP for the services they provide.

To do this:

- The licensed dental therapist must enroll with OHA. To find the forms to complete and submit to OHA, visit the OHP Provider Enrollment page (search for "non-payable provider" forms).
- When billing for services provided by the dental therapist, the clinic must enter the therapist as the rendering provider.

To learn more about billing:

- For services to coordinated care organization (CCO) members, please contact the member's CCO.
- For services to other OHP members, visit the OHP Billing page.

To provide care, dental therapists must:

- Perform under the supervision of a dentist and
- Have a collaborative agreement with the supervising dentist on file with the Oregon Board of Dentistry. The agreement outlines the level of supervision and the dentist's requirements for how the dental therapist will provide care.

Learn more about dental therapy on the Oregon Board of Dentistry website ■

Frequently Asked Questions

Q: Can I have a working interview?

A: Individuals who are waiting to get licensed or certified in Oregon cannot perform those duties that are required for licensure or certification without first becoming licensed or certified in Oregon. Under OAR 818-012-0010(4) it is Unacceptable Patient Care to permit any person to perform duties for which the person is not licensed or certified. Only persons holding an active license or certification can perform working interviews. Pursuant to OAR 818-021-0115 and OAR 818-042-0020 (3) all licenses and/or certifications must be posted and visible to people receiving services in the premises.

TIPS FOR AVOIDING COMPLAINTS BEING FILED WITH THE BOARD

By law, the Board is required to conduct an investigation of every complaint received. Board investigations take up your valuable time and may have been avoided with clear communication and good patient relations. There are recurring themes in the complaints the Board receives. Following are a few tips that are worth reviewing regularly and should assist you in preventing complaints being filed by frustrated patients.

- Train front-office personnel in providing information to your patients and potential patients in a friendly and courteous manner. Be sure they understand the importance of confidentiality. Also, any discussions about fees should include caveats about any additional services that may need to be performed. For instance, if a potential patient calls wanting to know the cost of an extraction, the caller should also be advised that there may be other services and fees required such as for examination and x-rays.

- Provide patients with a written copy of your office procedures including fees, payment expectations, insurance filings, management of pediatric patients, cancellations and patient responsibilities.

- Be specific with patients regarding the treatment plan and procedures that you will be following and the meaning of various terms.

- Document in the patient record that you have discussed the treatment plan, various options and risks with the patient and have answered the patient's questions. With some procedures, a signed consent form is appropriate prior to starting treatment. Do not perform any procedure without the patient's informed consent.

- Pre-authorize treatment to be done with the patient's insurance company prior to performing the procedure and share the outcome of the prior authorization with the patient before beginning treatment.

- Document all procedures performed, anesthesia administered, x-rays taken, treatment complications, etc. in the patient record. If it isn't documented – it can be argued that it didn't happen! Documentation is your best defense. No one has ever been disciplined by the Board for over documenting.

- If in doubt about your diagnosis or treatment plan, consult with a colleague or a specialist.

- If a patient is dissatisfied with the treatment received, or the outcome, discuss their concerns with them personally and immediately. Do not be defensive, listen to the patient's concerns and work with them for a mutually acceptable outcome.

- Delegate to dental hygienists, dental therapists and dental assistants only those functions that they are legally permitted to perform.

- Make sure that everyone in your practice/location that is required to have a license, permit or certificate has posted the license, permit or certificate where patients can see it and that the license, permit or certificate is current. If a license has expired, not only can the holder of the license be disciplined, the doctor can also be disciplined for allowing an unlicensed person to practice.

- If you have any questions, please call the OBD at 971 673-3200 or email information@obd.oregon.gov ■

Did You Know?

The Oregon Board of Dentistry (OBD) has implemented a new licensing system, and the process for requesting additional licenses or updating your contact info has changed.

To update your contact info or print a copy of your license, please log in or register for our Licensee portal at https://online.oregondentistry.org/#/

Dental Treatment of a Medical Condition – Sleep-Related Breathing Disorders

MICHELLE ALDRICH, D.M.D.

For decades dentists have been successfully treating Obstructive Sleep Apnea (OSA) and other sleep-related breathing disorders (SRBD). Oral appliance therapy (OAT) is usually very well tolerated and has been proven to have increased compliance as opposed to CPAP type therapies. There still is no easy way to predict which patient will have a better outcome with OAT. Therefore, it is very important to disclose this information to the patient in advance of starting this therapy.

Although snoring is nothing more than the vibration of tissues in the oropharynx, it can be a source of embarrassment and relationship difficulties. A dentist should never treat snoring without a diagnosis of "Primary Snoring" from a physician to rule out OSA. We cannot make assumptions and treat a patient inappropriately.

Organizations providing training and "standards of care" for the treatment of SRBD's work collaboratively with their physician counterparts. They agree in the co-management of patients with the physician being the diagnosing party and providing a prescription for OAT. They also agree the appliance must be properly titrated until maximum medical improvement. At that point, the physician must confirm efficacy of our treatment with a follow-up sleep study.

Physicians also agree a dentist (with appropriate training) is the professional to provide this therapy to patients. A dentist is uniquely trained to diagnose if a patient has dentition or implants stable enough to support OAT. Dentists are able to manage and predict potential side effects of treatment. The dentist can also decline to treat the patient if the risk of harm exceeds the potential benefit of the treatment and provide appropriate referrals.

Oral appliances must be titrated to determine when maximum medical improvement has been reached. This cannot be determined by subjective symptoms alone. An objective test must be administered to determine if the appliance is reducing apneic episodes and improving oxygen desaturations during sleep. The Oregon Dental Practice ACT does not prohibit the use of this testing equipment.

Extensive communication with our physician colleagues in the form of letters, FAX's, telephone calls, emails, etc., keeps them in the loop regarding the patients they have entrusted to our care. A major complaint of referring physicians is the lack of communication once the patient has been referred. Dentists must be consistent with communications so physicians can feel confident in the care of our mutual patients.

It is recommended we do at least annual follow-ups to see if the appliance is still effective, functional, and the patient is compliant. These visits should also trigger a letter to the referring physician. Side effects, such as open contacts or change in occlusion, should be documented, and reviewed with the patient.

It is the responsibility of the dentist to understand medical billing practices and not commit insurance fraud, even unintentionally. Insurance providers are not lenient in the case of ignorance. Protect yourself with knowledge and a mentor/organization with integrity.

Recent communications with the OBD from a leading dental sleep organization is recommending a dentist be able to order the initial home sleep apnea test from a third party, have it scored and diagnosed by a physician remotely, and a prescription given for OAT, if appropriate. Their reasoning is the lack of sleep physicians and the huge societal burden of undiagnosed people with OSA. The OBD has not taken a formal position on this recommendation. Remember, the use of telehealth does not expand the scope of practice of a dental care provider. However, working in close cooperation with our physician colleagues would be the preferred path of treatment.

Treating patients with OSA and SRBD can be a rewarding addition to your practice and provide a valuable service to your patients. Just like other specialties, if you chose not to provide this service, there are many knowledgeable providers you can collaborate with or refer to. ■

Frequently Asked Questions

Q: What information must I maintain in the patient record & give to the patient when placing implants?

A: OAR 818-012-0070(4) Requires when a dental implant is placed the following information must be given to the patient and maintained in the patient record: (a) Manufacture brand; (b) Design name of implant; (c) Diameter and length; (d) Lot number; (e) Reference number; (f) Expiration date. The product labeling stickers containing the above information may also be used in satisfying this requirement.

A message on wellness from dr. julie spaniel, Oregon Wellness Program

Dentists have long been regarded as the guardians of health, dedicating ourselves to caring for our patients' needs, alleviating their fears while pursuing perfection in our work. However, behind our white coats lies a poignant reality -dentists, like anyone else, can suffer from mental health disorders, burnout, or substance use disorder, to name a few. This unspoken struggle affects our well-being, patient care, and the healthcare system as a whole. There are challenges faced by dentists with mental health disorders to seek care for us. Many of us simply suffer in silence due to the stigma surrounding mental health or substance abuse as a healthcare provider. The Oregon Dental Association takes mental health seriously and has partnered with the Oregon Wellness Program to provide complementary and confidential counseling and education to dentists in the state.

The ODA understands the significant issues surrounding education, self-awareness, admittance of a problem and seeking help for any issues we may have with our mental health or substance use. The Wellness Ambassador program was implemented as a Confidential Peer to Peer model for dentists and dental students to simply talk with someone who understands. In 2020, the ODA partnered with the Oregon Wellness Plan and thanks to a 3-year grant from Permanente Associates, we were able to refer dentists for 8 free and confidential mental health sessions with a licensed therapist. The usage of OWP is now covered by a portion of our licensure fees.

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. The purpose of the Oregon Wellness Program is to ensure physicians, advanced care practitioners, dentists and other 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.

OWP affiliated providers offer:
Up to eight complimentary sessions per calendar year
Appointments are generally available within three business days.
Care without a "paper trail" or reporting to insurance or professional boards.

Understanding and acknowledging the issues in our profession is the first step to awareness that there could be a problem. Self-evaluation and self-awareness through an honest lens is vital.

1. Stress and Pressure: Dentistry is a high-pressure profession, we often face tight schedules, deal with challenging cases, and must maintain a high level of precision in our work. The pressure to perform flawlessly and handle a variety of patient needs can lead to stress and anxiety.

2. Emotional Toll: We may encounter patients in pain or distress, and witnessing the emotional struggles of our patients can take a toll on their own well-being. The empathetic nature of healthcare work can be emotionally draining.

3. Long Working Hours: Many of us, especially in our first decade of practice, can work long hours, juggling between patient appointments, administrative tasks, and continuing education. The demanding schedule can leave little time for self-care and relaxation.

4. Financial Burden: Student loan debt affects nearly all recent graduates. Balancing work, school loans, cost of living, is extremely stressful in the first few years of practice and can limit choices. Starting and maintaining a private dental practice can be financially prohibitive. Financial stress contributes to mental health challenges.

5. Isolation: Solo practitioners or dentists working in smaller clinics can easily hide their issues from others. Physical or emotional isolation exacerbates the problems.

6. Perfectionism: Dentistry requires precision and attention to detail, leading some dentists to develop a perfectionist mindset, which can worsen stress and anxiety. Feelings of inadequacy or comparison to others can lower self-worth.

7. Limited Work-Life Balance: Struggling to balance personal life with the demands of a dental career can lead to burnout and negatively impact mental well-being. This can be especially true in the first decade of practice when balancing a growing family and finances.

8. Stigma Surrounding Mental Health: The stigma surrounding mental health issues within the healthcare community may deter dentists from seeking help or admitting their challenges. Having insurance records show treatment sought for mental healthcare, or any written record of treatment can intimidate us from seeking the care we need.

Seeking help for mental health issues can be daunting for dentists. Fear of judgment from colleagues and the belief that admitting vulnerability may be perceived as weakness often prevents us from seeking support. The belief that we must be perfect and cannot have a human experience such as a mental health challenge, can also hinder their willingness to seek help, as they may feel they should always be strong and resilient. The ODA Wellness Ambassadors and the Oregon Wellness Program are available to help.

Our profession is extremely rewarding. It is a career choice that affords us the ability to help others and bring a better quality of life to people's lives. But we cannot pour from an empty cup. We can only do our best if we are at our best. ■

Oregon Wellness Program

Good news for Oregon Board of Dentistry licensees! Starting August 18th, all licensees – dentists, dental therapists, and dental hygienists – will have access to highly confidential mental health services through the Oregon Wellness Program (OWP). Self-referral is all that is required and the Board is not involved or aware of anyone accessing it.

The OBD included a policy option package in its 2023 -2025 legislatively approved budget to help fund this service through July 1, 2025. It more than likely will continue on after that as well.

Any Licensee may contact the OWP and receive up to eight free visits per calendar year. Interested licensees can make a self-referral by visiting the OWP website to review available providers and contact providers directly to schedule an appointment. Visits are available in-person or via telehealth. There is no reporting to a primary health provider or billing of insurance.

The Oregon Board of Dentistry is committed and supportive of our licensees to utilize all available tools for success in their practice and in all aspects of life.

If you are having thoughts of suicide, Call or Text 988, Veterans press 1.

Oregon Dental Hygienists' Association

OREGON DENTAL HYGIENE CONFERENCE
NOVEMBER 10-11, 2023
SALEM CONVENTION CENTER

Registration opens in August. Sponsors and Exhibitors can sign up now.

Link for more details: https://www.odha.org/odha-2023-annual-conference

The 2023 Oregon Dental Hygiene Conference will be in Salem at the Salem Convention Center, November 10-11 and ADHA Vice President Lancette VanGuilder, BS, RDH, PHDHE, will be our Friday keynote speaker presenting 'Don't Just Survive….Thrive! where she will talk about opportunities for dental hygienists to stay relevant, participate in meaningful work and fulfill their sense of purpose. She is also presenting two other courses on Friday: Make the Shift in Oral Cancer Prevention: HPV and Oral Health Care and AI: Artificial Intelligence in Health Care in Dentistry. Lori Killen Aus, RDHEP, MA, will be presenting a course on Speaking Alzheimer's/Dementia as a Second Language.

In addition to receiving two days worth of CE, enjoying student poster sessions, and celebrating our award recipients you'll have the opportunity to network and make new friends with fellow RDH's from all over the state. Join us in the capital city of Salem where we will be in the heart of downtown with so much to do within steps of our conference venue!

A new sponsorship package has been added to sponsor 25 students so they can benefit from being able to attend the conference! Your company will have a dedicated presentation time for the students, you'll have an exhibitor table and will be recognized in other ways throughout the conference. More details can be found here.

Details on the conference and hotel can be found here. Sponsors and exhibitors can sign up now and attendee registration opens in August.

OREGON RDH RETREAT
AUGUST 19, 2023
BORING, OREGON

Link for more details: https://ordha.memberclicks.net/index.php?option=com_jevents&task=icalrepeat.detail&evid=166&Itemid=115&year=2023&month=08&day=19&title=in-person-ce-oregon-rdh-retreat&uid=bd63185ce30999f62b85955c95444e21

The Oregon Dental Hygienists' Association is hosting our first Oregon RDH Retreat on Saturday, August 19, 2023. We are

excited to be gathering at President Tracy Brunkhorst's house in Boring, Oregon with beautiful and relaxing views of Mt. Hood as our retreat background.

This event will focus on clinician's health and after a morning mingle with our RDH colleagues we'll hear from Katrina Klein, RDH, CEAS, CPT who is the CEO of Ergo Fit Life. She will be presenting on Dental Career Longevity – Putting the Pieces Together (2.5 hours of CE). Katrina is dedicated to helping dental professionals stay pain-free during their career and with her extensive knowledge of biomechanics and ergonomic strategies, she has implemented daily practices that prevent injury and promote posture enhancement.

Lunch is included with your registration and all attendees will have a chance to win a $100 gift card as well as everyone will take home a special gift from the retreat. Space is limited so register today here!

MEDICAL EMERGENCIES AND NITROUS OXIDE SEDATION – UPDATE 2023
SEPTEMBER 9, 2023
IN-PERSON (PORTLAND) AND VIRTUAL

Link for more details: https://ordha.memberclicks.net/index.php?option=com_jevents&task=icalrepeat.detail&evid=168&Itemid=115&year=2023&month=09&day=09&title=in-person-a-virtual-ce-medical-emergencies-a-nitrous-oxide&uid=86a71eae0d32ef853d05976dac07a69e

Required Medical Emergencies CE being offered by ODHA for your RDH license renewal in September
The Oregon Dental Hygienists' Association is hosting Steven Beadnell, DMD, FICD, FACD in Portland for 4 hours of CE on a topic required for your license renewal in September: Medical Emergencies and Nitrous Oxide Sedation – Update 2023. Continental breakfast is included in your registration fee and you can attend either in-person or virtually.

Medical emergencies can and do occur in dental practices every day. Over the next fifteen years the segment of the population at highest risk for medical emergencies, those 65 and older, will become a larger percentage of our patients. This course will discuss the diagnosis, prevention, and management of common medical emergencies that might occur in dental offices.

More details and the link to register can be found HERE. ■

Oregon Dental Assistants Association

Is four-handed dentistry a lost art or has it just been on a pause for the past few years? Many things may contribute to the decline in the practice of four-handed dentistry including the funds for Dental School, Dental Auxiliary Utilization (DAU) programs that dwindled during the past several years. This resulted in dental students who graduate without the extensive 4-handed dentistry training they once had.

Interest in becoming a dental assistant has declined due to many reasons found in a study, Dental Workforce Shortages, Data to Navigate Today's Market by ADA, ADAA, ADHA and DANB. The pandemic which targeted dentistry as a highly contagious environment was a deterrent for many who were either working as a dental assistant or were thinking about becoming one. Or could it be the new high-tech dental equipment and techniques make it appear the need for a well-trained, four-handed dental team is no longer needed?

ODAA believes four-handed dentistry is alive and well and the backbone of a successful dental practice. The dental assistant is the navigator and co-pilot who supports the dental practice not only chairside while working directly with patients but throughout the entire dental practice. This is also the opinion of many successful dentists.

Oregon has 9 CODA community college dental assisting programs located throughout the state. A variety of non-CODA Programs are available as well. All these programs focus on four-handed dentistry skills, how to support the dental practice, provide optimum dental patient care and the importance of dental assisting as a profession. Also, the Oregon Board of Dentistry, Division 42 provides pathways to becoming a dental assistant through On-the-Job training by a licensed dentist.

The concept of four-handed dentistry was founded in the 1960's. In her book Four Handed Dentistry, Betty Ladley Finkbeiner, CDA, RDA, MS, wrote "Four-handed dentistry is a team concept where highly skilled individuals work together in an ergonomically designed environment to improve productivity of the dental team, improve the quality of care for dental patients while protecting the physical well-being of the operating team." Although this was a concept created long ago it still exists in dental and dental assisting textbooks and if practiced can create a positive working environment where dental team members can thrive.

Along with the unique practice of four-handed dentistry, dental assistant expanded functions provide professional growth and an increase of production which in-turn increases profit for the dental practice. Business minded dentists engage in these concepts, use dental assistants to their fullest potential and are realizing the benefit in a positive way.

Getting the word out about dental assisting as a viable profession has been challenging. High school career programs focus on dental school and dental hygiene as career options. Dental assisting is viewed as a pathway to these two careers and not necessarily a career that a person would remain employed in over a long period of time.

ODAA is collaborating with Adec to create a video that demonstrates a dental team using four-handed dentistry techniques to perform restorative procedures on a "live" dental patient. The concept is to have a finished product that can be obtained at no cost by anyone who may be interested in showing how a dental assistant works with a dentist using four-handed skills.

When a dental team works together using the four-handed dentistry technique, it is a bit like a dance and requires little discussion of the procedure during the restoration process. Dentists rely on their dental assistants to use critical thinking skills and to anticipate. These skills take time for both the dentist and the dental assistant to learn but once developed there is no going back to dentists grabbing their own instruments or making their own temporary crowns. It is a seamless team effort that dentistry cannot afford to ignore. ■

American Dental Therapy Association

The American Dental Therapy Association (ADTA) is a national organization (501c3) that promotes oral health and overall wellness to underserved communities, including American Indian/Alaska Natives, who have the largest disparities in oral health and wellness. Our current board consists of 5 dental therapists from Oregon, Minnesota and Washington. Our mission is to ensure that all Americans have access to high-quality oral health care.

Founded in 2006, the American Dental Therapy Association (ADTA) is the national professional society for dental therapists. Each year, the ADTA supports dental therapists in providing vital oral health care to hundreds of thousands of Americans. We educate the public about the value of dental therapists, create educational and career advancement opportunities for dental therapists, and support educational institutions in developing superior dental therapy programs.

In 2022, the ADTA received an in-kind donation from the Northwest Portland Area Indian Health Board and Community Catalyst to hire an interim Executive Director. We then were able to secure funding to hire a permanent staff member, an Executive Director, who was hired in December of 2022; Cristina Bowerman. In April 2023 we were able to hire a part time communications staff member; Chelsea Luong. Since then, the ADTA has transformed from an all-volunteer led association to a staff run association. We greatly thank those before us that made this path possible.

In 2022, the ADTA opened membership to all: dental therapists, dental therapy students, organizations, other oral health care provider types, and even members of the community.

Inaugural Annual Conference: The ADTA is hosting its Inaugural Annual Conference in Oklahoma City, Oklahoma October 5th-7th. The purpose of our conference being held in Oklahoma is to provide support to the state as they prepare to submit legislation that will authorize dental therapy in Oklahoma. This is meant to be an information session for professionals to network and learn all things dental therapy. There will also be dental continuing education offered up to 13.5 credits. You can see our flipbook including our agenda here. Registration for our Inaugural Annual Conference is now open and can be found here. ■

Have you moved recently?

ORS. 679.120(4), 679.615(5), and 680.074(4) requires that licensees update the Board within 30 days of any change of address.

To update your contact info, please go to www.oregon.gov/dentistry and click "Licensee Portal" for instructions.

It's the law!

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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

H8637	HARRIS, SHELBY LYNN	2023-06-08	RDH
H8638	BREAZILE, KACHELL	2023-06-12	RDH
H8639	MCINNIS, JESSICA JANE	2023-06-12	RDH
H8640	THOMPSON, ABIGAIL JANE	2023-06-12	RDH
H8641	CORPUS, MAKENA MARIE	2023-06-12	RDH
H8642	MCFADDEN, LORI DAWN	2023-06-13	RDH
H8643	BECKER, JENSEN RENEE	2023-06-23	RDH
H8644	MICK, KAILA IRENE	2023-06-23	RDH
H8645	PAREDES CALVA, CRYSTAL DAWN	2023-06-27	RDH
H8646	RUIZ, LAUREN JEANNE	2023-06-27	RDH
H8647	BOKEL, EMILY KRISTINE	2023-06-27	RDH
H8648	BURKE, NORA	2023-06-27	RDH
H8649	COUTANT, EMILY FERN	2023-06-27	RDH
H8650	LAND, ANNA MARIE	2023-06-27	RDH
H8651	KEIM, HANNAH MARY	2023-06-27	RDH
H8652	PIEPGRASS, CORA LINDA	2023-06-27	RDH
H8653	DEVERNA, MADELINE	2023-06-27	RDH
H8654	MANGER, KATHERINE ROSE	2023-06-27	RDH
H8655	SOVYAK, JASMYN ELIZABETH	2023-06-27	RDH
H8656	RUSSELL, SAVANNAH ALESE	2023-06-27	RDH
H8657	GUTIERREZ, REYNA ANN	2023-06-27	RDH
H8658	SIEBERT, HAILEE ESTHER MAE	2023-06-28	RDH
H8659	HESS, TAYLOR JANE	2023-07-06	RDH
H8660	LOTSPEICH, ELIZABETH ANN	2023-07-06	RDH
H8661	KOZLIK, MARSCIA MICHELLE	2023-07-06	RDH
H8662	LAKEY, SHAYLYN DAWN	2023-07-06	RDH
H8663	DU TELL, ALETRIS ANN	2023-07-06	RDH
H8664	HOLEVAS, OLIVIA	2023-07-06	RDH
H8665	MOSES, MORGAN MG	2023-07-06	RDH
H8666	BLAS, ANTIGONIE	2023-07-07	RDH
H8667	SANTIAGO, NIKKI	2023-07-07	RDH
H8669	SHAW, KAILA SIERRA	2023-07-10	RDH
H8668	FREEMAN, JESSICA PAIGE	2023-07-10	RDH
H8670	RAMIREZ, MONICA	2023-07-10	RDH
H8671	BATTIN, MICHAEL W	2023-07-11	RDH

H8672	SULLY, STEFANIE	2023-07-11	RDH
H8673	CAN RAMIREZ, YABILEX	2023-07-12	RDH
H8674	GOOLSBY, RILEY RENEE	2023-07-13	RDH
H8675	SLOY, KENNA DANIELLE	2023-07-13	RDH
H8676	LEE, NANCY YOON SUN	2023-07-17	RDH
H8677	ZOOK, TORUN ACACIA	2023-07-17	RDH
H8678	BRESTEL, EMMA JEAN	2023-07-17	RDH
H8679	MACIEL, SEHOYA RAIN	2023-07-19	RDH
H8680	POWELL, CHRISTINE MARGARET	2023-07-20	RDH
H8681	COX, KENDRA B	2023-07-25	RDH
H8682	YANG, REBECCA SAEROM	2023-07-28	RDH
H8683	MARSHALL, CARLYNN KAY	2023-08-01	RDH
H8684	STOUT, JENNIFER	2023-08-01	RDH
H8685	REID, ASHTON LOUISE	2023-08-01	RDH
H8686	BALDRICA, MARY	2023-08-02	RDH

DENTISTS

D11802	GOEI, JULIA	2023-06-06	DDS
D11803	MEYER, CHLOE S.A.	2023-06-06	DDS
D11804	NGUYEN, MICHELLE	2023-06-06	DMD
D11805	DI CARLO, MICHELLE ANDREA	2023-06-12	DDS
D11806	AHRAR, JASMINE ELAINE	2023-06-12	DMD
D11807	WHITE, MEGAN	2023-06-12	DDS
D11808	DIAL, ELIZABETH ANNE	2023-06-12	DDS
D11809	WELLS, SAMUEL THOMAS	2023-06-12	DMD
D11810	BENSON, KEVAN	2023-06-14	DMD
D11811	CRAVEN, TRENT SCOTT	2023-06-14	DMD
D11812	HOANG, TIEN THUY	2023-06-21	DMD
D11813	KODALI, GIDEON PRASANTH	2023-06-22	DDS
D11814	FELTEN, NICKOLAS	2023-06-22	DDS
D11815	LEVASA, COURTNEY RENEE	2023-06-22	DDS
D11816	RIDDER, LINDA KWON	2023-06-23	DMD
D11817	POUDEL, ASMITA	2023-06-27	DMD
D11818	WANG, STEVEN	2023-06-27	DMD
D11819	BAHR, ADAM SPENCER	2023-06-27	DDS
D11820	GRABOWSKI, KYLE JAMES	2023-06-27	DDS
D11821	HUH, JAMIE	2023-06-27	DMD
D11822	AGRAWAL, PRIYADARSHINI	2023-06-28	DDS
D11823	MIRZAZADEH JAVAHERI, ARIA	2023-06-28	DMD
D11824	LAI, SUSAN	2023-06-28	DDS
D11825	FUKUTO, YASUYUKI	2023-06-28	DMD

D11826	HOLMES, TRISTEN	2023-06-28	DDS
D11827	AREFIEG, LAWRENCE LITHE	2023-06-28	DMD
D11828	WILLIAMS, LUCAS BENJAMIN	2023-06-28	DMD
D11829	MANSUKHANI, KUNAL	2023-06-28	DMD
D11830	BIRRER, SARA MAUREEN	2023-06-28	DMD
D11831	DHARMALA, DEVIKA REDDY	2023-06-28	DDS
D11832	HUYNH, MONICA	2023-06-28	DMD
D11833	HANSON, MARY ALANNA	2023-06-28	DMD
D11834	MCCARTHY, HANNAH ELIZABETH	2023-06-28	DMD
D11835	COOK, ABIGAIL MEREDITH	2023-06-28	DMD
D11836	SCANLON, CONOR	2023-06-28	DMD
D11837	DAVIS, BARRON	2023-07-06	DMD
D11838	GURZHUY, YELISEY AURELOVICH	2023-07-06	DMD
D11839	BAJRACHARYA, YASHASWI	2023-07-06	DMD
D11840	YANCHUK, ALEKSANDR MARIN	2023-07-06	DMD
D11841	HUNSAKER, BROOKS	2023-07-06	DMD
D11842	DEGRAFFENRIED, DALLIN ASHTON	2023-07-06	DDS
D11843	BARBER, ERIN	2023-07-06	DMD
D11844	HARDIN, JOSHUA TOD	2023-07-06	DMD
D11845	PATEL, KAELAN	2023-07-06	DMD
D11846	OTGONBOLD, MURUUDUL	2023-07-06	DDS
D11847	ZAGORODNY, HELEN ALEXANDRA	2023-07-06	DMD
D11848	CHALISE, VASVI	2023-07-06	DMD
D11849	HAN, JEE YOUNG	2023-07-06	DMD
D11850	PATEL, KARAN ARUN	2023-07-07	DMD
D11851	CASEBEER, CHAD JOHNSEN	2023-07-07	DMD
D11852	CREIGHTON, CORAL ESTHER STROM	2023-07-07	DMD
D11853	NORLIN, SIERRA JEAN	2023-07-10	DMD
D11854	CHEN, DAVID	2023-07-11	DMD
D11855	OSBORNE, WYATT EDWARD	2023-07-12	DMD
D11856	MUDROW, KEVIN R	2023-07-13	DDS
D11857	SHIELDS, JENNIFER	2023-07-14	DMD
D11858	PHEN, CAMERON	2023-07-17	DDS
D11859	THOMSEN, KAILEY MARIE	2023-07-17	DDS
D11860	GILL, JASKIRAN KAUR	2023-07-17	DMD
D11861	SERCIA, ASHLEY ROSE	2023-07-17	DMD
D11862	UYEDA, EVAN TAIZO	2023-07-17	DMD
D11863	SILVA MERCADO, MARIA DEL SOCORRO	2023-07-17	DMD
D11864	YAHN, MARGARET MACKENZIE	2023-07-19	DMD
D11865	LAZAR, ASHLEY	2023-07-19	DMD
D11866	MUNN, GRAYSON ALEXANDER	2023-07-19	DMD
D11867	JAMES, ALLISON NICOLE	2023-07-19	DMD
D11868	PEDERSON, MELVIN DAVID	2023-07-20	DDS
D11869	LE, CHRISTIE	2023-07-20	DMD
D11870	HUANG, TIFFANY	2023-07-20	DDS
D11871	BOHNSTEDT, RYAN WALTER	2023-07-24	DMD
D11872	FOX, DYLAN CHARLES	2023-07-24	DDS

D11873	AMINI, SOROUSH T	2023-07-25	DMD
D11874	MOSHARRAF, HESAM	2023-08-02	DMD
D11875	SCHULTE, KRISTA CIARRA	2023-08-02	DMD

DENTAL THERAPISTS

DT0016	JOHNSON, DAWN	2023-06-12	DT

LICENSE, PERMIT & CERTIFICATION

Nothing to report under this tab